

The Uninsured:

A STUDY OF HEALTH PLAN INITIATIVES AND THE LESSONS LEARNED



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CONTENTS

Executive Summary	1
Discussion of Private Sector Initiatives	13
Lessons Learned	19
Recommendations	37
Policy Context	42
Conclusion	46
Acknowledgements/Endnotes	48
Appendix	51

About the NIHCM Foundation

The National Institute for Health Care Management Research and Educational Foundation is a nonprofit organization whose mission is to promote improvement in health care access, management, and quality.

About This Report

This report was written with support from the Robert Wood Johnson Foundation. The authors are solely responsible for the content and take full responsibility for any errors herein. The study is not in any way meant to represent the views of the Robert Wood Johnson Foundation or any other organization.

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY	1
II. DISCUSSION OF PRIVATE SECTOR INITIATIVES	13
What are the characteristics of the health plans offering products to the uninsured?	13
What are the characteristics of the products?	13
Have the initiatives reduced the number of the uninsured?	14
Are the private sector initiatives replicable?	15
III. LESSONS LEARNED	19
A. Marketing	19
B. Benefit Design	22
C. Financing	25
D. Target Population	29
E. Providers	31
F. Program Duration	32
G. Transitions	34
H. Enrollment and Operations	35
IV. RECOMMENDATIONS	37
Marketing	37
Benefit Design	38
Financing	39
Target Population	40
Provider	40
Program Duration	41
Transition	41
Enrollment and Operations	42
V. POLICY CONTEXT	42
How would the following proposed federal policy changes affect program recommendations and affordability of private sector products?	43
How would the following proposed state policy changes affect program recommendations and affordability of private sector products?	45
VI. CONCLUSION	46

ACKNOWLEDGEMENTS/ENDNOTES	48
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APPENDIX	51
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Objectives and Methodology	53
Federal Poverty Guidelines	54
Program Descriptions	55
Affordable HealthChoices	55
BlueCare	57
Buy Direct PPO	59
Chamber Choice	61
The Dues Subsidy Program (Child Health Plan-1 and -2, Steps)	64
Memorial Advantage	68
Mid America Health Choice	71
PlanScape and FlexScape	73
Small Business Health Insurance	77
Special Care	80



TABLES AND FIGURES

Figure 1: Uninsured Growth Rate by Household Income, 2001	1
Figure 2: Targeting Solutions for the Uninsured	2
Table 1: Description of Initiatives	6
Table 2: Lessons Learned	9
Table 3: Key Recommendations	11
Table 4: Private Sector Program Overview	14
Table 5: Synopsis of Small Group Insurance Products	17
Table 5: Synopsis of Individual Insurance Products	18
Table 6: Strategies Used to Market the 13 Initiatives	22
Table 7: Financing Mechanisms to Make Products More Affordable	28
Figure 1: Multi-Step Enrollment Process	35
Table 1A: Federal Poverty Guideline	54

THE UNINSURED: A STUDY OF HEALTH PLAN INITIATIVES AND THE LESSONS LEARNED

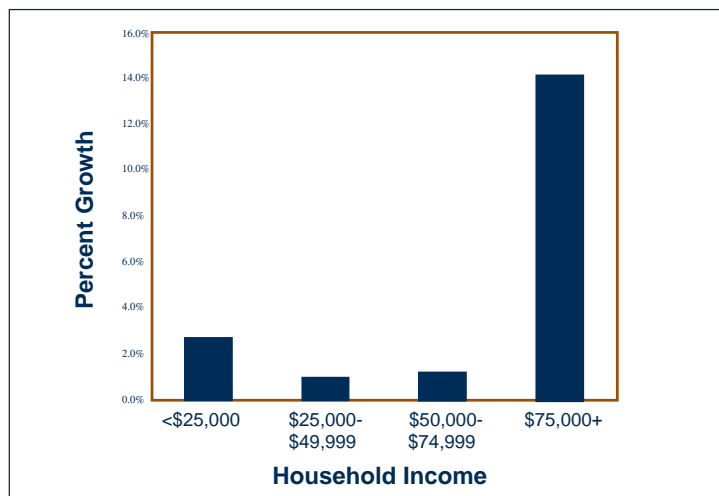
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I. Executive Summary

The number of Americans without health insurance rose to 41.2 million in 2001, up 1.4 million from 2000.¹ Of the 1.4 million Americans who joined the ranks of the uninsured in 2001, 800,000 – 57% – lived in households with incomes of \$75,000 or greater.² A further increase in the number of uninsured is widely anticipated for 2002 and 2003, attributable to the continued sluggish economy, state budget crises and rising health care costs.³

The uninsured are a heterogeneous population. They reflect the full spectrum of Americans. Indeed, broader swaths of the population are increasingly vulnerable to the loss of coverage. As the configuration of the uninsured changes to include a greater percent of middle- and higher-income people, strategies to address health insurance gaps must expand as well.⁴ The population of uninsured people with household incomes of \$75,000 and above grew 14% in 2001 (from 5.8 million to 6.6 million) compared to a 2.7% growth rate in the number of uninsured with household incomes of \$25,000 or below (see Figure 1).

FIGURE 1: UNINSURED GROWTH RATE BY HOUSEHOLD INCOME, 2001

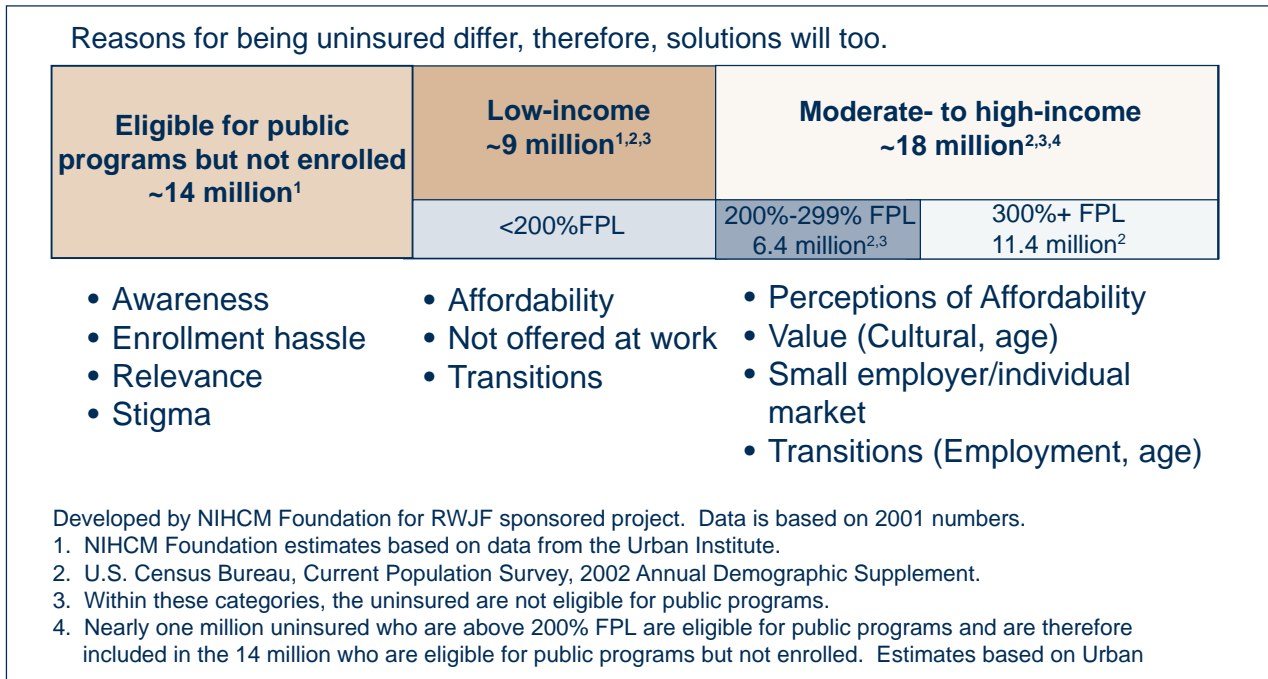


SOURCE: NIHCM Foundation analysis of U.S. Census Bureau data, 2002.

Although the dividing lines are porous and always in flux in real life, it is useful from a policy standpoint to place the 41.2 million uninsured (2001) into three categories according to both their eligibility, or lack thereof, for public insurance programs and their income bracket: (See Figure 2)

- Those eligible for public programs but not enrolled. Over 14 million uninsured Americans, most of them low-income, fall in this segment.
- Low-income people who do not qualify for public programs. About 9 million uninsured Americans fall in this segment.
- Moderate- to high-income Americans. About 18 million uninsured people fall in this segment, with 11.4 million having incomes over 300% of poverty or \$54,300 for a family of four.⁵

FIGURE 2: TARGETING SOLUTIONS FOR THE UNINSURED



The diversity and growing income stratification of the uninsured requires a segmented approach to addressing their plight rather than one single, simple solution.

- **Eligible for public programs but not enrolled:** Many low-income uninsured people eligible for Medicaid or the State Children’s Health Insurance Program (SCHIP) are not enrolled. This is because they may be unaware of the programs or how to enroll. Many are also reluctant to participate because of the stigma associated with state “welfare” programs. And the paperwork can be quite burdensome for potential enrollees who are poorly educated. Enhancing and simplifying eligibility, streamlining enrollment, and improving outreach are widely promoted as key paths to broaden coverage in this population group. Concerns going forward center around the ramifications of state budget crises.
- **Low-income but not eligible for public programs:** Affordability is the biggest issue for the low-income uninsured who are not eligible for public programs. A family of four in this segment earns between \$18,100 to \$36,200, and therefore has limited resources to purchase insurance. Because a large portion of this group is employed either full-time or part-time, some advocate increasing employment-based health insurance coverage using targeted state and federal subsidies. Others suggest expanding public programs to cover this group.

People between 100% and 200% of poverty would benefit most from programs that seek to identify those in a health insurance “transition” – those families, for example, where the breadwinner has lost a job and health coverage and whose children may be eligible for SCHIP. Likewise, people dropped from Medicaid because they move into the workforce and are no longer eligible may qualify for transitional Medicaid if they get a job that does not offer coverage. Hundreds of thousands if not millions of people fall into these transition gaps each year and could be helped by proactively identifying their status.

- **Moderate- to high-income:** While access and affordability remain a problem for some people and families in this segment, many appear to be able to afford to buy health insurance (either at work or on their own) but do not do so. About 11.4 million uninsured people make over 300% of poverty. Reasons they do not purchase insurance vary. One study shows that many individuals in this category perceive premiums to be more costly than they in fact are and that nearly one quarter would purchase insurance if they knew the real price.⁵ Some of the nonpoor opt out of buying insurance because they do not see a need for it, whether it be due to cultural reasons or because they do not see the value in it. For young healthy people, this is particularly an issue because in effect they subsidize health care expenditures of older, less healthy individuals. Those who work in small businesses or are self-employed may not be offered insurance or opt out. For this group, solutions look quite different than for a family that has been on and off the Medicaid program several times during the last five years.

While federal and state lawmakers have understandably and appropriately focused resources on expanding health insurance coverage among low-income Americans, and particularly children (under SCHIP), the trend to increasing numbers of nonpoor uninsured is forcing attention to solutions targeted at this group as well.

Expanding coverage among this group will likely involve private sector initiatives and programs that may sometimes be constructed in collaboration with government or supported by government.

FACTORS CAUSING LACK OF INSURANCE

Americans have short-term gaps in coverage or lack coverage for longer periods for a variety of reasons. These have been well documented and researched in recent years and include:

- **Age** – Young adults (18 to 30) are far more likely to be uninsured, primarily because they change jobs often, have more periods without a job, and are more likely to work part-time and at jobs where insurance is not offered. Almost 60% of the uninsured were younger than age 35 in 2001.
- **Ethnicity** – Hispanic Americans are three times and Black Americans are two times as likely to be uninsured as White Americans.
- **Employment** – People who own or work in small businesses (less than 25 workers) in 2001 were half as likely to have health insurance as those who work at companies with 100 or more employees.
- **Eligibility** – Millions of people lack coverage because of employer and public program eligibility criteria. Employers for example may have waiting periods before new employees can sign up for their health plans. They may also not cover temporary and part time workers. States can have elaborate eligibility criteria for Medicaid, SCHIP, and other public programs.
- **Transitions** – People lose coverage primarily when they change, or lose a job, retire before age 65, or age out of a parent's policy. Close to half of those who lose a job have a gap in coverage for at least one month. Medicaid and SCHIP enrollees may lose coverage when they lose eligibility. A quarter of Medicaid enrollees cycle off the program in any given year.
- **Income/Affordability** – Poor and near-poor Americans are more likely to be uninsured. They simply can not afford it. However, increasing numbers of middle income and even higher income people are uninsured.

MORE NONPOOR AMERICANS ARE UNINSURED. WHY?

In 2001, 11.4 million (28%) of the 41.2 million Americans without health insurance lived in households with incomes at 300% of the federal poverty level or above.

Increasing numbers of non-poor Americans are uninsured for a variety of reasons:

- ***An increase in the number of Americans in middle and higher income brackets.*** In 1980, 13.4% of American households had incomes of \$75,000 or more. That rose to 18.6% of households by 1990 and 24.6% by 2001.⁷ Between 1998 and 2000, almost 6 million Americans joined the ranks of those living in households with incomes of 400% or more above the federal poverty level (\$72,400 for a family of four; \$35,440 for an individual). In contrast, the number of Americans living in households below 200% of poverty (\$36,200 for a family of four; \$17,720 for an individual) declined by 300,000 between 1998 and 2000.⁸ Even young adults who typically earn substantially less than their elders have shifted to higher income brackets over the years.
- ***Labor market, business and economic trends.*** Self-employment, part-time, contract and so-called “contingent” work became more common throughout the 1990s. In 2001, 7.3% of all workers (9.8 million) were self-employed, up from 6% (7.1 million) in 1990. About 23 million people (17%) in the nation’s full-year work force of 134 million worked part-time in 2001.⁹ Health coverage is less likely in both situations; about one in four (23.6%) self-employed people are uninsured, for example. Likewise, 22% of part-time workers were uninsured.¹⁰ Many part-time workers are members of households that also have another working member. These workers, however, may not have insurance even though their household income may exceed poor or near-poor levels.
- ***Costs and premiums.*** More middle and upper income Americans are uninsured because of escalating health care costs. During the past two years health care spending increased by \$204.8 billion, or 16.8%, totaling over \$1.4 trillion in 2001.¹¹ Health care costs went up largely because of increasing spending on hospitals and prescription drugs. These increases have driven the rise in health insurance premiums. In 1998, the average cost of employer-sponsored health insurance was \$3,817 per employee. That rose to \$5,646 in 2002.¹²
- ***The retiree factor.*** Retiree coverage has steadily declined since the early 1990s. Two-thirds (66%) of U.S. companies offered retiree health benefits in 1988. That declined to 34% of companies in 2002.¹³ About 18% of early retirees were uninsured compared to 12% of those aged 55 and above who remain employed. Low-income 50 to 64 year olds (household income below \$25,000) were most at risk of having no health insurance – about 30% lacked it in both 1989 and 1999. But the proportion of middle and higher income 50 to 64 year-olds with no coverage rose between 1989 and 1999, from 12% to 14% of middle income (\$25,000 to \$75,000) and from 4% to 6% of those earning \$75,000 or more.¹⁴

For nearly two decades, private health plans have experimented with designing products to reach uninsured individuals and small businesses. In 1985, Highmark Blue Cross Blue Shield launched the Caring Program for Children. The program targeted uninsured children not eligible for Medicaid who lived in households with incomes up to 200% of FPL. The program was replicated nationwide by many other health plans and eventually served as an inspiration and model for the national SCHIP program (enacted in 1997). And today, it is integrated with Pennsylvania's SCHIP program to cover kids up to 300% FPL.

Most recently, again working with the state, the Blues plans in Pennsylvania participated in adultBasic in June 2002. Subsidized with money from Pennsylvania's share of the tobacco settlement funds, this new program is targeted at residents aged 19 to 64 who have been uninsured for at least 90 days, are not eligible for public programs and whose incomes fall below 200% FPL (\$36,200 for a family of four). As of January 2003, adultBasic had enrolled 45,600 Pennsylvanians, up from 11,874 in September 2002.¹⁵

Reasons for the study and description of initiatives

A large volume of research over the last decade has examined government efforts to expand health insurance among low-income Americans, primarily through the Medicaid and SCHIP programs but also through many innovative state programs and market reforms. Relatively little recent research, however, has focused on efforts to get more of the nonpoor uninsured to buy health insurance through their employer or on their own. The primary impetus to this study was the need to better understand how private health plans have tried in recent years to reach the uninsured, and to identify the lessons learned from these efforts.

Limited by design, this study examines in detail 13 initiatives by 10 health plans that do not rely on government funding to expand health insurance coverage among the uninsured in the late 1990s and into 2002. The 10 health plans are evenly divided between for-profit and not-for-profit organizations. Six of the initiatives targeted the small group (small business) market, and seven targeted the individual market (See Table 1 on page 6). While health plans began addressing the uninsured primarily by crafting privately subsidized individual products, they have increasingly moved towards economically viable products for the small group market. This report describes the initiatives and assesses their enrollment of uninsured people, as reported by the plans. It also provides a detailed analysis of the design of the initiatives, lessons learned in creating and marketing them, and factors that increased their chances of success.

Findings and Lessons Learned

I. Health plan interest in reaching the uninsured

Health plans interviewed for this project state that they are increasingly interested in finding workable solutions to expanding health insurance coverage – for social, political and business reasons. They recognize that those without health insurance face negative health and financial consequences. In addition, they realize that the uninsured have a profound effect upon the entire health care delivery

Table 1: DESCRIPTION OF INITIATIVES

Small Group Products

WellPoint's product for firms with two to 50 employees, **FlexScape**, offers an array of PPO and HMO options. Depending on price, benefits vary from basic catastrophic to comprehensive packages with a range of deductibles and coinsurance levels. FlexScape became available in California in April 2001. (Enrollment as of January 2002: 797,000, 63% previously uninsured.)

Chamber Choice is a product for small businesses with up to 50 employees. Endorsed by the Greater Kansas City Chamber of Commerce, the product was created in 1994 by Blue Cross Blue Shield of Kansas City to address the low rate of small businesses which offer insurance to employees. (Enrollment as of October 2001: 39,600, 30-35% previously uninsured.)

Mid America Health Choice is a comprehensive health plan with low copayments and coinsurance for small businesses with two to 50 full-time workers. Mid America Health (formerly known as Health Net) developed Choice in 1994 in response to the Greater Kansas City Chamber of Commerce's challenge to expand health insurance to small businesses. The product was changed and reintroduced in 1998. (Enrollment as of October 2001: 15,000, 25% previously uninsured.)

Affordable HealthChoices (AHC) is a low-cost, employer-based hospital indemnity product for uninsured small businesses with two or more employees. Launched in 1999 by Aetna Inc., it offers hospital and some medical services paid in fixed-dollar amounts with no coinsurance or deductibles. (Enrollment as of October 2001: 2000.)

Small Business Health Insurance (SBHI)* is a low-cost product for small employers with two to 50 employees for the working uninsured in parts of New York City. It ran from 1999 to 2001 as a two-year demonstration project by Group Health Incorporated in partnership with the New York City Health and Hospitals Corporation and the Office of the Mayor. (Enrollment as of July 2001: 515, 17% previously uninsured.)

Blue Cross & Blue Shield United of Wisconsin's **Buy Direct PPO** became available in October 2000 as a low-cost option for small employers, start-up businesses, and the working uninsured. Model 1 has lower premiums, but higher out-of-pocket costs for employees; Model 2 has higher premiums with lower out-of-pocket costs. (Enrollment data not available.)

Individual Products

Established in 2001, WellPoint's individual product, **PlanScape**, is designed to provide the general public and the nonpoor uninsured with affordable health coverage. Like FlexScape, enrollees may choose from an array of PPO and HMO options with benefits ranging from catastrophic to comprehensive services. (Enrollment as of January 2002: 815,000, 49% previously uninsured.)

Special Care* is a low-cost indemnity plan for uninsured Pennsylvanians with incomes too high for public assistance (at or below 185% FPL), but too low to afford commercial health insurance. Through a coordinated effort begun in 1992 by four Blue Cross Blue Shield plans, Special Care offers physician, hospital, medical, and surgical coverage with first dollar coverage and limited out-of-pocket costs at half the price of other products. (Enrollment as of July 2001; over 61,000, all previously uninsured.)

In 1990, Kaiser Permanente (KP) began the **Dues Subsidy Program** to cover low-income people who could not afford or did not have access to health insurance. The Dues Subsidy Program in California now has three plan-subsidized comprehensive benefit products: **Child Health Plan-1*** for children with family income between 250%–300% FPL; **Child Health Plan-2*** for noncitizen children with family income up to 250% FPL; and **Steps*** to move adults and families with incomes of 100%–300% FPL to full cost products via tiered premium levels. (Enrollment as of May 2002: 1,953, Child Health Plan-1; 3,131, Child Health Plan-2; and 14,501, Steps. All previously uninsured.)

Memorial Advantage* is a health cost assistance program for St. Joseph County, Indiana residents with incomes at or below 200% FPL. Started in 2001 as a two-year pilot, Memorial Advantage offers preventive medical, emergency, and hospital services. The program is sponsored by Memorial Health System along with a medical group, pharmacy, medical foundation, and physician specialty groups contracting with Memorial. (Enrollment as of July 2001: 250, all previously uninsured.)

BlueCare is an insurance plan for low-income uninsured individuals residing in Montana. With a coalition of providers and hospitals, Blue Cross Blue Shield of Montana launched BlueCare in July 2001 to provide limited benefits such as medical, hospital, and prescription drug coverage. Initially available to those with incomes up to 150% FPL, eligibility was increased in April 2002 to incomes up to 175% FPL. (Enrollment data not available.)

* Indicates subsidized product.

system. Uncompensated care is financed by the insured through taxes and higher premiums.¹⁶ Providing coverage for the uninsured has the potential to make health care delivery more affordable and efficient.

Plan representatives interviewed for this project also worried that failure to find collaborative public sector/private sector solutions to the uninsured problem would lead eventually to government intervention unfavorable to the insurance industry. Few health plan decision-makers want additional restrictions on their product rates, benefits, or other attributes.

Instead they would prefer to create new, innovative lines of products that would increasingly appeal to small businesses and low to moderate-income persons, including those lacking insurance. Plan representatives stated that they would like to work with the government to find the right balance of flexibility to create such products, recognizing the inherent tension between attracting younger, healthier workers with less expensive coverage and providing protection for older, sicker workers.

Health plan representatives saw opportunities to expand coverage in the small group and individual markets.

- *Small group market* – This study shows that some health plans have attempted in recent years to broaden coverage among small firms by providing a wider choice of benefit packages, increasing cost sharing, and cross-subsidizing premiums. Some health plan representatives stated that they would like more flexibility to craft products that appeal to the smallest employers (under 10 workers) who are the least likely to offer coverage.
- *Individual market* – Several health plan representatives said that their plans want to make coverage more broadly available to young adults. The large portion of young Americans who are uninsured skews the age range of the covered “pool” of the population. Enrolling more of this low-risk population could actually help make health insurance more affordable for everyone else since their premiums will cross subsidize care of less healthy older Americans. Some health plans created less expensive products through subsidies or by modifying product features to reach low-income, part-time, and temporary workers to aid their communities.

Health plan administrators said they were interested in trying new programs and products to target the uninsured. Such initiatives could be vital to extending coverage in a time of tightened government budgets. And generally, if such initiatives can be financially viable, they will grow without dependence on government funding which can rise or fall with tax revenues and other external factors.

Health plan representatives stated that tax credits or other subsidies would be beneficial to helping them provide services more broadly to the uninsured.

II. Enrollment

The findings here are mixed. Six of the programs met enrollment targets, with 25% to 100% of enrollees having been previously uninsured. These programs can be said to have been a success based on scope, enrollment targets and realistic expectations. Five of the initiatives did not reach

enrollment targets, though they did reduce the number of uninsured people, if only marginally, in their market areas. Two of the programs failed to get off the ground under their initial designs – primarily due to marketing problems. Both were being relaunched in 2002 after data collection and analysis of this study ceased.

Among initiatives targeted at the small group market, Chamber Choice, launched by Blue Cross Blue Shield of Kansas City, had enrolled 39,600 people as of October 2001. A third of the small firms signing on had not offered their workers coverage before and four in ten of the workers enrolled were uninsured when enrolled. Wellpoint Health Network's FlexScape program in California had enrollment of 797,000 as of January 2002 (including some consolidation into this program from previous small group programs.) According to company data, close to two-thirds (63%) of enrollees in FlexScape were uninsured when they signed up. Mid-America Health Choice, also in Kansas City, enrolled 15,000 people by October 2001, a quarter of whom were previously uninsured.

Among initiatives in the individual market, Special Care in Pennsylvania had enrollment of 61,000 previously uninsured people as of June 2001. Wellpoint's PlanScape (in California) had enrollment of 815,000 as of January 2002, 49% of whom had been uninsured for varying periods of time before enrolling, according to company data. Kaiser Permanente's Steps program had 14,501 enrollees as of May 2002, all of whom had been uninsured. Kaiser's Child Health Plan I and II had 5,084 enrollees (aged 0 to 18) as of May 2002, all of whom were also previously uninsured.

A detailed presentation of the findings can be found in Tables 5 and 6 on pages 17 and 18. Detailed descriptions of the initiatives can be found in the Appendix.

III. What Produced Success and Lessons Learned

Generally, health plans that were successful in reaching the uninsured developed products that were affordable and attractive. And they marketed them aggressively. In addition, they effectively managed situations in which people were transitioning out of one form of coverage into another, or one job to another.

Affordability: Keeping products affordable was central to success. Studies and health plan data show that most people who are very price sensitive or have been previously resistant to the purchase of health insurance do not want to pay more than \$100 to \$150 per month for individual insurance and not more than \$250 to \$300 a month for family coverage. The monthly premiums of initiatives described in this report ranged from a low of \$50 for an individual to \$300 for a family of four.

Such pricing forces tradeoffs. And keeping health insurance affordable is no small task in a time of escalating health costs. Most of the successful initiatives examined in this report used innovative product design, flexible and reduced benefits, enhanced cost sharing, and/or reduced profit margins to keep premiums as low as possible.

Most of the products in both the group and the individual markets were age-rated (premium varied according to age of applicants) but not all required medical underwriting – the process by which insurance is priced according to health status or past health care use and experience.

A few of the initiatives depended importantly on “cross-subsidies” within a health plan's scope of

business. That is, the company expected much smaller profit margins in the product line aimed at reducing the number of uninsured than in its other lines of business. Some products, particularly in the individual market, were totally subsidized by the health plans.

Table 2: LESSONS LEARNED

Marketing: Multifaceted approaches were generally associated with higher enrollment, particularly in the small group market. Brokers were essential in securing new members for small business products. Overall, health plans that did extensive market research to determine which marketing channels would most effectively reach their target population fared better than those that did not.

Benefit Design: Whether the benefit package was comprehensive or more limited did not appear to be the determining factor in appealing to the uninsured or meeting a program's enrollment target. Several health plans used market research to help refine their benefit packages, with one plan determining the composition of benefits around price points that the uninsured could potentially afford. This strategy attracted a large number of uninsured.

Affordability: All of the health plans attempted to keep premiums low since affordability is the most important reason people lack coverage. Lower premiums, however, did not guarantee higher enrollment because (a) the premium could have remained out of reach (b) the product's benefits may have been viewed as insufficient for its price; (c) the product may have seemed less desirable in comparison with the company's other offerings; or (d) insufficient marketing. Products using methods such as rate stability, reduced profit margins, and enhanced cost sharing fared better than those using other approaches. Although some products were cross-subsidized within the plan and others were profit-making or break even, this aspect of financing was not a defining factor in attracting the uninsured.

Target Population: Many programs restricted program eligibility because of limited funds or in order to avoid duplication with other coverage for the uninsured. But some products with extremely narrow target populations experienced difficulty reaching eligible people while those with less restrictive criteria had greater success. Plan-subsidized products tended to target lower-income uninsured individuals whereas several profit-making products were aimed at covering uninsured small business workers. Some non-subsidized products specifically identified their target market as people with incomes over 200% FPL. Greater opportunities to partner with the public sector exist for plan-subsidized models, as their target populations often share similar characteristics.

Providers: Realizing that provider networks can enhance the value of health insurance products, nearly all the health care organizations used the same network for their uninsured initiatives as for their other products. While a broad network does not guarantee the success of a program, a restricted panel seemed to have negative consequences on enrollment.

Program Duration: Pilot programs allow a health plan to try new, unproven, or otherwise risky approaches to coverage. Yet some pilots with limited availability due to service area, income, or number of potential enrollees experienced marketing and enrollment difficulties. One health plan was able to bypass some of these issues by enrolling current members into its new products.

Transitions: Products that addressed age, income, and public/private transitions generally achieved greater success in enrollment than those that did not.

Enrollment and Operations: A multi-step enrollment process may be cumbersome to applicants. Health plans found that streamlined application processes enhanced enrollment.

Marketing: Marketing was critical to the success of private initiatives, particularly in the small group market. The mere existence of affordable health insurance does not guarantee that the target population will purchase it. Successful initiatives used multifaceted approaches to marketing.

In the small group market, a multi-pronged marketing strategy yielded greater success. Small group initiatives that attracted more than 10,000 members used direct mail, many brokers, the Internet, toll-free telephone numbers, and television, print, and radio advertisements. Among these different strategies, health plan administrators indicated that brokers were essential in securing new members. Programs that had difficulty with enrollment either did not use brokers or worked with a limited number to recruit customers.

Among initiatives in the individual market, health plans were more likely than those selling small group products to use direct approaches such as distributing flyers and holding community events as part of a marketing campaign. Generally, health plans that conducted extensive market research to determine which channels and messages would most effectively reach their target population were more successful.

Transitions: Americans generally lose health insurance coverage when they lose a job or change jobs. Medicaid enrollees frequently lose coverage when their eligibility status changes. SCHIP enrollees may also be dropped if a family's income rises above the eligibility cut off. Young people often lose coverage when they "age out" of their parent's coverage (generally around age 21 to 25). Dependents may also lose coverage if an employer alters their plan to make such coverage more restrictive or expensive.

Studies overwhelmingly show that many people are unaware of their health insurance alternatives, and especially their eligibility for public programs, when they lose coverage. They may also overestimate the cost of health insurance in both the small group and individual market.

Transitions offer opportunities for creativity and public/private partnership in developing products to bridge the various sources of insurance. Successful health plan efforts managed these, identifying populations at risk of such transitions (such as those coming off Medicaid and the young who change jobs frequently). In some cases, over-aged dependents were allowed to retain coverage until they found alternatives or were transitioned into solo coverage. In another example, rates were guaranteed over time for enrollees in their late 50s and early 60s – to attract and retain the uninsured in this population group. Other initiatives provided subsidies to cover those in employment transitions for a number of years as well as partnered with the public sector to cross-refer applicants.

Recommendations

The findings from this study yield various recommendations as described on the next page in Table 3. They are based in large part on the comments from health plan staff about the successes of and barriers to their programs. Other recommendations, with detailed explanations, may be found in Section IV of the full report.

Table 3: KEY RECOMMENDATIONS

<p>Marketing</p> <ul style="list-style-type: none">• Use a multifaceted marketing approach to reach well-delineated target population. Health plans creating products for small businesses should consider using brokers as a key element of their marketing strategy.• Allocate sufficient resources to support aggressive marketing during the three months prior to product launch as well as one to two years after the program's introduction.
<p>Benefits Design</p> <ul style="list-style-type: none">• Conduct research before creating products to determine the right mix of cost and coverage.• Design benefits around price categories.
<p>Financing</p> <ul style="list-style-type: none">• Consider alternative methods to lower premiums such as rate stability, reduced profit margins, and enhanced cost sharing mechanisms.
<p>Target Population</p> <ul style="list-style-type: none">• Define a target population to support a multifaceted marketing approach. A target population that is too narrow or spread among too many states may hinder marketing strategies.• Moderate-income populations (income exceeding 200% FPL) may yield highest enrollment.
<p>Providers</p> <ul style="list-style-type: none">• Use the same provider network as your other commercial products. A limited provider panel may diminish the product's value.
<p>Program Duration</p> <ul style="list-style-type: none">• Analyze whether creating a pilot rather than launching a full-scale product may become a barrier in reaching the uninsured, due to limited health plan commitment.
<p>Transitions</p> <ul style="list-style-type: none">• Partner with state programs for cross-referrals from public programs and to target people likely to be between sources of coverage.• Allow "aged-out" dependents to remain on a parent's policy.
<p>Enrollment and Operations</p> <ul style="list-style-type: none">• Make enrollment procedures easier by providing materials in multiple languages and limiting the length of the application form.

Conclusion

This study, while necessarily limited to an analysis of a small number of initiatives, suggests strongly that private health insurance plans can play an important role in extending coverage to some uninsured Americans. Such efforts are most likely to be successful (and efficient) when targeted at people employed in small businesses and at nonpoor people who do not qualify for public programs. Continued health plan commitment to programs that target the uninsured is critical.

The study also demonstrates the success of public/private partnerships in launching programs aimed at expanding health insurance coverage. And it points to new opportunities for public/private sector collaboration aimed at identifying people who are entering insurance transitions. Such efforts

could enhance enrollment in *both* public and private insurance programs. In addition, partnerships aimed at enhancing outreach and marketing could make millions of Americans more aware of their health insurance options, both public and private. The study underscores that solutions to the uninsured problem are more likely to be found in coordinated efforts to address the various segments of the uninsured population.

At the same time, the study indicates a promising new model: that of financially viable programs and insurance products targeted at the nonpoor uninsured. Innovative product design, and the flexibility to create such products, is essential to the success of such initiatives. Over time, such programs could build and solidify to help millions of people avoid health insurance gaps and reduce the number of nonpoor uninsured.

Creating health insurance products that are affordable to an increasing number of Americans requires tradeoffs. While optimal comprehensive coverage is widely desired by many, and perhaps most, people shopping for health insurance today, it is simply too expensive for some small businesses and low- to moderate-income individuals. Carefully crafted and appropriately regulated insurance products that adequately protect enrollees against high medical costs can be affordable and desirable. Many health plan companies are convinced that a market exists for such coverage, and that choices in the marketplace are vital to attracting uninsured people who can afford to buy coverage on their own. Several initiatives profiled in this study indicate that well-designed marketing appears successful in identifying and enrolling people who desire such coverage.

All that said, the results of this study underscore what many past studies have found, that significant reductions in the number of uninsured Americans will be achieved only through combined government and private sector efforts.

Finally, lasting solutions to the problem of health insurance coverage in the U.S. will continue to be difficult to achieve in the face of sharply rising health care costs. Such costs make health insurance an ever more expensive commodity and product, meaning not only that fewer businesses and people can afford it but that government may have to scale back coverage as well. Government attempts to expand coverage must be accompanied by policies that seek to control health care costs.

II. Discussion of Private Sector Initiatives

This section presents an overview of findings from the interviews with program staff and documents about the private sector initiatives. Individual detailed descriptions of the products are presented in the Appendix.

What are the characteristics of the health plans offering products to the uninsured?

The 10 health plans include five of the largest managed care companies in the nation: Aetna Inc. (15 million members); Group Health Incorporated (3.5 million members); Highmark Blue Cross Blue Shield (BCBS) (over 3.6 million members); Kaiser Permanente (over 8 million members); and WellPoint (over 13 million members). The other five, Blue Cross Blue Shield of Kansas City, Blue Cross Blue Shield of Montana, Blue Cross & Blue Shield United of Wisconsin, Memorial Hospital and Health System, and Mid America Health, are smaller regional companies, but several have sizable membership and high market share. For example, BCBS of Kansas City's total enrollment exceeds 800,000. With 288,000 members, BCBS of Montana has 48% market share. The plans are evenly divided between for-profit and not-for-profit organizations. All but two participate in Medicare; six are SCHIP providers, and four contract with Medicaid.

What are the characteristics of the products?

Seven of the private initiatives are for the small group market, with the remainder focusing on the individual market. Seven products were described by their health plans as break-even or profit-making products, with the others financed in part from plan subsidies. Eight of the products were age-rated or both age-rated and medically underwritten. Some of the plan-subsidized programs offer transitional coverage and are not intended as a permanent source of insurance. Because three of the plans are national carriers, the initiatives are present in nearly every state.

The economically self-sustained products tend to have fewer benefits than those which were subsidized by the private health plans, possibly because limited benefit packages shift risk to the enrollee whereas in comprehensive products, the insurer bears the risk. Two of the self-sustained products offer a range of limited to comprehensive benefits with the limited package geared to the uninsured. Two other health plans provide comprehensive packages for their economically self-sustained small group products. These two companies may have created richer packages because of heightened competition for small employer business in their particular geographic region.

Table 4: PRIVATE SECTOR PROGRAM OVERVIEW

	INDIVIDUAL PRODUCTS	SMALL GROUP PRODUCTS
PLAN-SUBSIDIZED	<p>Child Health Plan-1 Kaiser Permanente 1,953 enrolled (5/02)</p> <p>Child Health Plan-2 Kaiser Permanente 3,131 enrolled (5/02)</p> <p>Memorial Advantage Memorial Hospital & Health System 250 enrolled (7/01)</p> <p>Special Care 4 Pennsylvania Blue Cross Blue Shield Plans 61,000 enrolled (6/01)</p> <p>Steps Kaiser Permanente 14,501 enrolled (5/02)</p>	<p>Small Business Health Insurance Group Health Incorporated 515 enrolled (7/01)</p>
NON-SUBSIDIZED	<p>BlueCare Blue Cross Blue Shield of Montana 200 enrolled (7/02)</p> <p>PlanScape WellPoint 815,000 enrolled (1/02)*</p>	<p>Affordable HealthChoices Aetna Inc. 2000+ enrolled (10/01)</p> <p>Buy Direct PPO Blue Cross & Blue Shield United of Wisconsin Enrollment N/A</p> <p>Chamber Choice Blue Cross Blue Shield of Kansas City 39,600 enrolled (10/01)</p> <p>FlexScape WellPoint 797,000 enrolled (1/02)*</p> <p>Mid America Health Choice Mid America Health 15,000 enrolled (10/01)</p>

* WellPoint moved existing small group and individual members into PlanScape and FlexScape.

Have the initiatives reduced the number of the uninsured?

Two of the small group products were not expressly created as “plans for the uninsured.” But, Chamber Choice from Blue Cross Blue Shield of Kansas City and Mid America Health Choice from Mid America Health (also based in Kansas City), were developed out of concerns that many small and low-wage businesses were not offering insurance to their employees. Furthermore, company representatives stated that both products have actually increased coverage in Kansas City. BCBS of Kansas City indicated that 30% to 35% of small businesses did not offer health benefits prior to enrolling their employees in Chamber Choice, so an estimated 12,000 workers previously lacked coverage. According to Mid America Health, one-quarter of Mid America Health Choice’s 15,000 members work for employers who previously did not provide health insurance to their employees. WellPoint’s products reached a large number of

uninsured individuals in California. Senior management estimates that 63% of small group employees (or over half a million workers) and 49% of PlanScape's individual members (approximately 400,000 enrollees) had been previously uninsured.

Two plan-subsidized programs have also enrolled a significant number of individuals who otherwise may not have been able to obtain coverage. Since 1992, Highmark Blue Cross Blue Shield has covered over 61,000 uninsured individuals annually with Special Care. Steps from Kaiser Permanente has 14,500 members who previously lacked insurance.

While other initiatives did not reach membership targets, they can still be credited with affecting the uninsured population. For example, Small Business Health Insurance from Group Health Incorporated reached only 515 lives or 17% of its target enrollment, but more than half of those employers offered no coverage prior to signing up for the pilot program. With about 2,000 children currently covered, Kaiser Permanente's Child Health Plan-1 has historically not met projections for membership, in part because a large proportion of applicants are eligible for California's SCHIP program, Healthy Families. Nevertheless, Child Health Plan-1 is part of the larger Kaiser Permanente Cares for Kids initiative with the goal of universal coverage for California's uninsured children. KP staff stated that collaborative efforts through the initiative have led to greater enrollment in California's public programs.

Some of the more established initiatives were able to retain 75%–90% of their members. Reasons people left these programs were diverse. Staff attributed enrollee attrition to member relocation, financial difficulty, transitioning to government programs, or buying into the commercial market, rather than dissatisfaction with the benefit design or other features. Chamber Choice staff specifically noted that their relatively high retention rate of 82%–86% was the result of their guarantee that rates would remain stable for two years.

Meeting enrollment goals was not significantly influenced by a product's plan-subsidized or profit-making status. Marketing, target population, and other elements seemed to have greater roles in influencing membership numbers.

Are the private sector initiatives replicable?

Most of the health plans were fairly positive about the replicability of their products. Some suggested specific conditions necessary for recreating their efforts. For example, Mid America Health, Blue Cross Blue Shield of Montana, and Memorial Health System cited strong relationships with the community and local providers as integral to designing successful products. Blue Cross Blue Shield of Kansas City believes that rate stability is critical, while acknowledging

that the only way to achieve rate stability is through establishing a significant amount of business.

As for the plan-subsidized initiatives from Highmark Blue Cross Blue Shield, Kaiser Permanente, and Memorial Health System, the availability of funding largely dictates their replicability. Highmark credits its success to the company's high market share as well as state regulatory support, thus allowing a limited benefit design and lower cost product. Kaiser Permanente staff indicated that benefit design and marketing efforts for its plan-subsidized children's coverage could be replicated elsewhere. But employees also believe that the unique socioeconomic characteristics present in the state of California dictate the rationale behind offering these products. KP's other program, Steps, was characterized as replicable by state governments to assist individuals in buying into the private health care system.

While Aetna staff believes it is replicable, Affordable HealthChoices is a hospital indemnity product with minimal coverage which cannot be sold in some states due to lack of compliance with state mandates.

WellPoint labels FlexScape and PlanScape "collections of products built into a program" and views the biggest challenges for replication as marketing and actual product design. A company may not be successful in coupling a product like FlexScape with a conventional high option plan for small groups, because the two types of products can compete with each other for sales. Also, some plans may be hesitant to develop a portfolio of products that vary cost sharing to provide premium price options.

Table 5: SYNOPSIS OF SMALL GROUP INSURANCE PRODUCTS

PLAN	Affordable HealthChoices	Buy Direct PPO	Chamber Choice	FlexScope	Mid America Health Choice	Small Business Health Insurance
SPONSORING COMPANY	Aetna U.S. Healthcare	Blue Cross & Blue Shield of Wisconsin	Blue Cross Blue Shield of Kansas City	WellPoint Health Networks	Mid America Health	Group Health Incorporated
LOCATION	36 states	Wisconsin	Kansas City metropolitan area (Kansas & Missouri)	California	Kansas City metropolitan area (Kansas & Missouri)	Sections of New York City
PROGRAM SUMMARY	Low-cost employer-based hospital indemnity product. Offers hospital and medical services paid in fixed-dollar amounts with no coinsurance or deductibles.	Low-cost product for small employers with two models: one with a lower premium and higher out-of-pocket costs; one with a higher premium and lower out-of-pocket costs.	Product endorsed by Greater Kansas City Chamber of Commerce to address uninsured small firms. Offers rate stability over two years to allow employers to budget health benefits.	Product with array of options varying in benefit, premium, and cost sharing levels. Low- and medium-priced options are targeted to nonpoor uninsured at or above 200% FPL.	Product developed for small firms in response to Greater Kansas City Chamber of Commerce's call to address uninsured small businesses.	Low-cost, comprehensive product for working uninsured. Developed through partnership between health plan and New York City Health and Hospital Corporation.
TARGET POPULATION	Uninsured small businesses (2 to 50 employees); 50% must participate.	Uninsured/underinsured small businesses and start-up companies.	Small businesses (2 to 50 employees).	Small businesses (2 to 50 employees).	Small businesses (2 to 50 employees).	Small businesses (2 to 50 employees).
BENEFITS	Limited benefits. Includes 6 emergency room visits, hospital stay, 6 to 10 physician office visits, mental health and substance abuse confinement, and accident services.	Comprehensive benefits. Includes preventive, hospital services, and dental care.	Comprehensive benefits. Includes preventive, hospital, dental, life insurance, and accidental death and dismemberment coverage.	Benefits vary. Low-priced option includes physician office visits, maternity, diagnostic laboratory, hospital stay, outpatient services, and prescription drugs, and well-baby care.	Comprehensive benefits. Includes preventive and hospital care.	Comprehensive benefits. Includes preventive and hospital care.
FINANCING	Break-even product with low employer contribution, low premiums (\$46 to \$91 per month for individual and \$156 to \$275 per month for family), increased cost sharing, limited benefit package.	Financially self-sustainable. Reduced premiums, increased cost sharing. ^a	Financially self-sustainable. Range of low to high premiums (average monthly premium of \$167), variable cost sharing, reduced profit margin. ^b	Financially self-sustainable. Employer contributions, variable cost sharing, low premiums (average of \$116 per month, with low individual and \$250 to \$300 for family). ^b	Financially self-sustainable. Employer contributions, low premiums (average \$160 per month), increased cost sharing. ^a	Plan subsidized. Low premiums (\$100 per individual, \$161 per employee and children, \$224 per employee and spouse, \$235 per employee, spouse, and children), provider discounts, increased cost sharing.
ENROLLMENT (PERCENT UNINSURED)	2000+ (unknown) as of October 2001.	N/A as of November 2001.	39,600 (30% to 35%) as of October 2001.	797,000 (63%) as of January 2002. ^c	15,000 (25%) as of October 2001.	515 (17%) as of July 2001.
PROGRAM START DATE	1999	October 2000; relaunched October 2001	1994	2001	1994; relaunched in 1998	1999; ended in 2001

^a Age-rated. ^b Both age-rated and medically underwritten. ^c WellPoint rolled over existing small group members into FlexScope.

Table 6: SYNOPSIS OF INDIVIDUAL INSURANCE PRODUCTS

PLAN	BlueCare	Child Health Plan-1	Child Health Plan-2	Memorial Advantage	PlanScope	Special Care	Steps
SPONSORING COMPANY	Blue Cross Blue Shield of Montana	Kaiser Permanente	Kaiser Permanente	Memorial Hospital and Health Systems	WellPoint Health Networks	4 Blue Cross Blue Shield Plans in Pennsylvania	Kaiser Permanente
LOCATION	Montana	California	Parts of Los Angeles, California	St. Joseph County, Indiana	California	Pennsylvania	California
PROGRAM SUMMARY	Limited benefits product for low-income uninsured Montanans developed through partnership between BCBS of Montana and providers.	Subsidized, comprehensive product for low-income children developed as part of Dues Subsidy Program.	Subsidized, comprehensive product for low-income, noncitizen children in Los Angeles area as part of Dues Subsidy Program.	Two-year subsidized health cost assistance pilot program for low-income St. Joseph County residents, including noncitizens.	Product with an array of options varying in benefit, premium, and cost sharing levels. Low- and medium-priced plans are geared to nonpoor uninsured.	Subsidized, low-cost indemnity plan for uninsured with limited benefits at half the price of commercial products.	Product for low-income uninsured, designed to incrementally move uninsured into commercial market via tiered premium levels.
TARGET POPULATION	Low-income uninsured up to 175% FPL.	Uninsured children (0-18) between 250% and 300% FPL.	Noncitizen, uninsured children (0-18) up to 250% FPL.	Uninsured up to 200% FPL who are ineligible for public programs.	Nonpoor uninsured with income at or above 200% FPL for lower priced options.	Uninsured up to 185% FPL who are not eligible for public programs.	Uninsured individuals with incomes between 100% to 300% FPL.
BENEFITS	Limited benefits. Includes some preventive and mental illness benefits, emergency room, hospital services, limits physician visits to 6 annually; excludes vision and diabetes management.	Comprehensive benefits. Includes hospital, preventive services, vision (excluding optical), and prescription drugs.	Comprehensive benefits. Includes hospital, preventive services, vision (excluding optical), prescription drugs, and dental.	Comprehensive benefits. Includes preventive services and hospital services. Limited prescription drug coverage.	Benefits vary depending on price of product from basic catastrophic coverage for lower-priced products to high cost, comprehensive products.	Limited benefits package with fixed number of physician visits and inpatient hospital days. Excludes prescription drugs and pre-existing conditions.	Comprehensive benefits. Includes preventive services, hospital services, vision, and prescription drugs. Vision benefits do not include optical.
FINANCING	Priced to break-even. Low premiums (\$58 for 25-29 years, \$103 for 50-54 years), provider discounts, increased cost sharing, waived administrative fees. ^b	Plan subsidized. Low premiums (\$15 per child per month for first three children; additional at no cost), low cost sharing.	Plan subsidized. Low enrollment fee (\$24 per family), low cost sharing.	Plan subsidy of \$400,000. Low cost sharing, provider discounts.	Financially self-sustainable via low premiums (ranges from \$65 to \$75 per individual or \$250 to \$300 per family with average of \$116), and variable cost sharing. ^b	Plan subsidy of \$8 million. Member cost sharing, lower reimbursement to providers, and limited benefits. ^a	Plan subsidized. Tiered premium levels. Members pay percent share of full premium. Each year, share is increased until member pays full premium. ^a
ENROLLMENT (PERCENT UNINSURED)	200 (100%) as of July 2002.	1,953 (100%) as of May 2002.	3,131 (100%) as of May 2002.	250 people (100%) as of July 2001.	815,000 (49%) as of January 2002. ^c	61,000+ (100%) as of June 2001.	14,501 (100%) as of May 2002.
PROGRAM START DATE	July 2001	September 1998	July 2001	2001	2001	1992	October 1999

^a Age-rated. ^b Both age-rated and medically underwritten. ^c WellPoint rolled over existing individual members into PlanScope.

III. Lessons Learned

This section analyzes various aspects of the 13 private sector initiatives for the uninsured based upon comments and documents provided by health plan representatives. Throughout this section, products are identified as (Ind) for individual product, or (SG) for small group product.

A. **MARKETING**

SUMMARY ANALYSIS. Marketing was critical to the success of private initiatives. The mere existence of a quality product at a low cost did not guarantee that the target population would purchase it.

For small group products, a multifaceted approach to marketing was generally associated with higher enrollment. Successful small group initiatives that attracted more than 10,000 members used direct mail, brokers, the Internet, toll-free telephone numbers, and television, print, and radio advertisements. Among these different strategies, health plan representatives indicated that brokers were essential in securing new members. Indeed, programs that had difficulty with enrollment either did not use brokers or worked with a limited number to recruit customers. Brokers are not only a bridge between health plans and consumers, but also educate employers about the value of health insurance and the different options available for purchase.

Among individual products, a greater number of marketing strategies did not necessarily translate into a higher number of enrollees. Health plans offering individual products were more likely than those selling small group products to use direct approaches such as distributing flyers and holding community events as part of a marketing campaign. The three health care organizations that managed to enroll more than 10,000 relied on a variety of marketing techniques, but few were common among the three. The use of the Internet and toll-free numbers is common among the three individual products, but it is also shared among nearly all programs examined in this study. All three individual products did, however, conduct extensive market research to determine which channels would most effectively reach their target population. (See Table 7 on page 22 for the range of marketing strategies used by health plans).

EXAMPLES

Multifaceted Strategies: Four of the six health plans selling small group products relied upon a broad marketing campaign. Multifaceted strategies generally led to greater enrollment.

- Blue Cross Blue Shield of Kansas City, Mid America Health, and WellPoint achieved high membership by using diverse channels to promote their products.

- Aetna's lack of aggressive and targeted marketing to small business owners and employees, such as through television, radio, print ads, or direct mail, may have contributed to the lower numbers of enrollees in **Affordable HealthChoices (SG)**.
- During its first year, **Buy Direct PPO (SG)** was marketed primarily on-line to cut down on administrative costs. But Blue Cross & Blue Shield United of Wisconsin probably missed some of its target population who do not have access to the Internet.
- Group Health Incorporated used multifaceted strategies, but staff believe that its marketing budget for **Small Business Health Insurance (SG)** should have been quadrupled. Moreover, restricted geographic eligibility to small businesses from specific zip codes in New York City diminished the effectiveness of marketing since a large number of applicants from outside those areas were not able to enroll. Fourteen months after beginning the pilot, GHI held focus groups with representatives from businesses enrolled in Small Business Health Insurance to evaluate its marketing campaign. Participants reported hearing about SBHI from various sources, but most did not initially learn about the program through GHI's direct marketing efforts.¹⁷

Brokers: Small group products advertised through brokers tended to have greater success in attracting customers. For some health plans, brokers were the primary means of recruitment.

- Blue Cross Blue Shield of Kansas City achieved **Chamber Choice's (SG)** enrollment goals via a broker community of around 1000. Brokers recruited 96% of enrollees through contact with Chamber of Commerce members. Another Kansas City carrier, Mid America Health, also relies heavily on brokers for marketing **Mid America Health Choice (SG)**.
- Group Health Incorporated worked with a limited number of brokers to offer **Small Business Health Insurance (SG)**. This approach, however, produced less business than anticipated since their commission is based on a percentage of the product's premium. Because SBHI is half the price of similar products in the market, the brokers' incentive to refer potential customers may have been lower since the return would be reduced.

Affordability: Marketing campaigns stressing affordability and actual cost of insurance may have enticed the uninsured to purchase coverage.

- WellPoint's marketing of **FlexScape (SG)** and **PlanScape (Ind)** educates people about reasons to purchase health insurance and cost options. The health plan's analysis of past data showed that pricing is essential in attracting and retaining new members. Due in part to the transfer of existing small groups and individual members into the products, enrollment in FlexScape and PlanScape has been high. The products have also attracted a significant number of uninsured.

Name Recognition: Community events and direct marketing seemed to contribute to greater insurer and product name recognition.

- Blue Cross Blue Shield of Kansas City enlisted the Chamber of Commerce to endorse **Chamber Choice (SG)** to small firms.
- To distinguish its **Mid America Health Choice (SG)** product from those of national carriers, Mid America Health's campaign stresses the relationship with its customers through community sponsorships and events, targeted direct mail, and one-on-one meetings with employers.
- Highmark's name recognition in the state and promotion of a toll-free number for all of the participating BCBS plans contributed to meeting enrollment goals for **Special Care (Ind)**.

Sales Force Training: Health plan representatives needed to be aware of a company's efforts to attract people who are uninsured, so that they will refer customers to the appropriate products.

- Blue Cross & Blue Shield United of Wisconsin's sales force directed some potential applicants to other richer products, based on a lack of understanding of **Buy Direct PPO's (SG)** purpose as an

affordable alternative for the uninsured and underinsured.

Strategy Development: Several health plans used market research to develop and/or modify their campaigns. This approach may have helped the plans refine messages and attract members.

- WellPoint conducted focus groups to determine whether marketing strategies for its **FlexScape (SG)** and **PlanScape (Ind)** products were effective. The focus groups revealed that the health plan should redirect the emphasis from price to other aspects of the products.
- In 1999, Kaiser Permanente enlisted the UCLA Center for Health Policy Research to conduct focus groups with Latino and white parents of uninsured children¹⁸ to determine, among other things, methods to tailor messages for a public awareness campaign. Key findings included that Latinos needed more general information about how to procure health coverage; some were unaware that insurance was available from sources other than employers. Participants offered advice on television advertising, including the need for honest and credible ads, using racially diverse, mature, “everyday” people. The most commonly cited marketing strategies were to use flyers in schools, markets, hospitals, clinics, and ads in newspapers and on billboards.¹⁹
- Before developing **Special Care (Ind)**, Pennsylvania Blue Shield²⁰ engaged Widener-Burrows & Associates in 1991 to help the plan assess the benefits and cost needs of small groups and individuals as well as address marketing issues. Focus group members commented that they would be most likely to read direct mail on health insurance from a well-known carrier.²¹

Community Events: To reach a large number of people outside of the workplace, health plans promoted individual products at community events. This method had mixed results.

- **Special Care (Ind)** reached its target population of individuals with incomes at or below 185% FPL through advertisements at doctors’ offices, job fairs, and at schools through flyers and brochures.
- In marketing **Steps (Ind)** and **Child Health Plan-1 and -2 (Ind)**, Kaiser Permanente’s partnerships with community-based organizations, coalitions, schools, and government agencies resulted in increased synergy, better coordinated outreach efforts, and stronger community relations.
- Blue Cross Blue Shield of Montana and Memorial Health System held community events, but these efforts did not attract many new members for **BlueCare (Ind)** and **Memorial Advantage (Ind)**.

Direct Mail: Direct mail did not always translate to greater membership in uninsured programs.

- The response rate to a direct mail campaign for Kaiser Permanente’s **Child Health Plan-1 (Ind)** was 1%. The low response rate may be partially explained by the program’s narrow income eligibility, which complicated efforts to locate potential applicants within the general population.

Door-to-Door Soliciting: Some of the uninsured found door-to-door soliciting intrusive.

- **Memorial Advantage’s (Ind)** predecessor, Community Health Plan, was advertised via television and radio, flyers, and door-to-door soliciting. Public reaction to the soliciting was not positive, and people expressed concerns about why the product cost so little. Most people have enrolled in Memorial Advantage through direct referrals at clinics.

Multicultural Materials: Some health plans customized strategies to local markets. As minority groups have a higher uninsurance rate per capita, this approach may have led to higher membership.

- WellPoint and Kaiser Permanente market their products through television and radio advertisements in English and Spanish, as well as print ads in English, Spanish, Chinese, and Korean.

Table 7: STRATEGIES USED TO MARKET THE 13 INITIATIVES

	Direct Mail	TV Advertisements	Print Advertisements	Radio Advertisements	Community Events	State Partnerships	Brokers	Toll-Free Number	Internet	Press Events	Door-to-door	Flyers	Multilingual materials	Chamber of Commerce	Plan Newsletters
Small Group	<i>Affordable HealthChoices</i>						x	x	x	x				x	
	<i>Buy Direct PPO</i>							x	x						
	<i>Chamber Choice</i>	x	x	x	x	x	x	x	x					x	x
	<i>FlexScope</i>	x	x	x	x		x	x	x			x	x		x
	<i>Mid Am Health Choice</i>	x	x	x		x		x	x						
	<i>SBHI</i>	x	x	x	x	x		x		x		x	x	x	
Individual	<i>BlueCare</i>		x	x		x	x	x	x	x		x			x
	<i>Child Health Plan-1</i>	x		x	x	x		x	x	x		x	x		x
	<i>Child Health Plan-2</i>					x		x				x	x		
	<i>Memorial Advantage</i>	x	x		x	x					x	x			
	<i>PlanScope</i>	x	x	x	x		x	x	x			x	x		x
	<i>Special Care</i>					x	x		x	x		x			
	<i>Steps</i>	x				x	x		x	x		x			

B. BENEFIT DESIGN

SUMMARY ANALYSIS. The level of benefits and services offered by the health plans varied significantly, reflecting different approaches to creating affordable products. Some of the health plans offered comprehensive services, patterned after products available to other commercial members. In an effort to reduce the cost of coverage, one small group product and two individual products provide more limited benefit packages. Several health plans conducted market research to develop packages, with one plan determining the composition of benefits around price points that would appeal to the uninsured. This strategy as well as product arrays, which allowed enrollees to choose among various benefit designs and prices, attracted more enrollees.

Whether the benefit packages were comprehensive or limited, however, did not appear to be the determining factor in appealing to the uninsured or meeting a program’s enrollment targets. Rather, the reason a particular product attracted its intended audience was more attributable to a combination of the benefit package with product price, marketing approach, and/or target population.

Creating the “right benefit package” is frequently touted as key to reaching the uninsured. Health plans face two major policy issues in devising alternative benefit packages. First, limiting benefits and services to foster affordability raises the question of equity. Most people who are

insured through public and private sources enjoy more comprehensive packages than some products directed at the uninsured, in part because the insured's coverage is facilitated by government subsidies. Furthermore, reliance upon cost sharing to offset premiums for a broader benefit package can impose potential barriers to appropriate care. While more benefits may seem to be available, individuals may be unable to afford a particular service because of the copay.

EXAMPLES

Market Research: Health plans using market research to determine the composition of benefits at a price which the uninsured could afford generally fared better than those that did not.

- Focus groups predating the introduction of **Special Care (Ind)** helped create a reduced benefit package which has been well-received. Respondents were asked about the minimum level of coverage desired under an affordable plan. Results indicated considerable interest in the basic package proposed but respondents expressed reluctance to pay more than \$75 to \$100 per individual because the product lacked prescription drug and substance abuse benefits.
- Market research conducted prior to implementation of **Small Business Health Insurance (SG)** showed that small business owners wanted emergency room coverage and open access, with a monthly premium at or below \$100. After implementation, employers in focus groups indicated that they were pleased enough with SBHI to recommend it to friends. Several participants cited the comprehensiveness of coverage and the availability of prescription drugs at an affordable price.
- **FlexScope (SG)** and **PlanScope (Ind)** represented a departure from WellPoint's prior approach to product design, that is, with emphasis on benefits. Instead, WellPoint focused on creating a continuum of price points and modified benefits, deductible, and coinsurance levels to fit each price category. Product design and marketing were based on various studies including a California HealthCare Foundation survey on perceptions of the cost of health insurance. The survey found that nonpoor Californians perceived insurance as more costly than in reality. About a third of the respondents cited a price that exceeded the typical cost for a \$10 copayment health plan, with 68% overestimating the cost for a \$40 copayment or \$2,000 deductible plan.²² About one-quarter indicated their willingness to pay when told of the actual premium.

Product Array: An array of product designs enabled health plans to vary benefits and allow for a range of lower to higher premiums. This approach appealed not only to previously uninsured moderate income individuals but also to others who have had coverage.

- **Chamber Choice's (SG)** benefits remain the same, but out-of-pocket maximums and copayments vary. Blue Cross Blue Shield of Kansas City has recently designed the PPO and HMO options actuarially equivalent to each other in order to stabilize the product and keep adverse selection low. Though not designed as a "product for the uninsured," approximately 30%–35% of members did not have previous coverage.
- WellPoint created **FlexScope (SG)** and **PlanScope (Ind)** to range from basic catastrophic coverage to comprehensive packages, with options for cost sharing and premiums as well. Approximately 63% of FlexScope and 49% of PlanScope members were previously uninsured.

Comprehensive Benefits: Eight products either consisted solely of comprehensive benefits or offered such a package as an option. Some comprehensive packages attracted thousands of enrollees, while others did not sell as well.

- **Chamber Choice (SG)** and **Mid America Health Choice (SG)** from the two Kansas City carriers offer comprehensive benefits at reasonable prices by varying cost sharing. Currently, Chamber Choice has nearly 40,000 enrollees and Mid America Health Choice has 15,000.
- Through **FlexScape's (SG)** and **PlanScape's (Ind)** array of benefit designs, WellPoint offers comprehensive benefits at a higher price alongside a more basic package which is more affordable for most middle-income, uninsured people. Approximately one out of four FlexScape members purchase the most comprehensive plans.
- Kaiser Permanente's **Child Health Plan-1 (Ind)** and **Child Health Plan-2 (Ind)** have comprehensive medical benefits nearly identical to California's SCHIP program, Healthy Families. **Steps (Ind)** mirrors KP's lowest priced individual product. All three programs are financed by plan subsidies as part of Kaiser Permanente's commitment to the community and justification of its nonprofit status. Nearly 20,000 members are enrolled in these programs.
- Group Health Incorporated based the product design of its **Small Business Health Insurance (SG)** on market research and supported the benefits through partial plan subsidies. Although SBHI is a comprehensive plan, it did not attract as many people as GHI had anticipated.
- While it does not have as many benefits as Blue Cross & Blue Shield United of Wisconsin's standard PPO product, **Buy Direct PPO (SG)** still provides a fairly comprehensive package with a lower premium through higher cost sharing. Yet some customers may have viewed its benefits as too slim.

Limited Package: The limited benefit design products had varying degrees of success in reaching the intended population.

- **FlexScape's (SG)** less comprehensive products have sold well with one out of five members purchasing the most basic plans and one-half choosing the medium-priced plan with reduced benefits.
- Highmark was able to secure exemptions from diabetes, mental health, and substance abuse benefit mandates to keep the costs down for **Special Care (Ind)**. This success was attributed in part to the company's relationship with regulators and its high market share in Pennsylvania.
- Though offering a comprehensive package with physician visits, preventive services, emergency and hospital services, and specialty care, **Memorial Advantage (Ind)** limited prescription drug coverage because its predecessor program, Community Health Plan (CHP), spent \$20,000 to \$25,000 per month on 220 patients with a comprehensive drug plan. Ninety percent of CHP's members reported that the program served their health needs.
- The underlying premise of Aetna's **Affordable HealthChoices (SG)**, that employers are interested in any kind of insurance product for employees, was not substantiated by actual enrollment. Moreover, the market for a product like Affordable HealthChoices can be restricted. Some states, such as California, prohibit the sale of insurance with reduced benefit packages unless offered as part of another comprehensive benefits plan.
- Blue Cross Blue Shield of Montana, with the advice of doctors and hospitals, created a less costly benefit package for **BlueCare (Ind)** by restricting physician visits to six per year; offering limited preventive and some mental illness benefits; using a three-tiered prescription drug coverage model; and excluding vision, dental, diabetic education, chemical dependency, and rehabilitation benefits.

Additional Benefits: Linking health insurance coverage to additional benefits enticed some businesses to purchase the product, but did not guarantee reaching target enrollment.

- Blue Cross Blue Shield of Kansas City attributes **Chamber Choice's (SG)** success in reaching the uninsured population not only to its comprehensive coverage, but also because employees can choose from additional products that best suit their needs: life insurance of \$20,000 per employee; dental benefits; and accidental death and dismemberment policies. **Mid America Health Choice (SG)** also makes similar products available.

- In contrast, **Affordable HealthChoices’ (SG)** options such as dental and vision discounts, alternative medicine, life insurance, and accidental death and dismemberment benefits apparently did not serve as significant inducements to potential purchasers.

Internal Competition: Whether a health plan can be successful in offering multiple benefit designs for small businesses depended upon many factors, including the composition of the market place.

- Small employers comprise 95% of businesses in the Kansas City metropolitan area, so Blue Cross Blue Shield of Kansas City is able to offer a variety of small group products, and still meet enrollment goals for **Chamber Choice (SG)**.
- WellPoint’s senior management decided not to sell **FlexScape (SG)** simultaneously with a conventional high option small group plan, because the two products can compete with each other.
- Blue Cross & Blue Shield United of Wisconsin experienced competition between potential customers for its standard PPO product and **Buy Direct PPO (SG)**, which was cheaper but had fewer benefits.

C. FINANCING

SUMMARY ANALYSIS. Lack of affordable products is the reason many are uninsured and health plans attempted to find methods to lower product premiums. Eight were either age-rated or both age-rated and medically underwritten. Several products were available at 50% of commercial rates. Seven had premiums of less than \$100 (for individuals), with all but three offering some variation of the product at less than \$50. These ranges reflect the results of market research conducted by the health plans and other studies, which have consistently shown \$100 to be the maximum price consumers are willing to pay.

The health plans used numerous methods to reduce premiums, through negotiated discounts with providers, rate stability, limited benefit packages, plan subsidies, enhanced cost sharing, lower profit and administrative fees, and premium alternatives.²³ Despite lower premiums, some plans found that their products did not attract the anticipated number of customers, because (a) the premium remained out of reach; (b) the product’s benefits were viewed as insufficient for its price; or (c) the product seemed less desirable in comparison with the company’s other offerings.

All of the products charged copayments, ranging from a low of \$2 for primary care office visits to a high of \$500 per day for hospital stay. Products that used increased cost sharing mechanisms experienced good enrollment, but no data exists to determine if cost sharing deterred members from seeking necessary health care.²⁴

Five small business offerings and two individual offerings are break-even or profit-making products. The remaining six are financed in part by moderate to heavy plan subsidies. The lack or existence of plan subsidies was not a defining factor in attracting the uninsured. But, health

plans may find some advantages in subsidizing products such as enhancing the provider-plan relationship through partial reimbursement for services which would otherwise be uncompensated. Also, some health plans recognized the uninsured as a potential future market for individual or group coverage, since most people do not remain uninsured permanently. Plan-subsidized initiatives offer exposure to the plan and may build loyalty when the individual or family is in a position to obtain commercial health insurance. (See Table 8 on page 28 for financing mechanisms employed by health plans).

EXAMPLES

Affordability: Low-priced products did not consistently attract the anticipated number of customers.

- **Special Care (Ind)** is approximately half the price of other commercial coverage and has met enrollment goals. Special Care is supported by a subsidy from Highmark's assessment on group renewals (20%), reduced reimbursement to providers (15%), a limited benefits design (15%), and member cost sharing (50%). Monthly premiums depend upon which of the four BCBS participating plans provides coverage, from a low of \$62 per individual under Highmark BCBS to a high of \$218 for two adults, one child under Capital Blue Cross/Pennsylvania Blue Shield.
- The average monthly premium for **Mid America Health Choice (SG)** at \$160 is supported by increased cost sharing. Premiums vary based on industry type as well as employee age and gender.
- At \$167, the average price of **Chamber Choice (SG)** is cheaper than commercial products from other carriers (with the exception of premiums in the high-risk groups). Monthly premiums range from \$125 per person for healthier, lower risk groups to \$208 for an individual in extremely high-risk groups. Chamber Choice's enrollment grew 10% per year from 1994 to 1997, with the rate of growth increasing to nearly 30% from 1999 to 2001. The annual retention rate ranges from 82%–86%.
- Monthly premiums for **Small Business Health Insurance (SG)** were 50% less than comparable plans in the target areas in New York City, ranging from \$100 for an individual to \$235 for an employee plus spouse and children. Employer-employee contributions averaged approximately 65%/35% of SBHI premiums, respectively. GHI expended "unquantifiable soft costs" for implementation, marketing, and ongoing program support. But GHI staff maintains that the product was still unaffordable for some of the small business market and enrolled less than 20% of its membership goal.
- For **Affordable HealthChoices (SG)**, premiums vary from \$46 to \$91 for individuals and \$156 to \$275 for families based upon benefit level selected. Although Affordable HealthChoices is available in 36 states, it did not attract its target membership.
- Kaiser Permanente's **Child Health Plan-1 (Ind)** had the lowest premium of all products at \$15 per child per month. The rate was dropped from its initial maximum of \$35 per child to encourage enrollment. This change has resulted in slow but steady membership increases.
- **Steps (Ind)** is designed to help the uninsured move into the commercial market by paying graduated levels of the full premium over one to four years. Members with lower incomes begin at 20% of the premium, based upon KP's cheapest individual plan, while others at higher incomes start at 40%, 60%, or 80%. In 2001 the average monthly cost of the Steps Plan was \$244, with KP subsidizing \$205 and members contributing \$39. Steps levels 20 and 40 have attracted the most enrollees with more members able to advance from Plan 20 to 40 than anticipated.

- In comparison to similar products in Montana, **BlueCare (Ind)** is approximately 70% of the cost. Even so, Blue Cross Blue Shield of Montana is concerned that some low-income uninsured may still be unable to afford BlueCare.

Cost sharing: Many plans used some form of cost sharing to lower premiums. This approach had mixed results as not all who are uninsured can afford increased cost sharing. Also, the offset of premiums through cost sharing may impose potential barriers to appropriate care.

- **FlexScope (SG)** is financed by employer and member contributions, with more extensive use of conventional deductibles and percentage cost sharing than fixed dollar copayments. While the product offers first dollar coverage for routine care, out-of-pocket costs are higher for catastrophic care (\$2,000 to \$4,500 annual out-of-pocket maximum in network and \$2,000 to \$10,000 out-of-network). With FlexScope, an employee can select between premium and copay levels to obtain fewer benefits at a lower premium or more benefits at a higher cost. Of those enrolled under the Defined Contribution option, which allows the employer to pay a fixed amount towards the monthly premium, 26% purchased low-priced plans and 51% chose medium-priced plans. Sixty-three percent of the 797,000 FlexScope members were previously uninsured.

Product Arrays: Products that varied financing mechanisms provided employers and individuals with greater choice and may have enhanced value. Nevertheless, giving the uninsured such choices did not have constant appeal in every market.

- **FlexScope (SG)** and **PlanScope (Ind)** were designed with several financing options and differing levels of benefits. The lower-priced products offer fewer benefits than those which are higher-priced. The low- to medium-priced products are directed at uninsured with income at or above 200% FPL. Forty-six percent of members purchased PlanScope's lower-priced products, and 45% purchased the medium-priced products (as of January 2002). Of those enrolled, 49% indicated that they had no prior coverage.
- **Mid America Health Choice (SG)** provides six different packages ranging from traditional HMOs to PPOs with different financing mechanisms. One in four businesses enrolled in Mid America Health Choice previously did not offer coverage. **Chamber Choice (SG)** also varies its financing configurations. Each of these products reached a large number of uninsured.
- **Buy Direct PPO (SG)** has two models with identical benefits but differing coinsurance and deductibles. Model 1 has a lower premium, but higher out-of-pocket payments for employees, while Model 2 has a higher premium with lower out-of-pocket costs. Whether Buy Direct PPO costs less than a given competitor's products depends upon the model chosen. These options have not been as popular as anticipated. Blue Cross & Blue Shield United of Wisconsin has increased deductibles for out-of-network services to generate more cost savings.

Administrative Costs: The initial offering of some new products had higher than normal administrative costs. Outside sources may scrutinize the percentage allocated to administration, but must also realize that plans usually need enhanced infrastructure to support new initiatives.

- Kaiser Permanente's three individual programs have higher administrative expenses than KP's usual 4% rate, because of application review, recertification, and tracking. Memorial's administrative rate was 28% one month after **Memorial Advantage (Ind)** began. This figure is expected to fall as more people enroll in the program.

Table 8: FINANCING MECHANISMS TO MAKE PRODUCTS MORE AFFORDABLE

1) Negotiated Discounts with Providers

<i>BlueCare</i> (Ind)	Hospitals and doctors accept substantially reduced compensation, averaging 50%.
<i>Memorial Advantage</i> (Ind)	Primary care physicians accepted a 40% discount for services, with discounts for specialty physicians varying as negotiations were conducted one-on-one.
<i>Small Business Health Insurance</i> (SG)	Provider network discounts averaged 40% of commercial rates.
<i>Special Care</i> (Ind)	Providers are reimbursed in full for preventive services, but take a 70% discount for surgery. Provider discounts represent 15% of Special Care's total financing.

2) Rate Stability

<i>Chamber Choice</i> (SG)	Annual rate hike was limited to 9% during 1994 through 2000; 10.9% in 2001 and no more than 14% in 2002.
<i>FlexScope</i> (SG) and <i>PlanScope</i> (Ind)	Premiums for subscriber plus spouse are based on younger spouse's age. The products use a single rating band for ages 55-64.

3) Limited Benefit Packages

<i>Affordable HealthChoices</i> (SG)	Product has limited number of physician visits, emergency visits, and accident services, with no x-ray or diagnostic examinations in Option 1. Hospital stay is covered but at significantly higher rates with increasing number of days.
<i>BlueCare</i> (Ind)	Product has no vision, dental, mental illness, diabetic education, chemical dependency, and rehabilitation benefits, but has limited preventive benefits.
<i>Buy Direct PPO</i> (SG)	A fairly comprehensive plan, the product has fewer benefits than BCBS United of Wisconsin's standard PPO plan. Most services have coinsurance and deductibles.
<i>FlexScope</i> (SG) and <i>PlanScope</i> (Ind)	The lowest-priced plans do not include office visits or annual physical exams, or maternity. Other medium-priced options include these services.
<i>Special Care</i> (Ind)	The Product has diabetes, mental health, prescription drugs, or substance abuse benefits. Benefit design represents approximately 15% of Special Care's total financing.

4) Plan Subsidies

<i>Child Health Plan-1</i> (Ind)	The program's rate is subsidized by Kaiser Permanente at 73%.
<i>Memorial Advantage</i> (Ind)	From a 10% allocation of revenue to fund community services, Memorial has directed \$400,000 over two years to this program.
<i>Small Business Health Insurance</i> (SG)	GHI and the hospital system took a 40% discount to implement and market SBHI.
<i>Special Care</i> (Ind)	Highmark BCBS assesses group renewals to produce about \$8 million annually. This amount represents approximately 20% of Special Care's total financing.
<i>Steps</i> (Ind)	Plan subsidies comprise approximately 84% of the average monthly cost per individual. In 2001, the overall cost of Steps was \$19.8 million.

5) Greater Cost Sharing

<i>Buy Direct PPO</i> (SG)	Model 2 has higher deductibles, \$2,000 in-network or \$5,000 out-of-network, for lower rates. Model 1's are \$500 in-network or \$1,000 out-of-network, with higher premiums.
<i>Chamber Choice</i> (SG)	Premium can be reduced by copayments for physicians of \$30 in-network, \$60 out-of-network; hospital stay \$2,500 per calendar year; prescription drugs three-tiered.
<i>FlexScope</i> (SG)	The lowest-priced plan, Basic PPO, offers higher annual deductibles of \$1,000 to reduce rates, compared to medium-priced PPO 30's deductibles of \$250 for higher premiums and more benefits. Out-of-network services have higher cost sharing.
<i>Mid America Health Choice</i> (SG)	Nearly all services require copayments or coinsurance, but no annual deductible if services are provided in-network. Out-of-pocket maximums range from \$1,000-\$8,000. Out-of-network care requires greater cost sharing, and in some cases is not covered.
<i>PlanScope</i> (Ind)	The lowest-priced plan, Basic PPO, offers higher annual deductibles of \$1,000 and lower premiums, compared to medium-priced PPO Share 500 with deductibles of \$500, higher premiums, and more benefits. All services are subject to either deductibles or copayments. Out-of-network care has higher cost sharing options.

6) Reduced Profit and/or Administrative Fees

<i>BlueCare</i> (Ind)	Product is priced to break even, and BCBS of Montana administers at own cost.
<i>Chamber Choice</i> (SG)	Profit margin is four to six times less than other BCBS of Kansas City products.

7) Premium Alternatives

<i>Child Health Plan-2</i> (Ind)	\$24 annual enrollment fee covers all children in family to reinforce the notion of value while minimizing the family's cost.
<i>FlexScope</i> (SG)	Defined Contribution allows the employer to limit its premium cost to \$80, \$100, or a fixed amount (over \$100) per employee. Under Traditional Contribution, the employer pays at least 50% of the premium. When an employer selects Defined Contribution, employees tend to choose lower-priced plans: (a) 25.5% under Defined Contribution selected low-priced plans compared to 16.3% in Traditional Contribution; (b) 32.2% of the Traditional Contribution population chose the two highest-priced plans compared to 22.7% in Defined Contribution. Data shows enrollees in Defined Contribution plans are slightly younger.
<i>Steps</i> (Ind)	Members pay a percentage of the full premium, based upon Kaiser Permanente's lowest-priced individual plan. A gradual increase in the rate over a one to four year period is intended to help the uninsured move into the commercial market.

D. TARGET POPULATION

SUMMARY ANALYSIS. Many uninsured initiatives restricted program eligibility due to limited funds to support the product or in order to avoid duplication with other coverage for the uninsured. Six of the seven individual products established income eligibility limits. This approach had greater success in states with stable eligibility requirements for public coverage and a large pool of uninsured at various income levels. The public sector has created opportunities for people to gain or retain insurance through (1) state program expansions, and (2) state application of provisions which generally prohibit discontinuation of coverage. In some cases, however, these

expansions and provisions have had unintentional consequences, which effectively negated specific income eligibility of private programs.

Some of the private sector products with criteria more restrictive than others experienced mixed results on enrollment. Two health plans which did not reach desired membership in their products had conducted preliminary assessments before initiating their programs, but attracted many applicants who were not eligible. Regardless of the target population, most new health insurance products took time to attract members. Some successful initiatives did not achieve enrollment goals until one to two years after product launch.

EXAMPLES

Geographic Eligibility: While limiting geographic eligibility can cause a health plan to turn away applicants, broad availability did not always enable the plan to reach all of its potential customers.

- Begun as a pilot, **Small Business Health Insurance (SG)** was available to firms with two to 50 employees in sections of the Bronx, Brooklyn, Manhattan, and Queens. Group Health Incorporated expected to meet its enrollment goals, based upon a preliminary assessment that showed a potential market of 100,000 lives. In retrospect, GHI believes this restricted geographic area hampered the pilot because many interested firms were outside of the area. Also, many businesses had employees who resided in sections of New York City such as Staten Island, which did not have participating providers. This may have contributed to low enrollment and possibly decreased the perceived value of the product.
- In contrast to SBHI's limited eligibility criteria, Aetna's **Affordable HealthChoices (SG)** was available to small businesses in 36 states. Aetna managed to enroll only 2,000 across the nation despite the product's large eligible pool of 26 million small group workers. This result may have occurred because the target population was too broad and marketing was not tailored.

Income: How income limitations affected the applicant pool depended in part upon the stability of eligibility criteria for other programs in the state. Products with broader, rather than narrower criteria, had a greater likelihood of reaching the uninsured population.

- **Special Care (Ind)** is limited to uninsured Pennsylvania residents with incomes up to 185% FPL. Sustaining an enrollment target of 60,000 since 1997, Highmark attributes the program's capacity to reach its intended population to several factors: preliminary market research; a large pool of eligible people (470,000 low-income uninsured); collaboration between the BCBS plans and public programs; and Highmark's high market share. Special Care has had problems in maintaining its income cut-off. The state has interpreted the guaranteed renewability provision in the Health Insurance Portability and Accountability Act (HIPAA) to allow enrollees to continue coverage regardless of income. This development has led Highmark to consider a second tier of eligibility for those with incomes exceeding 185% FPL, who would pay higher premiums with no discount on provider services.
- Kaiser Permanente unveiled its initiative for uninsured children prior to Congress' creation of SCHIP and intended to offer a plan-subsidized product where eligibility for Medi-Cal, California's Medicaid program, left off. When SCHIP was enacted in California, KP assisted the state with its design of Healthy Families and altered its proposed product so as not to compete. Like GHI, KP's preliminary analysis indicated that **Child Health Plan-1's (Ind)** potential market of up to 250,000 lives (based upon initial eligibility criteria) should have been sufficient to meet enrollment targets.

Child Health Plan-1 has subsequently modified eligibility several times as income levels expanded for Healthy Families; it is now available to children in families with income between 250%–300% FPL, with a potential market of 80,000 to 100,000. KP acknowledges difficulty in reaching its population, as two-thirds of applicants qualify for Healthy Families. Partnerships with the state enable cross-referral of applications received for Child Health Plan-1, Medi-Cal, and Healthy Families, and have increased enrollment in each program.

Immigrants: Two of the individual initiatives were available for noncitizens, who represent one of the largest populations lacking insurance, and have few alternatives for coverage.

- **Memorial Advantage (Ind)** is open to the uninsured in St. Joseph County, Indiana between the ages of 19 and 65 with income at or below 200% FPL who are ineligible for public programs; residents may be undocumented. Approximately 25 to 30 undocumented residents have enrolled.
- In 2000, Kaiser Permanente received a \$275,000 planning and demonstration grant from the California Endowment to conduct a feasibility study on extending coverage to noncitizen, uninsured children who lack access to affordable health coverage. The resulting initiative, **Child Health Plan-2 (Ind)**, is a 30-month pilot (July 2001 to December 2003) for children in parts of southeast Los Angeles County who are in families with incomes up to 250% FPL. The pilot's purpose is to examine how best to reach and serve noncitizen children, who comprise one of the largest segments of uninsured in California. Following the completion of the pilot, Kaiser Permanente will decide whether to continue the program in its current form, revise, or discontinue it.

E. PROVIDERS

SUMMARY ANALYSIS. Provider choice affected program marketability and price, as networks were a factor for some applicants in assessing the product's value. Nearly all the health care organizations used the same network as for their other products, concluding that product success depended in part on having a network identical to that of other commercial coverage. While a broad network did not guarantee that consumers would purchase a product, a restricted panel did have negative consequences on enrollment.

Four health plans negotiated discounts with providers as a means to keep premiums low. Products that utilized provider discounts coupled with restricted panels experienced more difficulty attracting enrollees than products that used discounts and the usual provider network. One health plan reimbursed primary care services in full while specialty care services were partially reimbursed to provide incentives for preventive care for the uninsured.

EXAMPLES

Provider Panel: Offering a more restricted provider network than for its other commercial members may have affected one health plan's capacity to reach potential members. However, others with broad provider choice had difficulties as well.

- **Buy Direct PPO (SG), Chamber Choice (SG), FlexScape (SG), PlanScape (Ind), Special Care (Ind), and Mid America Health Choice (SG)** use the same provider panel as other products offered by their companies, contributing to their appeal to target populations.

- As a hospital indemnity policy, **Affordable HealthChoices (SG)** allows enrollees to obtain services from any provider, yet still experienced limited sales.
- While **Memorial Advantage (Ind)** members may only use providers within the Memorial network, its predecessor program significantly reduced members' use of the emergency room and lowered hospitalization rates. Members expressed satisfaction regarding their health care needs.
- Group Health Incorporated used New York City Health and Hospitals Corporation and its more than 750 affiliated physicians through two PPO networks for **Small Business Health Insurance (SG)**. Many of SBHI's members had previously seen these same providers at no cost. Some enrollees wanted more choice in networks or physicians used by friends and family with health insurance. Other members viewed the network favorably because of the facilities' proximity to the employers.
- Blue Cross Blue Shield of Montana's **BlueCare (Ind)** began with a limited provider panel as part of a statewide coalition formed in spring 2000 to devise solutions for the uninsured. Many more providers now contract for BlueCare.

Provider Discounts: Discounts coupled with restricted networks had mixed success.

- Highmark's high market share and good relations with providers facilitated participation and negotiation of discounts for **Special Care (Ind)**. Full reimbursement for primary care providers and a significant cut of 70% for specialty physicians reinforces preventive care rather than tertiary care, which is more costly to the health care system.
- **BlueCare (Ind)** and **Memorial Advantage (Ind)** utilized provider discounts with their restricted networks but the savings have not been correlated with high levels of enrollment.

F. PROGRAM DURATION

SUMMARY ANALYSIS. Six of the initiatives were either time-limited pilot programs or intended to serve as short-term insurance. Among the new, shorter-term programs, enrollment has been lower than anticipated, as some pilots with limited availability due to service area, income, or number of potential members experienced marketing difficulties. Long-established programs were better able to meet membership targets. One health plan indicated that pilots not supported by senior management may have problems achieving their goals. A pilot launched in competition with another commercial product could garner less investment and less aggressive marketing. Short-term pilots provide only temporary coverage for the uninsured since the closing of a program marks the end of health benefits. Also, some employers who have made the commitment to join a short-term pilot may face a predicament: once the program terminates, they must maintain coverage without plan subsidies, find another affordable product, or discontinue health benefits.

Nonetheless, under certain circumstances, a pilot may be desirable. Pilot programs allow plans to try new, unproven, or otherwise risky approaches to coverage. Plans are able to make changes on a small scale and refine their products over time, before investing significant resources in major program modifications.

To overcome the barriers inherent in pilot programs, one health plan created a product

intended for those currently covered as well as the uninsured to replace its existing programs. By rolling over its current members into new individual and small group products, the plan mitigated the risk that initial enrollment projections would not be met. Over time, however, a health plan has no guarantee that every member will prefer the new product over the old or that all members will choose to renew. Moreover, the replacement products still face obstacles similar to pilots or other new programs in attracting the uninsured.

EXAMPLES

Replacement Products: One health plan created a replacement product rather than a pilot program to extend coverage to the low-income uninsured. This approach has had success in retaining current members as well as attracting new, moderate-income uninsured individuals.

- **PlanScope (Ind)** represented a new approach based on price and increased options for cost sharing. Instead of conducting a pilot, WellPoint decided to move existing individual members into PlanScope and has over 815,000 currently enrolled. Company representatives viewed this approach as preferable, believing member/agent education could happen more quickly and effectively with this method of transition.

Testing Approaches: Even when pilots did not achieve expected results, they did provide coverage for people who were previously uninsured as well as insight into features that members found to be of value. Some of the plans used pilots to refine their programs and learn how to serve populations that exhibit high rates of uninsurance.

- **Small Business Health Insurance (SG)** was a pilot to enroll 3,000 lives. At the conclusion of the two-year period, the goal was to duplicate the model city- and statewide. Although Group Health Incorporated invested significant time and resources in SBHI, the demonstration project ended in July 2001 without reaching target enrollment. However, evaluations by GHI and outside sources revealed that SBHI achieved its goals of improving health status and access to care. Primary care visits increased while emergency room visits and hospitalizations decreased. Case managers were successful in helping enrollees navigate their way through the health care system. In focus groups, employers and employees gave positive feedback on SBHI and the treatment they received. More than half of the enrollees had no coverage prior to SBHI.
- **Child Health Plan-1 (Ind)** is part of a broader initiative to achieve universal coverage for all of California's children. The expectation was to enroll 50,000 children over five years and work toward expanded coverage under public and private programs. Child Health Plan-1 has not achieved its projected membership. But during this timeframe, the state of California enacted Healthy Families and increased its income eligibility twice, along with expanding Medi-Cal, which significantly reduced the need for a private subsidized plan for children. Child Health Plan-1 continues to enroll eligible children and currently has 1,953 members.
- **Memorial Advantage (Ind)** began in July 2001 as the latest in a series of pilot programs to: (1) generate community cohesion; (2) increase access to health care for uninsured residents; (3) improve the health status of the uninsured through primary care; (4) create replicable models for community-based health care delivery reform; and (5) fulfill Memorial Health System's social responsibility and support its tax-exempt status. Pilot results have been used to reduce potential prescription drug costs, focus on immunizations, screening programs, and building trust between the hospital and patients, and redirect marketing away from door-to-door soliciting to direct referrals.

G. TRANSITIONS

SUMMARY ANALYSIS. Recognizing that many people become uninsured as a result of transition issues, some health plans designed products for those who (a) lose status as a dependent on another's policy but are unable to secure one's own coverage; (b) change jobs or become unemployed; and (c) lose eligibility for public programs but are unable to secure private coverage. Five products addressed these age, income, and public/private transitions by: allowing over-aged dependents to remain on their parents' policies; guaranteeing rate stability for the near-elderly; providing subsidies to pay for a percentage of one's premiums for a fixed amount of time; and bridging the divide between the public and private sectors through cross-referrals. Some of the transition efforts conflict with other plan strategies, for example, seeking relief from community rating to pursue age banding versus directing products to the uninsured who are near-elderly. In general, products attempting to address transition issues have generated higher enrollment than those that have not.

EXAMPLES

Age Transitions: One product incorporated features for covering the age groups that typically have a greater rate of uninsurance: young adults as well as for the near-elderly. The plan may have been able to secure higher enrollment by catering to the needs of these two populations.

- **PlanScope (Ind)** allows dependents over age 18 to remain on a parent's policy through age 23. Upon turning 23, such dependents are automatically enrolled into their own policies, with premiums based on age. Also, WellPoint has a single premium band for members aged 55-64.

Income Changes: Since studies show that many are only temporarily uninsured, one health plan created a product to accommodate income transitions encountered by individuals and families.

- **Steps (Ind)** is for the uninsured with incomes between 100%–300% FPL, who have lost coverage through a qualifying event, are in job-training, or are parents of children in **Child Health Plan-1** or **Child Health Plan-2 (Ind)** or California's AIM (Access for Infants and Mothers) or Healthy Families program. Steps allows a gradual transition from a payment of less than 100% of the full premium for Kaiser Permanente's least expensive individual plan, for a maximum period of four years. KP's experience with Steps has been both positive and negative: more enrollees are able to move up from Plan 20 to 40 than anticipated. The Steps concept has not been well understood by all members, and KP has encountered some resistance when the premium level increases after a year. Retrospective studies are planned to determine whether there is a need to create more plan levels to help ease enrollees into paying the full premium rate.

Public/Private Program Referrals: Programs allowing for public/private program transitions may have greater success in reaching the uninsured.

- Although a member of **Special Care (Ind)** may remain in the program indefinitely, annual recertification of income means that some will no longer qualify. Special Care's underlying premise is to serve as a transition to permanent coverage under an employer or individual plan. Also, as Pennsylvania rolls out adultBasic, a new public program for 19 to 64 year-olds with incomes below 200% FPL, Special Care may be modified to serve as a bridge between this program and private

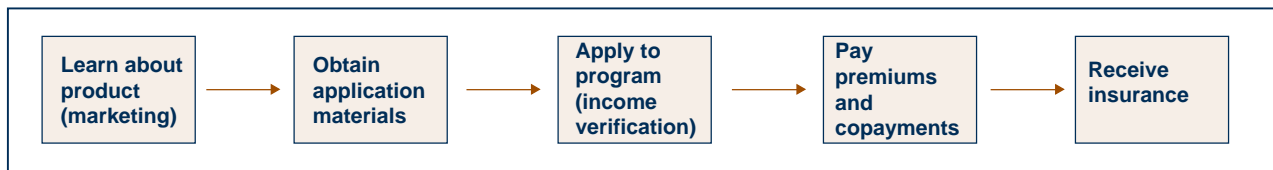
coverage. Highmark and the other Pennsylvania BCBS plans have worked closely with the state to ensure that applicants who qualify for Medicaid and SCHIP are referred to those programs. Likewise, the state agencies inform applicants ineligible for Medicaid about Special Care.

- Kaiser Permanente's **Child Health Plan-1 (Ind)** also bridges the gap between the public and private sectors by offering insurance to children who are above the income criteria for Medi-Cal and Healthy Families, but unable to afford conventional products. Cross-referrals between the state agency for public programs and Kaiser Permanente's products have also eased transitions between the public and private sectors and led to higher enrollment in both state-sponsored and private coverage.

H. ENROLLMENT AND OPERATIONS

SUMMARY ANALYSIS. Health plans acknowledged enrollment and operational problems as major barriers to obtaining health coverage since applicants must go through a multi-step process prior to obtaining coverage. A failure in any step of this process can result in lack of coverage. Figure 3 below summarizes the basic enrollment process for all of the products.

Figure 3: MULTI-STEP ENROLLMENT PROCESS



Source: S.A. Glied, *Inquiry*, Vol. 38, No. 2, Summer 2001, p. 94; authors' interpretation.

Several products examined in this study addressed enrollment issues by streamlining applications, allowing self-declaration of income, and providing multilingual application materials. These products attracted a greater percentage of the uninsured than others. Those health plans with less success had problems upstream in the enrollment sequence such as in marketing.

Because some people are unable to obtain care due to language or cultural barriers, two health plans attempted to increase access by using multilingual case managers to help new members navigate their way through the health care system. Members positively received case managers as long as the focus was on health, rather than social or career issues.

EXAMPLES

Paperwork Reduction: Streamlining the application process, through use of shorter forms and the Internet, did not always enhance enrollment.

- **Child Health Plans-1 and -2 (Ind), Memorial Advantage (Ind), Special Care (Ind), and Steps (Ind)** have one to four page application forms which may be viewed by potential enrollees as positive features.

- **Buy Direct PPO (SG)** relies on the Internet to enroll new members to simplify the process and reduce administrative costs. This approach has enjoyed limited success in part because of difficulties in navigating through Blue Cross & Blue Shield United of Wisconsin's website and because the sales force directed potential applicants to richer products due to a lack of understanding of the product's purpose as an affordable option for the underinsured or uninsured.

Multilingual Application Forms: To facilitate enrollment for various ethnic groups, some health plans provided multilingual application forms. This may have made coverage more accessible to some populations.

- To attract the Asian and Hispanic populations in California, WellPoint has materials in Chinese, Korean, and Spanish for its **FlexScape (SG)** and **PlanScape (Ind)** products. Kaiser Permanente produces **Child Health Plans-1** and **-2 (Ind)** materials in English and Spanish.
- Group Health Incorporated printed brochures and applications for **Small Business Health Insurance (SG)** in Spanish to address New York City's large Hispanic community.

Case Managers: For the uninsured who are unaccustomed to the health care system, case managers were sometimes viewed as positive features and increased a product's value.

- **Small Business Health Insurance's (SG)** "care managers" were seen as one of the best aspects of the initiative: expediting treatment through scheduling; making reminder calls for appointments; and greeting patients in the hospital lobby to facilitate check-in. Care managers also assisted members who encountered difficulties when medical facility staff were unaware of the SBHI program.
- **Memorial Advantage's (Ind)** predecessor program, Community Health Partnership, assigned case managers to each enrollee to serve as a support and assist members in understanding how to access health care services. Some enrollees viewed case management as intrusive, which has led Memorial Health System to decrease use of social case management and enhance focus on immunizations, screening programs, and building relationships between providers and patients.

Self-declaration: One of the three products that allowed self-declaration of income met target enrollment. It is too early, however, to determine whether the other products enjoyed the same success. The uninsured may perceive self-declaration of income as a positive feature.

- Enrolling in **Memorial Advantage (Ind)** requires completion of a two-page application form and self-declaration of income. Like Memorial Advantage, **Special Care's (Ind)** two-page form allowed self-declaration of income from 1992 to 2001. While income documentation was not necessary, the Blue Cross Blue Shield plans have the right to audit anyone for verification. On several occasions, BCBS has audited applicants; less than 1% have been found in violation of the guidelines. In response to the state's interpretation of HIPAA's guaranteed renewability provision and to coordinate with the SCHIP program, the BCBS plans started verifying income in January 2002.
- The **Child Health Plan-1 (Ind)** application is three pages, and Kaiser Permanente requests proof of income. The one-page **Child Health Plan-2 (Ind)** application for noncitizen children permits self-declaration of income. **Steps (Ind)** uses a four-page form and requires income certification.

IV. Recommendations

The recommendations below are based upon the previous section’s discussion of lessons learned. Implementing these recommendations does not guarantee a program’s success. Not all recommendations apply in every situation as they were based on specific circumstances encountered by the health plans as well as unique characteristics of the plans and their markets.

<i>MARKETING RECOMMENDATIONS</i>	<i>EXPLANATION</i>
1. Allocate sufficient resources to support aggressive marketing during the three months prior to product launch as well as one to two years after the program’s introduction.	1. Marketing is key to attracting members. Even with comprehensive packages at affordable prices, people must be exposed to and educated about the importance of such products.
2. Use a multifaceted approach to reach the target population.	2. In general, a variety of marketing strategies attracts a higher number of enrollees. For example, using on-line advertising as the sole source of advertising can backfire, as some uninsured people may be less likely to have access to the Internet than higher-income individuals.
3. Customize marketing strategies to local markets and distribution channels, analyzing the likelihood of success before using specific marketing techniques.	3. Certain segments of the uninsured respond more positively to particular marketing channels than others do. Health plans should use multilingual, culturally sensitive materials and techniques that appeal to ethnic groups within the target area. Advertising at faith-based community centers and schools can reach some minority populations, who are at higher risk of being uninsured.
4. Collaborate with the public sector to advertise to lower-income segments of the uninsured.	4. Health plans promoting products to those ineligible for public assistance but unable to afford commercial products can benefit from public sector partnerships. The public sector’s experience with outreach to low-income populations and the appeal of private sector products may yield high enrollment numbers.
5. Ensure that the sales force and customer services staff have been properly trained about the product’s purpose to help the uninsured.	5. Representatives who are unaware of the purpose of a product may unintentionally direct lower-income, uninsured individuals to more expensive and comprehensive products.
6. Consider campaigns that build upon the company’s reputation in the community.	6. A company’s high market share and name recognition can enhance the desirability of a product.
<i>Specific to Small Group Products</i>	
1. Use brokers at full commission.	1. Small firms view brokers as reliable sources for coverage. Anecdotal evidence suggests that when health plans alter the terms of standard broker arrangements, brokers have less incentive to refer potential applicants to a particular initiative.
2. Partner with the Chamber of Commerce in the marketing campaign.	2. The Chamber of Commerce endorsement increases exposure to potential buyers and may enhance insurer and product credibility.

BENEFIT DESIGN RECOMMENDATIONS**EXPLANATION**

1. Conduct research before creating and unveiling products to determine the right mix of cost and coverage.	1. The basic price point for coverage remains around \$100. Yet, the minimum level of benefits desired by individuals and employers may not match the maximum price customers are willing to pay or which is required to break even. Focus group studies may enable health plans to create products that reconcile this discrepancy.
2. Design benefits around price categories, rather than vice versa.	2. Recognizing that affordability is a major barrier in obtaining insurance, health plans should determine the price that consumers are willing to pay and create the best benefit package for that amount.
3. Assess the feasibility of creating comprehensive products.	3. Due to price sensitivity of some uninsured, comprehensive benefits, while more desirable, may not be affordable unless the product has substantial funding from plan subsidies or other sources.
4. Determine the receptivity of state regulators to benefit design during the initial stages of product development.	4. Some states, but not all, may have the flexibility and interest in working with an insurer to create an alternative package with basic benefits for the uninsured.
5. Create an array of choices within the product to enhance affordability.	5. A product with multiple options may require more administrative functions, such as additional enrollment and accounting processes or creation of a broader range of written materials. Therefore, this approach works best for target populations of sufficient size to absorb potentially higher costs of administration, rather than for those programs with narrow eligibility criteria.
<i>Specific to Small Group Products</i>	
1. Consider combining a small group product with other related services desired by employers, such as life insurance and dental discounts.	1. Health benefits bundled with other services may enhance a product's value. The success of this approach, however, depends upon the strength of the core insurance product.

FINANCING RECOMMENDATIONS

EXPLANATION

1. Offer reduced premiums in exchange for increased cost sharing or a limited benefits design to bring a product into reach of uninsured consumers with lower to moderate incomes.	1. Creating such products does necessitate tradeoffs. Increased cost sharing may preclude those with limited financial means from obtaining necessary care. Also, basic benefit packages may not include services required by the chronically ill. But, with limited resources, health plans must choose between affordable, basic benefits for many people, or more expensive but comprehensive care for fewer people. If the goal is to provide health care to all, then designing products with increased cost sharing and reduced benefits is one way for private health plans to support that goal.
2. Price a product to achieve a lower profit margin.	2. This compromise may be acceptable for a health plan that desires to provide affordable coverage without supporting a product through plan subsidies.
3. Use plan subsidies to reach lower-income populations.	3. Even though the ideal is to create economically self-sustainable products, some lower-income populations may not be able to afford a health plan's low-priced product. In order to reach these people, health plans may want to consider private sector subsidies to reduce uncompensated care and provide exposure to the plan for people whose circumstances may later change.
4. Negotiate discounts with providers if possible.	4. Providers may be willing to accept a lower level of reimbursement for services that otherwise would remain uncompensated. But, discounts must be applied to all providers to avoid segmenting potentially higher-risk, uninsured individuals to a few doctors.
5. Budget for higher than normal administrative costs.	5. While external perceptions may be negative, greater administrative costs may be necessary to support enhanced infrastructure for applications processing and income certification.
<i>Specific to Small Group Products</i>	
1. Create a defined contribution option to assist employers in managing health benefit costs.	1. Defined contribution allows an employer to pay a fixed dollar amount per employee towards the monthly premium. It appears to influence employee behavior and may be a tool to create affordable products for small businesses. Note that defined contribution is still a little used concept, and regulators and consumers may require additional education about its attributes.
2. Offer product rate caps that allow small employers to budget their health care costs over several years.	2. Product rate caps are attractive to small business employers since it makes purchase of coverage for their workers more feasible.

TARGET POPULATION RECOMMENDATIONS**EXPLANATION**

1. Begin with broader eligibility criteria when the product first comes on the market. Consider modifying criteria in year two or three if enrollment begins to exceed projections. Alternatively, maintain criteria and accept applications for a waiting list.	1. Broader eligibility reduces confusion among potential applicants and assists in reaching the target population. By restricting a product to a subset of the uninsured, a plan may not attain membership goals or the product's pool may become concentrated with less healthy, higher-risk individuals.
2. For nonsubsidized products, consider moderate income populations, those with incomes exceeding 200% FPL.	2. Those with incomes below 200% FPL appear to require subsidies from public or private funds in order to make the purchase of health care coverage affordable.
3. Work with state regulators at the beginning stages of product development to create scenarios for highly, moderately, and less successful enrollment along with options for product changes to attract members.	3. Altering eligibility criteria after unveiling a product may generate concerns among regulators, unless the health plan has been working collaboratively with the state from the outset.
4. Establish a method of referring applications between private and public sector coverage before introducing a product based on income and designed to complement state programs.	4. Since applicants for private products may include those who actually qualify for public coverage, health plans can reduce the number of uninsured by collaborating with state agencies. Also, state agencies can help the nonpoor uninsured by referring them to private programs.
5. Discuss with the state regulators the possibility of obtaining an exemption from laws designed to protect those currently insured from loss of coverage (such as HIPAA) but which may conflict with product eligibility restrictions.	5. Though such laws generally protect the uninsured, applying them to programs with income criteria defeats the purpose. Their restrictions potentially allow individuals who no longer qualify to remain in programs designed for lower-income individuals and create barriers to care for those in greatest need.
6. Consider specific programs for undocumented populations.	6. Although raising political issues, such initiatives reinforce public health principles, allow health plans to improve their cultural competencies, and provide access to health care for populations that disproportionately lack insurance.

PROVIDER RECOMMENDATIONS**EXPLANATION**

1. Determine whether an expanded network will enhance the desirability and sales of a product as opposed to the potential for a limited provider panel to diminish its value.	1. Health plan products that use restricted provider networks compared to other commercial products may not achieve enrollment levels that other programs attain. The uninsured apparently do not always find value in a restricted provider panel.
2. If negotiating discounts with providers, reimburse primary care services in full and discount specialty care.	2. This reimbursement strategy may promote incentives for preventive care for the uninsured. Anecdotal information points to greater cost savings through primary rather than tertiary care.

PROGRAM DURATION RECOMMENDATIONS**EXPLANATION**

1. Analyze whether the elements of a pilot may become barriers to reaching target enrollment.	1. Pilots with limited availability due to service area, income, or number of potential enrollees can make marketing and meeting enrollment goals more difficult.
2. Consider how much support a pilot project will garner from senior executives and management if implemented simultaneously with another commercial product.	2. Pilot projects that do not have management's backing may encounter significant barriers in achieving success. If the pilot is launched in competition with another product, senior staff may not invest as much time in the pilot as into the other product.
3. Create a process to transition enrollees in pilots to other programs or otherwise ensure that coverage will not be disrupted.	3. Pilots or short-term programs may provide temporary coverage for the uninsured, but when the pilot ends, so does coverage. To maintain progress in reducing the number of uninsured, health plans should find methods to transition enrollees to public programs or other private coverage.
4. Plan a strong marketing campaign prior to the pilot's launch.	4. Because pilots are generally time-limited, the success of a pilot depends on enhanced marketing efforts to encourage high enrollment during the first few months.

TRANSITION RECOMMENDATIONS**EXPLANATION**

1. Partner with state agencies to help the uninsured move between private and public programs.	1. Accepting applications on behalf of or directing applicants to appropriate public and private sector programs can allow for seamless transitions from one program to another as well as greater enrollment in each.
2. Retain "over-aged" dependents on a parent's policy, to permit a young adult to continue coverage until able to secure an individual plan or group insurance through an employer.	2. Many young adults become uninsured because they lose their status as dependents and are either unemployed or working in jobs that do not offer insurance. Products that retain older dependents may find an increase in the insurance pool of young, healthy individuals. This approach may help decrease overall insurance prices.
3. Guarantee rate stability for members over age 55.	3. Many near-elderly people are uninsured because of significant premium increases at ages 55 to 64. Providing a stable rate may reduce the likelihood that these individuals will drop insurance.
<i>Specific to Individual Products</i>	
1. Consider the incremental approach, which subsidizes an individual's partial payment of premiums at the outset of coverage and moves him to full premium rates over time.	1. This approach enables those who have experienced adverse financial situations to budget for health insurance over a few years and allows for a feasible progression of premium levels. It also recognizes that most people will not always need subsidies for coverage.

**ENROLLMENT AND OPERATIONS
RECOMMENDATIONS**

EXPLANATION

1. Simplify and limit application forms to two to four pages.	1. Many people do not obtain insurance through private or public channels because the application process is cumbersome. Reducing paperwork may encourage more people to apply for coverage.
2. Create application forms in multiple languages reflecting the diversity of the target population.	2. Materials should be available in various languages to reflect cultural diversity and enhance minorities' access to insurance.
3. Provide case managers for those unfamiliar with how to access the health care system. Make bilingual staff available to assist nonnative English speakers.	3. While having insurance is key to accessing services, operational issues may also become barriers to receiving health care. Case managers and multilingual staff can expedite treatment through scheduling, making reminder calls for appointments, and helping people better understand their insurance policies.
<i>Specific to Individual Products</i>	
1. Consider allowing self-declaration of income for initial enrollment to simplify the application process.	1. Studies have shown most people do not falsify their eligibility. Therefore, eliminating income documentation as part of the application process may remove barriers and encourage more people to apply to programs.
2. Recertify income for members in year two or three to allow others in need to access coverage. For those who exceed eligibility criteria, health plans could develop a second tier with greater cost sharing.	2. For plan-subsidized products in which enrollment maximums are fixed, health plans may consider recertifying income. This strategy allows low-income individuals with the greatest need to obtain insurance, rather than continuing coverage for those whose financial circumstances have improved.

V. Policy Context

Health plans encounter a number of significant barriers in developing solutions for the uninsured. Financing remains a key issue especially when some uninsured people are unable to afford even those products specifically designed to meet their economic needs. Facing state mandates to include benefits for various chronic conditions, many health plans are incapable of reducing premiums to a level that would be affordable for most lower-income individuals. Even with a supportive policy environment, most private health plans will probably not create programs for the poorest segment of the uninsured. Therefore, the public sector retains its essential role in extending coverage.

This section highlights some proposals addressed by health plan executives and program directors that may enhance the private sector's ability to develop affordable products.

How would the following proposed federal policy changes affect program recommendations and affordability of private sector products?

TAX CREDITS. Tax credits have been discussed for many years as a mechanism to subsidize the purchase of private health insurance. The 107th Congress in 2002 passed a bill that provides refundable tax credits to trade-displaced workers, but it deferred action on broader tax credit proposals most recently championed by the Bush Administration. Recent Census Bureau statistics indicate that a large number of moderate- to high-income individuals became uninsured in 2001. Because of this, policy analysts anticipate a renewed interest in tax credits and other means to extend health insurance to those without coverage.

The Bush Administration proposes to provide tax refundable and advanceable credits of up to \$1,000 for adults and \$500 for children with a maximum family credit of \$3,000. According to an analysis by the Council of Economic Advisers, Bush's tax credit proposal would provide most low-income people with money to cover the majority of health insurance premiums, while for others receiving the tax credit, over one third of the costs would be covered. The Bush tax credit proposal also allows people to choose to purchase either private insurance or join state high-risk pool/purchasing groups. The Treasury Department projects 6 million uninsured to take advantage of the proposal and another 11 million to benefit from reduced premiums through the tax credits.

Some policy makers believe that Bush's proposal may compel some employers to drop employee coverage, leading to a phenomenon known as crowd-out. With individuals able to secure their own tax advantage, some businesses may decide to forgo the expense and burden of administering health benefits for employees and supplement wages instead. But the Bush proposal is aimed primarily at low-income Americans who are less likely to have health insurance available at work. In addition, the size of the tax credit is inversely proportional to income with lower-income individuals receiving a greater tax subsidy. For these and other reasons, proponents of the Bush proposal believe that the credit amount will not cause employers to drop coverage. Also, many believe that tax credits can bolster the individual market and make insurance more affordable overall as more people enter and stabilize that market.

Critics of the Bush proposal and tax credit concept in general believe that tax credits for health insurance will be inadequate to buy high-priced, comprehensive insurance. It could, however, ease the purchase of a moderately priced health insurance product. For example, a person receiving a \$1,000 tax credit would end up paying \$32 per month instead of \$116 per month, for WellPoint's individual product, PlanScape. The President of Blue Cross Blue Shield of Montana cited tax credits as key to supporting his organization's attempt to reduce the uninsured population through its new BlueCare product.²⁵ A \$1,000 tax credit would permit a 49 year-old

Montana resident to purchase BlueCare at \$11 per month, which decreases the cost of coverage to less than 1% of the total income for a person at 175% FPL.

Other tax credit proposals have set subsidies at a percentage of the premium, which may allow individuals to purchase broader coverage packages. Ultimately, the usefulness of tax credits will depend on the size of the subsidy and how they are administered, since some low-income people have very limited interaction with the income tax system.

Several health plan representatives participating in this project voiced interest in premium assistance, another variation of tax credits. Funding would be directed towards health insurers and/or employers, rather than consumers, to reduce the cost of health insurance coverage. Premium subsidies can encourage health care companies to develop more innovative products aimed at low-income uninsured people. On the other hand, the availability of such funding could provoke some health plans to raise the price of products for a greater profit margin. Subsidies to small group employers may increase the affordability of health insurance products, motivating employers to purchase benefits to attract and retain employees. With premium assistance paid directly to businesses, targeting low-income populations for support may be problematic. Many low-income and part-time workers are ineligible for employment-based insurance. Also, even with subsidies, many low-income workers may still find the premium levels prohibitive.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) EXPANSION. Under COBRA, a recently unemployed worker can retain her health insurance through a former employer by paying 102% of the premium. Only 65% of the workforce would be eligible for COBRA upon loss of employment because many are uninsured workers, employed in businesses with fewer than 20 employees, or dependents on another's policy. Since few employees are ever responsible for the entire premium cost, many laid-off workers find COBRA unaffordable.

In August 2002, President Bush signed a bill to provide uninsured trade-displaced workers with premium subsidies of 65%. One study reveals that premium subsidies of 75% to 85% are needed to keep health insurance through COBRA affordable, especially to the lower-income unemployed.²⁶ These subsidies coupled with expansions of the amount of time an unemployed individual could remain eligible for COBRA may ease transitions between different insurance sources. Critics argue that such proposals favor carriers with predominantly employer-based coverage over those offering individual coverage. In addition, employers are concerned about added responsibilities for health insurance. The time expansion could be a vehicle for the large group market segment to take on more of the uninsured. Similarly, extending COBRA eligibility to small firms would allow the recently unemployed to retain coverage until able to purchase individual insurance or find a job with health benefits. Although COBRA subsidies and expansion

would not considerably affect program recommendations, such changes would make health insurance more affordable to laid-off workers. Allowing individuals and families to remain insured is important so that they may continue to have access to health care services as well as be less likely to face barriers in obtaining insurance in the future.

How would the following proposed state policy changes affect program recommendations and affordability of private sector products?

PUBLIC COVERAGE. The current health care system relies on the public sector to provide coverage to low-income uninsured people and the private sector to insure the rest of the population. But many who are near-poor or nonpoor are left behind in this fragmented system. Due to budget constraints, many states are cutting their Medicaid funding. States are reluctant to decrease budgets because they also lose the federal matching funds and further reduce the cash flow to the Medicaid and SCHIP programs. In addition, many states now face the “SCHIP dip” because of a loophole in Title XXI of the Social Security Act which reduces the SCHIP funds by \$1 billion between 2002 and 2004. The reduction in funding may lead some states to define eligibility more narrowly, with the result that some lose public coverage. This change in the composition of the uninsured population would provide health plans with a tremendous challenge, as many private sector initiatives target the nonpoor.

Despite problems balancing budgets, some states have applied for waivers from the Department of Health and Human Services to expand Medicaid or SCHIP under the Health Insurance Flexibility and Accountability Initiative. A few, however, have cut benefits from nonmandatory enrollees in order to increase eligibility criteria. Several states are proposing eligibility expansions to Medicaid for parents of children in public assistance programs. States such as California, Florida, Alabama, Iowa, and New Jersey are using tobacco settlement dollars to expand Medicaid and SCHIP. Pennsylvania is spending \$76 million of the tobacco settlement fund to create a public program called adultBasic, which is slated to begin July 2002. Based on the SCHIP model, adultBasic will provide health insurance coverage for 40,000 individuals aged 19 to 64 with incomes below 200% FPL who do not qualify for Medicaid. Enrollees will be required to pay a \$30 monthly premium, and copayments of \$5 for physician visits and \$25 for emergency room visits.²⁷ The advent of the adultBasic program will aid private coverage for the uninsured; the BCBS plans in Pennsylvania will be able to cover more people with a lower subsidy by adjusting eligibility criteria for Special Care to incomes above 200% FPL.

The expansion of Medicaid, SCHIP, and other public programs may have a positive effect on the private sector. In some states, health plans may participate in these solutions as contracting organizations with public programs. If state payments for services cover the cost of

the insurance product, the companies do not suffer financially for their efforts to help reduce the uninsured. But even if health plans do not cover the uninsured as contractors under such programs, they still benefit because the uninsured market is narrowed. Therefore, pressure upon health plans to find ways to cover the lower-income uninsured may be diminished.

REGULATORY CHANGES. Six health plans interviewed for this project cited regulatory burdens in developing and offering affordable products. Several indicated that fewer benefit mandates would enhance plans' ability to offer more affordable and innovative product designs. Arkansas and North Dakota recently passed mandate relief law to allow insurers to offer cheaper products with fewer benefits; 12 states are contemplating similar legislation.²⁸ Insurers could design packages with modified benefits to decrease premiums and allow more low-income uninsured to buy into the private market.

One health plan executive mentioned that tight rate bands can limit some small businesses from entering the insurance market because it prevents insurers from basing premiums on health status and other factors. If the band requirement is relative, that is, the health insurer cannot vary any individual's premium by more than $\pm 5\%$, then bands may prohibitively increase premiums keeping low-income people out of the market. If the requirement is absolute, that is, rates in a given year are limited to a specific range by product, bands may induce an insurer to deny coverage to groups or individuals with higher health risks. This concept is supported by a study that indicates that the probability of being uninsured increases by 29% in the small group market and 11% in the individual market when the state mandates guaranteed-issue requirements with rate bands or community rating.²⁹

VI. Conclusion

Much attention is focused on public sector initiatives to help reduce the number of uninsured. But with so many uninsured across the nation, public funds cannot provide everyone with health insurance unless significant changes are made to the current health system. This study revealed how some private sector health insurers and organizations are providing relief to the uninsured through subsidized or cheaper products and highlighted the factors that health plans deem to be integral in creating viable alternatives for the uninsured.

The private sector initiatives presented in this report do not represent model programs. The initiatives varied in their levels of success as measured by enrollment numbers. No single product or approach is transferable to all states, health plans, or subsets of the uninsured. Moreover, not every recommendation is compatible with all of the others as they were based on

specific situations encountered by certain health plans. However, the lessons learned and recommendations are intended to serve as a resource for health plan decision makers: (1) those who desire to learn about the efforts of others; (2) those who are already contemplating whether to develop products for the uninsured; or (3) those who have decided to target some portion of the population. The analysis may also be helpful to state agencies and policy makers as they consider new approaches to expand health insurance through public and private sources.

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²⁹ W. Custer, "Health Insurance Coverage and the Uninsured," (Washington, DC: Health Insurance Association of America, January 1999).

APPENDIX

OBJECTIVES AND METHODOLOGY

This research project relied upon qualitative analysis to identify private sector initiatives and generate recommendations for programs for the uninsured. NIHCM Foundation staff found products through various sources: articles, state associations, phone contacts, the Internet, and personal contacts. For further analysis, private sector initiatives were limited to programs or insurance plans that are not subsidized with public funds, offered in conjunction with a public program, or funded primarily through charitable contributions.

After locating several initiatives, NIHCM Foundation conducted a working session on July 9, 2001 in Washington, DC, to refine the project's focus. Attendees included executives and senior managers from the following health plans and health policy organizations: Arkansas Blue Cross and Blue Shield; Group Health Incorporated; Highmark Blue Cross Blue Shield; Horizon Blue Cross Blue Shield of New Jersey; Kaiser Permanente; Memorial Hospital and Health System; Trigon Healthcare, Inc.; WellPoint/Blue Cross of California; Academy for Health Services Research and Health Policy; Alliance of Community Health Plans; Institute for Health Care Research and Policy at Georgetown University; Mathematica Policy Research, Inc.; and the Robert Wood Johnson Foundation.

Representatives from five health plans with private sector programs — WellPoint, Highmark, Kaiser Permanente, Group Health Incorporated, and Memorial Health System — presented their initiatives and fostered discussion on: (1) where opportunities for private sector solutions lie; (2) the role of the private sector in covering the uninsured; and (3) market forces and policy principles that would support products for the uninsured. Topics included market segments and transitions between dependent and own subscriber coverage, employer and individual coverage, and public and private coverage.

Following the working session, NIHCM Foundation conducted interviews with program staff and executives of 10 health plans. NIHCM Foundation based the interviews with health plans on a two-part questionnaire developed for this project. The first part, executed as an in-person or telephone interview, covered the history of the initiative, product design and plan operations, relations with providers, description of beneficiaries, staffing and management, and lessons learned. The second half, designed as a written questionnaire, examined general information on the plan sponsor, regulatory environment, and market conditions.

APPENDIX

NIHCM Foundation conducted three on-site interviews and six telephone interviews. One company completed the questionnaire in writing. In addition to the interviews, NIHCM Foundation staff used annual reports, program documents and evaluations, and marketing material to supplement the information obtained from the plans. Staff analyzed this information to assess the barriers to and successes of each program and to generate recommendations for future private sector initiatives for the uninsured.

NIHCM Foundation gave health plan interviewees the opportunity to review a draft of the final report. Interviewees' comments were incorporated into the final report prior to its release.

Table 1A: FEDERAL POVERTY GUIDELINES

Number of Family Members	Income (in 48 contiguous states and DC)		
	100% FPL	200% FPL	300% FPL
1	\$8,860	\$17,720	\$26,580
2	\$11,940	\$23,880	\$35,820
3	\$15,020	\$30,040	\$45,060
4	\$18,100	\$36,200	\$54,300
5	\$21,180	\$42,360	\$63,540
6	\$24,260	\$48,520	\$72,780
7	\$27,340	\$54,680	\$82,020
8	\$30,420	\$60,840	\$91,260

SOURCE: *Federal Register*, Vol. 67, no. 31, February 14, 2002, pp. 6931-6933

AFFORDABLE HEALTHCHOICES

Aetna Inc.

Location: 36 states

Affordable HealthChoices (AHC) is a low-cost, employer-based hospital indemnity product for uninsured small business workers. Launched in 1999 by Aetna Inc., it offers hospital and some medical services paid in fixed-dollar amounts with no coinsurance or deductibles. The goal of AHC is to decrease the working uninsured population across the United States. Aetna is a national, for-profit, publicly-traded plan with 15 million members. Over the past year, Aetna has restructured its business by decreasing the number of products offered to small businesses with under 50 employees. Aetna is focusing on assuming an administrative role for self-insured medium and large firms to reduce its financial risk.¹ Since 2001, Aetna has withdrawn from the Medicaid and Medicare markets, but participates in SCHIP in some states.

BACKGROUND

In May 1999, Aetna Inc. executives introduced Affordable HealthChoices during a press conference in Washington, DC, as a remedy to decrease the number of working uninsured. Senators Bill Frist and John Breaux, and Representatives John Larson, Nancy Johnson, and Bill Thomas participated in the event to show support for the product.

The development of AHC was stimulated by the desire of Aetna Inc. executives to reduce the growing number of uninsured among private firms with fewer than 25 employees. While not a comprehensive, major medical plan, AHC's low cost was designed to motivate employers who cannot afford other commercial plans to purchase health benefits for their employees. Aetna executives also announced the creation of a \$100,000 grant from the Aetna Foundation to fund forums on local private sector initiatives to help the uninsured.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Targets small businesses with two or more employees; 50% of eligible employees must purchase the plan.
<i>Location</i>	36 states across the U.S.
<i>Target Enrollment</i>	No target specified.
<i>Potential Market</i>	Approximately 60%, or over 26 million, of the nation's uninsured are small business owners, employees, and their families.
<i>Actual Enrollment</i>	Over 2,000 members from 85 to 100 businesses.
<i>Retention</i>	N/A
<i>Staffing</i>	The same staff responsible for other Aetna products work on Affordable HealthChoices.

BENEFITS AND SERVICES

Affordable HealthChoices' three plan options offer differing levels of coverage, but have the same base benefits: hospital stay (from \$500 to \$1,500 for the first 3 days and decreasing amounts thereafter); mental health and substance abuse confinement at \$50 a day; physician office visits (6 to 10 visits per year) at \$50 per visit; 6 emergency visits per year at \$50 per visit; 6 accident services per year at \$50 per visit; access to a 24-hour health information hotline; prescription drug,

APPENDIX

dental, and vision discounts²; and alternative medicine services. Options Two and Three offer additional services such as diagnostic, x-ray, and laboratory tests, and life insurance, accidental death and dismemberment benefits.

PROVIDERS

Because AHC is a hospital indemnity policy, enrollees may obtain services from any provider.

FINANCING

Intended as a break-even product, Affordable HealthChoices is funded by member cost sharing. Depending on the option chosen, monthly premiums range from \$46 to \$91 for individuals and \$156 to \$275 for families. Employees face no deductibles or coinsurance, but are responsible for paying providers at the time of service. Employees are reimbursed the fixed-dollar amount only after a claim is submitted.

MARKETING

Affordable HealthChoices is marketed by Aetna's sales division and brokers. Aetna did not use radio or billboard advertisements. Aetna notified the U.S. Chamber of Commerce and local chambers about the product. The kick-off in Washington, DC also generated interest from the press. Aetna has partnered with HealthAxis.com to offer AHC online.

PROGRAM ANALYSIS AND LESSONS LEARNED

Aetna Inc.'s first step as a large, national insurer to provide health benefits to the working uninsured population has had limited success. Although the launch of Affordable HealthChoices garnered government support as well as media attention, the product has not substantially decreased the number of working uninsured. Some conclusions about the small numbers enrolled in AHC include:

- 1) *Marketing.* Aetna did not aggressively market Affordable HealthChoices. A contributing factor may have been Aetna's restructuring and exiting out of small group markets with less than 50 employees. Enrollment may have been greater with a more extensive campaign focusing on small business owners as well as employees.
- 2) *Benefits Design.* Aetna's product design staff believed that employers would be interested in purchasing any kind of insurance plan for their employees, even one with limited services. Despite its low cost, the slim benefits package may have actually deterred employers from enrolling because of the perception that the product did not provide enough value.
- 3) *State Regulation.* Aetna experienced problems rolling out Affordable HealthChoices in some of its small group markets. Some state regulators were slow to approve AHC. Also, Aetna product designers had to refine the product to meet restrictions in other states. For example, California regulations preclude AHC from being offered as a stand-alone health insurance product, because it does not meet benefit mandates and other requirements. So, AHC has to be sold in conjunction with another comprehensive plan, which negates its purpose.
- 4) *Replicability.* While Aetna representatives believe the product is replicable, regulations may prohibit the sale of similar hospital indemnity programs in some states.

SOURCES AND ENDNOTES

Roberta Downey, Product Manager, Affordable HealthChoices, Aetna Inc.

¹Jackson, Cheryl. "Aetna Reduces Small-Business Coverage." *American Medical News*. August 6, 2001.

²To receive discounts, members must obtain services from providers participating in Affordable HealthChoices.

BLUECARE

Blue Cross Blue Shield of Montana

Location: Montana

BlueCare is an insurance plan for low-income uninsured individuals residing in Montana. With the cooperation of a coalition of providers and hospitals across the state, Blue Cross Blue Shield of Montana launched BlueCare in July 2001 to provide a limited design plan with benefits such as medical, hospital, and prescription drug coverage to those with incomes below 150% FPL.

Eligibility is now up to 175% FPL. BCBS of Montana is a private, not-for-profit company with 288,000 members and 48% of the market share. BCBS of Montana offers network model HMO, POS, and indemnity plans, and participates in Medicare, SCHIP, CHAMPUS, and FEHBP. BCBS of Montana also serves people up to 200% FPL through the Caring Foundation of Montana, which oversees the Caring Program for children, and the Care Screenings Program for adults. The Caring Program also provides benefits to children on the SCHIP waiting list.

BACKGROUND

Montana ranks 49th out of the 50 states in median household income, and the state's uninsured rate at 18.6% is seventh highest in the nation. Blue Cross Blue Shield of Montana, hospitals, and physicians created a statewide coalition in spring 2000 to address affordability of coverage and lack of access to health care and insurance. The coalition charged BCBS of Montana with the task of designing an affordable product for the uninsured. Since many of the uninsured in Montana are between the ages of 19 and 34, BCBS of Montana based premiums on age to make the product more affordable for this population. Negotiating among the coalition members on pricing and benefit design, BCBS of Montana launched BlueCare on July 1, 2001.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Uninsured Montana residents with incomes up to 175% FPL.
<i>Location</i>	Montana
<i>Target Enrollment</i>	One percent of the uninsured or 1,750 people over one year and 5% of the uninsured or 8,750 people within two years.
<i>Potential Market</i>	168,000 are uninsured in Montana; 41% of residents are low-income.
<i>Actual Enrollment</i>	200 as of July 2002.
<i>Retention</i>	N/A
<i>Staffing</i>	For basic operations, the staffing is the same as for other products. In addition, two people are responsible for this program, and approximately four people work on the product on a regular basis.

BENEFITS AND SERVICES

BlueCare has a limited benefit design as follows: emergency room services with \$75 copayment; hospital services with \$500 copayment per year for inpatient stay, for outpatient use no copayment with a \$1,000 annual maximum; 6 physician visits per year at \$20 per visit; hospice care; severe mental illness services; mammograms; maternity and newborn care; well-child care; chemotherapy and radiation therapy; three-tiered \$20/\$30/\$45 prescription drug coverage; medical supplies and orthopedic devices; walk-in clinics at \$40 per visit; and urgent care. BlueCare provides a \$10,000 maximum benefit per year and does not provide vision, dental, diabetic education, chemical dependency, or rehabilitation, but includes some preventive benefits.

APPENDIX

PROVIDERS

Providers for BlueCare include the members of the coalition: St. Vincent Healthcare in Billings; Benefis Healthcare in Great Falls; St. Patrick Hospital and Health Sciences Center in Missoula; the Western Montana Clinic in Missoula; the Great Falls Clinic; and the Rocky Mountain Health Network, a physician group within St. Vincent Healthcare. Additional providers have signed with BlueCare since the product's launch. The hospitals and doctors have agreed to accept substantially reduced compensation for their services in order to make the premiums more affordable. Provider discounts average approximately 45% to 50%.

FINANCING

Financing for BlueCare is generated from participants' premiums and copayments of \$20 to \$500 depending on the service rendered provider discounts. The BlueCare premiums are age-based and medically underwritten. The following is the average monthly premium a low-risk, healthy individual would pay for BlueCare:

Age Bands	Premium	Age Bands	Premium	Age Bands	Premium
0-24	\$53.83	40-44	\$80.99	60+	\$136.40
25-29	\$57.78	45-49	\$94.68	One Child	\$39.39
30-34	\$62.86	50-54	\$102.72	2+ Children	\$78.78
35-39	\$71.06	55-59	\$136.40		

Premium dollars are allocated to the medical cost of the individual with 50% distributed to the hospital, 40% to the doctors, and 10% to BCBS of Montana. The product was carefully priced in order to break even. BCBS of Montana administers the product at its own cost.

MARKETING

Marketing for BlueCare is statewide and provided by BCBS of Montana and the coalition. BCBS of Montana uses brokers for BlueCare and distributes brochures in hospitals and doctors' offices. Blue Care is advertised on television, the Internet, and in newspapers, and its newsletters. Working with the Department of Public Health and Human Services, BCBS of Montana developed brochures targeted to low-income parents whose children are in SCHIP to inform them about BlueCare. Those interested in BlueCare may also request applications by calling a toll-free number. BlueCare's media attention has resulted in additional inquiries from prospective members.

PROGRAM ANALYSIS AND LESSONS LEARNED

- 1) *State Regulation.* State regulators were impressed that BCBS of Montana and the providers devised BlueCare without government prodding and were quick to support and approve it.
- 2) *Providers.* Without the support and cooperation of providers, the price of BlueCare would be substantially higher. Providers were willing to accept the reduced reimbursement to help keep the premiums affordable. Providers were also integral in designing a product to meet the needs of Montana's working poor.
- 3) *Affordability.* Even at a low price of \$53 per month, BCBS of Montana is concerned that some low-income uninsured will not purchase BlueCare. Families with low incomes may have other competing financial priorities such as food and shelter. This concern prompted BCBS of Montana to broaden eligibility to individuals with incomes up to 175% FPL in April 2002.
- 4) *Replicability.* A product like BlueCare may have success in areas in which insurers and providers have established relationships and in states with residents who earn higher incomes.

SOURCES

Chuck Butler, Vice President, Government and Public Relations, Blue Cross Blue Shield of Montana

BUY DIRECT PPO

Blue Cross & Blue Shield United of Wisconsin

Location: Wisconsin

Launched in October 2000 by Blue Cross & Blue Shield United of Wisconsin, Buy Direct PPO was designed to offer a low-cost option for small employers, support to start-up businesses, and reduce the number of the working uninsured in Wisconsin. Employers choose between two Buy Direct PPO models to offer their employees. Model 1 has a lower premium, but higher out-of-pocket costs for employees, while Model 2 has a higher premium with lower out-of-pocket costs. Buy Direct PPO was designed as a profit-making product. BCBS United of Wisconsin is a business unit within Cobalt Corporation, which has been a for-profit, publicly traded entity since March 2001. BCBS United of Wisconsin currently has 561,486 members and participates in Medicare, and Wisconsin's Health Insurance Risk Sharing Plan, which offers coverage to individuals who are unable to purchase private insurance.

BACKGROUND

The rate of uninsured in Wisconsin in 1999 was 12%, well below the national rate of 16%. Still, this number represents over half a million people who lack health coverage. The rate of nonelderly Wisconsin residents with employer-based insurance is 81%. Only 39% of Wisconsin residents with incomes under 200% FPL, however, are insured through employers.

Buy Direct PPO was developed in response to the large number of people in Wisconsin who are not insured through employers and the desire of company marketing executives to launch a new product simultaneously with the new website, <http://www.bluecrosswisconsin.com>. BCBS United of Wisconsin's product development team wanted to design a product for the uninsured and underinsured at starter companies and businesses that could not afford conventional insurance. The goal was to set the price at 20% less than the current PPO offering. Presented to the market in October 2000, Buy Direct PPO was reconfigured in October 2001 with slimmer benefits and different deductible and coinsurance levels.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Small businesses and start-up companies.
<i>Location</i>	Wisconsin
<i>Target Enrollment</i>	No target was set prior to the launch.
<i>Potential Market</i>	65,000 uninsured small business employees.
<i>Actual Enrollment</i>	No groups enrolled; Buy Direct PPO has been altered to attract members.
<i>Retention</i>	N/A
<i>Staffing</i>	Staffing for Buy Direct PPO does not differ from staffing for other commercial products.

BENEFITS AND SERVICES

Buy Direct PPO is fairly comprehensive but offers fewer benefits compared to BCBS United of Wisconsin's standard PPO product. All benefits except childhood immunizations, mental health services, and routine care are subject to deductibles and coinsurance. Both models within Buy Direct PPO include the following services: inpatient hospital stays; outpatient hospital services such as emergency care and diagnostic, x-ray and laboratory procedures; surgical services including physician, transplants, anesthesia; medical office visits, accident care, childhood immunizations,

APPENDIX

chiropractor services; chemotherapy, radiation, dialysis, physical, speech, respiratory, and occupational therapy; maternity; mental health; prescription drugs; ambulance; dental and oral surgery; and routine care.

PROVIDERS

The provider panel for BuyDirect PPO is the same as for other BCBS United of Wisconsin's commercial products. The network is well-established and statewide. Fourteen percent of the providers are in solo practices, 20.4% in IPAs, and 65.5% in group practices. While most services may be obtained out-of-network at a higher cost, routine care is not covered outside of the network.

FINANCING

Buy Direct PPO is financed by employer and employee cost sharing. Employers pay monthly premiums, and employees are responsible for remaining amounts such as deductibles, coinsurance, out-of-pocket maximums, and copayments. Obtaining services out-of-network incurs higher costs.

Models 1 and 2 have the same benefits but different levels of coinsurance and deductibles. The annual deductibles for an individual in Model 1 are \$500 in-network or \$1,000 out-of-network. For Model 2, an individual's annual deductibles are \$2,000 in-network or \$5,000 out-of-network. Coinsurance for in-network services in both models is 80%/20%. For out-of-network services, the coinsurance in Model 1 is 50%/50% and in Model 2 is 60%/40%. The cost for a small group in Dane County with four employees (including a 25 year-old single female, a 29 year-old single male, a 37 year-old male and his family, and a 46 year-old male and his spouse) under Model 1 would amount to \$1055.73 per month. For a similar group under Model 2, the cost would be \$938.41 per month.

MARKETING

BCBS United of Wisconsin has a marketing campaign to encourage employers to purchase health insurance online. Applicants may obtain information about Buy Direct PPO by navigating through links at BCBS United of Wisconsin's main webpage or calling a toll-free number. Buy Direct PPO was designed to stimulate online purchasing, which would cut down on administrative costs.

PROGRAM ANALYSIS AND LESSONS LEARNED

- 1) *Marketing.* BCBS United of Wisconsin plans to increase awareness of Buy Direct PPO through a targeted marketing campaign to small employers struggling to offer insurance. Although marketed on-line, some uninsured may not have access to the Internet. Shifting the focus to include print or radio advertisements may increase the likelihood of reaching the uninsured.
- 2) *Training.* BCBS United of Wisconsin retrained its sales force during the 3rd Quarter of 2001 because they did not understand that the product was for the uninsured. Since Buy Direct PPO has slimmer benefits compared to the standard PPO product, the sales force referred many potential Buy Direct PPO purchasers to the more expensive standard product instead.
- 3) *Financing.* BCBS United of Wisconsin has increased deductibles for services obtained out-of-network in order to persuade members to use in-network providers and to increase cost-savings.
- 4) *State Regulation.* Wisconsin's 21 benefit mandates affect the ability to limit benefits, which hinders insurance plans from creating low-cost alternatives for the uninsured. The use of rate bands inhibits the ability to give healthier individuals better rates.
- 5) *Replicability.* Buy Direct PPO is replicable in other areas, but the sales division must be properly trained to increase awareness to the target audience.

SOURCES

Sue Janczak, Director, Corporate Marketing, Blue Cross & Blue Shield United of Wisconsin

CHAMBER CHOICE

Blue Cross Blue Shield of Kansas City
Location: Kansas City Metropolitan Area

Chamber Choice is a product designed for small businesses with up to 50 employees in the Kansas City metropolitan area. Endorsed by the Greater Kansas City Chamber of Commerce, Blue Cross Blue Shield of Kansas City introduced the product in 1994 to address the high rate of small businesses not offering insurance to employees. BCBS of Kansas City is the largest for-profit insurance plan in the 32 county region serving the greater Kansas City area and northwest Missouri, offering PPO and HMO products to 805,000 members. BCBS of Kansas City participates in Medicare and Medicaid.

BACKGROUND

Chamber Choice began in response to a Greater Kansas City Chamber of Commerce initiative in which Peter Levi, the Chamber President, challenged the private sector to increase health insurance offerings for small and low-wage businesses. Small businesses dominate approximately 95% of Kansas City's marketplace. Several private health insurance companies, including Blue Cross Blue Shield of Kansas City, participated in the challenge to develop affordable, small group products.

Since the launch of Chamber Choice, there have been several changes. Eleven local Chambers of Commerce have joined the Greater Kansas City Chamber of Commerce to endorse BCBS of Kansas City's Chamber Choice because of its rate stability. As health care costs have continued to increase, the health plan has had to adjust rates. In 1994, BCBS of Kansas City guaranteed that the rate hike would not exceed 9%. In 2001 the rate rose to 10.9%, and in 2002 the rate hike will probably be 14% because of increases in utilization and state mandates to cover more conditions. In addition to the rate changes, BCBS of Kansas City has expanded the eligibility criteria from small businesses with 2 to 25 employees to firms with up to 50 employees.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Small businesses in Kansas City with up to 50 employees.
<i>Location</i>	Small businesses must be located in the core metropolitan area of Kansas City, which includes Jackson, Clay, Platte, and Cass counties in Missouri, and Johnson and Wyandotte counties in Kansas.
<i>Target Enrollment</i>	Instead of a fixed enrollment number, BCBS of Kansas City has a target growth rate of 15% per year. While the enrollment grew 10% per year from 1994 to 1997, the rate of growth increased from 1999 to 2001 to nearly 30%.
<i>Potential Market</i>	1,515,994 uninsured in the Kansas City Metropolitan Area, with 1,076,356 with incomes above 250% FPL.
<i>Actual Enrollment</i>	39,600 members. Approximately 30% to 35% of businesses were not offering health insurance prior to joining Chamber Choice. Four out of 10 employees were uninsured prior to enrollment.
<i>Retention</i>	82% to 86% of the members remain in Chamber Choice each year.
<i>Staffing</i>	Chamber Choice staff is the same as staff of other products.

APPENDIX

BENEFITS AND SERVICES

Chamber Choice allows employers to choose among five different plan arrays. Each array consists of a PPO, a traditional HMO, and an open-access HMO product. Employees then choose one of the three products within the array. The basic plan benefits include: physician visits at \$15 to \$25 per visit; inpatient and outpatient hospital procedures; hospital stay at \$100 to \$500; a \$5/\$20/\$40 to \$10/\$30/\$50 three-tiered prescription drug plan; life insurance; dental benefits; and accidental death and dismemberment benefits.

PROVIDERS

The provider networks and physician reimbursement levels for Chamber Choice are the same as for other BCBS of Kansas City products.

FINANCING

Chamber Choice is financed by member cost sharing and premiums. Copayments range from \$15 to \$500 depending on the plan. Monthly premiums are group and member specific with average premiums of \$125 for healthier, lower-risk groups and \$208 for extremely high-risk groups. The average premium per member per month is \$166.56. The average price of Chamber Choice is lower than other commercial products offered by competitors (except for those in the high-risk groups).

Approximately 87% to 88% of the total overall cost of the product is used for health benefits, 12% to 13% for administration, and 0.5% for profit. The profit margins for other BCBS of Kansas City products are four to six times greater than for Chamber Choice.

MARKETING

BCBS of Kansas City's multifaceted marketing approach includes print, radio and television ads as well as direct mail to very small employers. A broker community of around 1,000 brokers recruit 96% of the members through direct contact with Chamber businesses. Chamber Choice is also marketed on the Internet. Employers may obtain information by calling BCBS of Kansas City's toll-free number.

PROGRAM ANALYSIS AND LESSONS LEARNED

Although Chamber Choice was not created as an uninsured product, it targets a segment of Kansas City's population without insurance. With few small firms offering health insurance, many employees were leaving their jobs to work at the new riverboat casinos which did offer health benefits.¹ BCBS of Kansas City representatives believe that Chamber Choice has been instrumental in increasing the number of the insured in Kansas City since 30% to 35% of small businesses had not offered insurance prior to enrolling in this product. Some of the reasons cited for the success in reaching the uninsured population include the following:

- 1) *Benefit Design.* Chamber Choice not only offers comprehensive coverage, it also provides life insurance of \$20,000 per employee, dental benefits, and accidental death and dismemberment policies. The multiple options within Chamber Choice allow employees to choose products that best suit their needs. BCBS of Kansas City has recently designed the PPO and HMO products as actuarially equivalent in order to stabilize the products and keep adverse selection low.
- 2) *Rate Stability.* Many small employers do not offer health insurance because of annual increases in health care costs. Chamber Choice provides small businesses a reasonably priced plan with a rate cap which allows employers to budget for health benefits over several years. BCBS of Kansas City sees Chamber Choice's rate stability as a key feature in attracting the uninsured.

- 3) *Marketing*. Chamber Choice has gained recognition among the small businesses in Kansas City as being an affordable product due to an extensive marketing campaign. BCBS of Kansas City stated that a less well-known insurance company interested in marketing a small group product such as Chamber Choice may benefit from the local Chamber of Commerce's support.
- 4) *Replicability*. Replicability of this program depends on an insurer's ability to offer stable rates to a large pool of businesses.

SOURCES AND ENDNOTES

Jeffrey Nelson, Manager, Marketing Communications, Blue Cross Blue Shield of Kansas City

¹Lagnado, Lucette. "Small Firms Offer Health Benefits to Lure Workers in Kansas City." *The Wall Street Journal*, 14 April 1999.

APPENDIX

DUES SUBSIDY PROGRAM

Kaiser Permanente
Location: California

Kaiser Permanente's (KP) Dues Subsidy Program began in 1990 as an effort to subsidize programs for low-income people who could not afford or did not have access to health insurance. Built in the context of KP's social mission to improve the health of its members and communities, the Dues Subsidy Program in California now has two subsidized programs for the uninsured — the health plans under the Kaiser Permanente Cares for Kids initiative for children and Steps for adults and families. The state of California has one of the nation's highest rates of uninsured. Kaiser Permanente is a not-for-profit, health care service plan with 6.3 million members in California and 8.3 million members nationwide, and participates in Medicare, Medi-Cal (California's Medicaid program), SCHIP, Access for Infants and Mothers (AIM), and the state's high-risk pool, MRMIP (Major Risk Medical Insurance Program).

BACKGROUND

Kaiser Permanente created the Direct Community Benefit Investment initiative (DCBI) with the following three objectives: (1) to improve children's health; (2) to improve the health of the uninsured through subsidized coverage or care; and (3) to advance medical knowledge through clinical and health services research. The Dues Subsidy Program is the part of DCBI under which KP establishes plan-subsidized products targeted at specific audiences.

As part of the focus on children's health, Kaiser Permanente partnered with President Bill Clinton and Mayor Richard Riordan of Los Angeles to announce Kaiser Permanente Cares for Kids in June 1997. The goal of the \$100 million initiative was to ensure universal coverage for all of California's uninsured children within five years. The initiative predated the creation of SCHIP and was intended to provide coverage for children where Medi-Cal left off. Child Health Plan-1 (CHP-1) provides coverage to children who are ineligible for public assistance and cannot afford commercial products. Less than 14% of uninsured children in California are eligible for CHP-1. In 2000, KP received a \$275,000 planning and demonstration grant from the California Endowment to conduct a feasibility study to extend coverage to noncitizen, uninsured children who lack access to affordable health coverage. In July 2001, Child Health Plan-2 (CHP-2) was launched as a 30-month pilot through December 2003.

In 1999, Kaiser Permanente implemented the Steps Plan to provide plan-subsidized insurance for low-income individuals and families who lost coverage through a qualifying event and who are unable to afford private insurance but ineligible for government assistance. The product is designed to help the uninsured incrementally move into the commercial market, via a tiered premium level. Steps members pay a percentage of the full premium. The member share of the premium is increased over a period of one to four years. Steps is intended to influence behavior, demonstrate the value of health care coverage, and encourage the uninsured to build the cost of health care into their family budget over time.

Since inception, Steps and CHP-1 have modified eligibility criteria. Previously available only to former KP members who had lost coverage due to a qualifying event, Steps is now open to parents of children enrolled in public programs, CHP-1, Healthy Families (California's SCHIP) and AIM, and students enrolled in occupational and vocational training programs. CHP-1 has been altered significantly to keep it complementary and not competitive with income requirements under Healthy Families.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

	Child Health Plan-1	Child Health Plan-2	Steps
<i>Population</i>	Uninsured children whose families' incomes are between 250% and 300% FPL; must not be eligible for employer-subsidized coverage.	Noncitizen, uninsured children up to 250% FPL and who permanently reside within the KP service area; must not be eligible for employer-based coverage.	Uninsured individuals and families with incomes between 100% to 300% FPL.
<i>Location</i>	California	Various zip codes in Los Angeles, California	California
<i>Target Enrollment</i>	2,000 children by the end of 2002.	5,000 children.	20,000 by the end of 2002.
<i>Potential Market</i>	80,000 to 100,000 children.	20,000 to 30,000 children.	More than 2.5 million Californians.
<i>Actual Enrollment</i>	1,953 children as of May 2002.	3,131 children as of May 2002.	14,501 as of May 2002.
<i>Retention</i>	N/A	N/A	N/A
<i>Staffing</i>	Staffing is the same as for other KP products, plus the KP Cares for Kids team, which consists of a program manager, coordinator, administrator, writer, and six processors. Processors also handle the Steps Plan.		Staffing is the same as for other KP products, plus an enrollment team consisting of 11 staff members who handle Steps. Staff includes a program manager, supervisor, assistant supervisor, systems analyst, and the six processors from CHP-1 and CHP-2.

BENEFITS AND SERVICES

CHP-1 and CHP-2 have comprehensive benefits with low copayments, including: hospital care; medical office visits; allergy injections; prenatal and well-baby care (until age two); hearing and vision tests; laboratory and x-ray services; up to 100 days' supply of prescription drugs; emergency services; ambulance services; 30 days of inpatient mental health care and outpatient mental health therapy; and vision care/eyeglasses (vision care does not include optical services). The maximum copayment is \$250 per child or \$500 per family. CHP-2 also offers dental coverage for basic diagnostic and preventive dental services through DeltaCare/PMI providers.

The comprehensive package for Steps includes: outpatient office visits; allergy testing and injections; well-child preventive care visits; prenatal care; immunizations; emergency room visits; hospital care; alcohol or drug dependency therapy; outpatient treatment; ambulance service; prescription drugs; durable medical equipment during inpatient stays; family planning; hearing tests; laboratory tests; inpatient and outpatient procedures; inpatient and outpatient mental health care; rehabilitation; skilled nursing facility care; and vision care. Copayment levels range from \$2 to \$35 depending on Steps Plan level and service rendered.

APPENDIX

PROVIDERS

The Permanente Medical Group, Inc. and the Southern California Permanente Medical Group provide services to Dues Subsidy plan members on the same basis as to all other KP members.

FINANCING

Most of Dues Subsidy's financing comes from DCBI. In 2000, Kaiser Permanente allocated approximately \$365 million (about \$300 million in California) from its revenue to DCBI activities, with \$19.3 million (\$5.8 million in California) of the total directed to subsidized programs. Dues Subsidy products are also financed by some member cost sharing through premiums and copayments.

From 1998 to 2001 the CHP-1 premium was \$35 per child per month, capped at three children; it decreased to \$15 per child per month in January 2002. CHP-2 has an annual enrollment fee of \$24, covering all children in a family, and no premiums. CHP-1 premiums are subsidized at 73% and CHP-2 is fully subsidized.

The Steps Plan allows members to pay a percentage of KP's lowest-priced individual plan. Steps has four different payment options — Steps Plan 20, Plan 40, Plan 60, and Plan 80 — which follow a fixed payment schedule. For example, during the first year, a member who qualifies for Steps Plan 20 pays a premium approximately equal to 20% of the current full premium of the KP Individual Product. In each subsequent year, the percentage of the premium paid increases by about 20% until the fourth year when the member is paying approximately 80% of the premium of the KP Individual Product. At that point, the premium of the KP Individual Product is only 20% greater than payments under Steps Plan 80.

Premiums are based on age and family size. Family income determines the Plan Level at which the member enters the program. Seventy percent of enrollees are in Plan 20 or 40. In 2001, the premium for Plan 20 ranged from \$20.94 for an individual under age 30, to \$119.12 for a family with at least one adult between ages 60–64. The Plan 60 premium ranged from \$60.61 for an individual under 30, to \$330.30 for a family with at least one adult between 60–64. Steps average monthly cost was \$243.61, with \$204 coming from the subsidy and \$39.61 from member contributions. The total cost of Steps was \$19.8 million in 2001.

Approximately 8%–10% of the total cost of CHP-1, CHP-2, and Steps is allocated to administration with \$710,000 directed towards application processing. Application processing and the Steps processing and enrollment system causes the administrative costs for these products to exceed the 4% fee for other KP products.

MARKETING

Marketing for CHP-1 includes print and radio advertising as well as direct mail. Parents may also request an application through the Internet, at various community-based organizations, schools, and KP facilities, or upon request by calling a toll-free number.

Kaiser Permanente is working with the Los Angeles unified school district CHAMP staff to develop a system of localized outreach and application assistance for CHP-2. KP is also providing funds to community-based organizations and other participating school districts and coordinating with community health centers, faith-based groups, immigrant resource agencies, and worksite programs to help families enroll their children in CHP-2. Currently, 22 locations are available in which an Enrollment Assister may help families learn about and enroll their children in the plan.

For Steps, previous KP members who have experienced a qualifying event may contact or go to KP facilities directly to obtain an enrollment kit. KP markets the program through print material and brochures, the Internet, vocational training schools, and a toll-free phone number. KP also targets those in vocational training through presentations and materials disseminated to case workers, as well as the parents of children enrolled in Kaiser Permanente through Healthy Families, AIM, and CHP-1.

PROGRAM ANALYSIS AND LESSONS LEARNED

- 1) *Marketing.* Kaiser Permanente's partnerships with community-based organizations, coalitions, schools, and government agencies resulted in increased synergy, better coordinated outreach efforts, and stronger community relations. This has been invaluable in marketing all Dues Subsidy Programs. However, KP has encountered difficulties in targeting the CHP-1 population because many who are eligible are difficult to locate within the general population and not necessarily in touch with community or social services. For CHP-1, the health plan tried a direct mail campaign, and the response rate was 1%. Press conferences and community events generated some interest, but did not produce an overwhelming response. Changing eligibility criteria complicated marketing efforts. Also, because of its complexity, the Steps program has been difficult to explain to some enrollees. KP has encountered some resistance when the premium subsidy level is decreased after the enrollee's first year.
- 2) *Internal Support.* Senior management has been strongly supportive of CHP-1, CHP-2, and Steps, and open to considering new programs that extend coverage to the uninsured.
- 3) *Flexibility.* KP had flexibility to modify products in response to enrollment barriers and environmental changes. For example, eligibility criteria for both CHP-1 and Steps was changed.
- 4) *Enrollment.* CHP-1 membership has historically not met targeted projections. Two-thirds of the applicants are eligible for and thus referred to Healthy Families. Some had applied to CHP-1 because of stigma associated with government programs. However, the health plan is learning from and testing various outreach strategies that may help increase membership. Enrollment in CHP-2 has met targets. Also, Kaiser Permanente Cares for Kids is not a subsidized product, but a multifaceted initiative for universal coverage for children. Its strong emphasis on advocacy and coalition work contributed to increased enrollment in Medi-Cal and Healthy Families.
- 5) *Cultural Competence.* Focusing on specific populations as in CHP-2 has raised some important delivery system requirements such as accessibility to culturally competent providers. Increasing cultural competence may boost member retention.
- 6) *Plan Design.* While Kaiser Permanente is encouraged that more Steps enrollees than anticipated are able to move up the premium level from Plan 20 to 40, retrospective studies are planned to determine whether there is a need to create more plan levels to ease Steps enrollees into paying full premium rates. Also, Dues Subsidy plans are intended as transitional coverage, not as a permanent source of insurance.
- 7) *Replicability.* KP staff believe Dues Subsidy can be implemented by others, but the health plan's unique delivery system and heavy plan subsidies may make replication less likely. KP staff would like to see state governments implement a Steps-type program to help people enter the commercial health care system.

SOURCES

Jean Nudelman, Director, Kaiser Permanente Cares for Kids, Kaiser Permanente
 Rita Zwern, Manager, State Programs, Business Line, Kaiser Permanente
 Annabel Hom, Business Line Team Lead, Kaiser Permanente

APPENDIX

MEMORIAL ADVANTAGE

Memorial Hospital and Health System

Location: St. Joseph County, Indiana

Memorial Advantage is a health cost assistance program for residents of St. Joseph County with incomes at or below 200% FPL. Launched in 2001 as a two-year pilot, Memorial Advantage offers preventive medical, emergency, and hospital services to enrollees. The program is sponsored by Memorial Hospital and Health System with support from the Health and Hospital Corporation of Marion County, Memorial Medical Group, Memorial Family Pharmacy, South Bend Medical Foundation, Radiology, Inc., and physician specialty groups contracting with Memorial. Memorial Health System is a private, community owned health care system headquartered in South Bend, Indiana. Memorial Hospital is a Catholic institution with 526 beds and dedicated to improving the health and quality of life of community members and providing a model of success for other hospitals. Memorial does not participate in publicly financed programs.

BACKGROUND

Since 1993, Memorial Hospital and Health System has created pilot programs to: (1) generate community cohesion; (2) increase access to health care for uninsured residents; (3) improve the health status of the uninsured through primary care; (4) create replicable models for community-based health care delivery reform; and (5) fulfill its social responsibility and support its tax-exempt status.

Memorial Advantage evolved from two previous initiatives – Community Health Partnership (CHP) and Primary Care Access (PCA). CHP was a three-year program heavily subsidized with “tithing funds,” that is, a 10% portion of hospital revenue earmarked for community services. Memorial collaborated with PARTNERS Health Plan, Turning Point, and the Southeast Quality of Life Neighborhood Organization to plan a project addressing the health care needs of the uninsured. Focus groups were conducted with the Broadway Christian Parish and other community residents. Case managers were assigned to each enrollee to serve as a support and to help members navigate their way through the system. Initial enrollment was slow, but reached 700 by the end of the third year.

Primary Care Access is a transition program offering primary care services, some dental care, and prescription drug benefits for the uninsured residents of St. Joseph County. PCA is sponsored by Memorial Hospital, Memorial Medical Group, Memorial Family Pharmacy, South Bend Medical Foundation, which provides laboratory services, and Radiology, Inc. PCA is funded by subsidies and a sliding scale fee schedule. While still operating, fewer funds are allocated to this program and more individuals are being referred to Memorial Advantage.

The elements of Memorial Advantage are based on Wishard Advantage, which was sponsored by Wishard Hospital, a public hospital in Marion County, Indiana, and lessons learned from previous initiatives. Memorial Advantage began in July 2001 to provide more comprehensive benefits such as primary, preventive, emergency, and hospital care for the uninsured. Currently, the staff is contemplating the implementation of a medical assistance program for the indigent who are trying to transition into Memorial Advantage.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Uninsured residents of St. Joseph County between the ages of 19 and 65 with income at or below 200% FPL and ineligible for public programs; residents may be undocumented.
<i>Location</i>	St. Joseph County, Indiana
<i>Target Enrollment</i>	1,000 to 1,500 people.
<i>Potential Market</i>	Fourteen percent of Indiana's population is uninsured; 66% of the uninsured have incomes under 200% FPL.
<i>Actual Enrollment</i>	250 people (25-30 undocumented residents).
<i>Retention</i>	Approximately 80%. Twenty percent of members are transient or sever contact with Memorial.
<i>Staffing</i>	Staff includes the executive director, manager, and three coordinators who work on enrollment for Memorial Advantage and PCA.

BENEFITS AND SERVICES

Memorial Advantage provides comprehensive coverage, including primary care physician office visits and consultations, immunizations, preventive services for women, check-ups and exams, laboratory and x-ray procedures, primary care physician authorized emergency and specialty services, and inpatient and outpatient hospital care. Benefits must be sought within the Memorial Advantage network.

PROVIDERS

Enrollees may obtain primary care services at three clinics: Memorial Neighborhood Health Center Southeast Clinic; Memorial Neighborhood Health Center Central Clinic; and Memorial Family Practice Center. Specialty services, laboratory and x-ray procedures, and hospital care are provided at Memorial Hospital and Health System, South Bend Medical Foundation, Radiology, Inc., and through other physician groups contracting with Memorial.

FINANCING

Financing for Memorial Advantage relies on Memorial's tithing, member copayments, and lower reimbursement to providers. As a Catholic hospital, Memorial allocates 10% of revenue to fund community services; \$400,000 over two years is allocated with \$200,000 directed to the program and \$200,000 for staff and in-kind clinics. Payment levels to physicians differ. Primary care physicians accept a 40% discount for services. Discounts from specialty physicians vary as negotiations were conducted on a one-to-one basis. South Bend Medical Foundation gives Memorial a 96% discount on laboratory work.

The estimated overall cost of caring for enrollees in Memorial Advantage based on figures from PCA range from \$50 to \$1,000 with an average of \$189 per month. Enrollees are responsible for copayments and do not pay monthly premiums. The chart on the next page shows the copayments for various services.

APPENDIX

Memorial Advantage Copayment Table
Percentage of Federal Poverty Guidelines

	<100%	101-150%	151-170%	171-190%	191-200%
Primary Care Office Visit	\$2	\$5	\$10	\$15	\$20
Specialty Office Visit	\$5	\$10	\$15	\$20	\$25
Med-Point	\$2	\$5	\$10	\$15	\$20
Emergency Room Visit	\$5	\$15	\$30	\$40	\$50
Hospital Admission	\$50	\$100	\$150	\$300	\$450

In the first three months of the program, 28% of finances were used for administrative services. As the program enrollment increases, the percentage designated for administration is expected to decrease significantly.

MARKETING

Memorial's aggressive marketing campaign for CHP included television and radio advertisements, flyer handouts, and door-to-door soliciting. Enrollment did not increase until Memorial began mass mailings and school-based educational programs. Most people have enrolled in Memorial Advantage through direct referrals at clinics.

PROGRAM ANALYSIS AND LESSONS LEARNED

Because Memorial Advantage is a relatively new program, staff were unable to elaborate on lessons learned. Based on experiences from previous programs, Memorial has tried to refine Memorial Advantage. Staff are optimistic that this project will improve the health of the uninsured based upon evaluations of its predecessor, CHP. That program reduced members' use of the emergency room by 97%, lowered hospitalization rates by 60%, and created an estimated savings of \$826,047 to Memorial, which in 2000 faced \$14,809,000 in uncompensated care. Ninety percent of CHP's members reported that it served their health needs; 100% would recommend CHP to a family member or friend. Other lessons from prior initiatives include:

- 1) *Marketing/Enrollment.* The target market did not respond to CHP's television and radio ads, flyers, and door-to-door soliciting. People questioned Memorial's motives for offering CHP at such low cost and found the soliciting unwelcome. Thus, Memorial is concentrating on direct referrals and word-of-mouth to recruit the uninsured into Memorial Advantage.
- 2) *Case Management.* Because enrollees in CHP viewed case management as intrusive, Memorial Advantage will decrease social case management and focus on immunizations, screening programs, and building trust between the hospital and patients.
- 3) *Benefit Design.* Prescription drug coverage was excluded as a result of the expenses incurred from PCA. Although only 20% of the 1,100 people enrolled in PCA needed medication, prescription drug coverage cost \$20,000 to \$25,000 per month.
- 4) *Financing.* Tithing and provider discounts were essential in establishing the programs. Without tithes or discounts, Memorial staff believes that other health care organizations would have difficulty raising the funds for such a program.
- 5) *Replicability.* Memorial Staff believe that all three programs are replicable with heavy investment, supportive senior management, and a focus on improving the health of the community.

SOURCES

Margo Demont, PhD, Executive Director, Office of Community Affairs, Memorial Hospital and Health System
Stacy J. Chelminiak, Health Care Access Manager, Office of Community Affairs, Memorial Hospital and Health System

MID AMERICA HEALTH CHOICE

Mid America Health
Location: Kansas City

Mid America Health Choice is a health insurance product for small businesses with 2 to 50 full-time employees offered by Mid America Health. Developed in response to the Greater Kansas City Chamber of Commerce's challenge to expand health insurance to small businesses, Mid America Health Choice offers affordable and comprehensive health benefits with low copayments and coinsurance. Mid America Health, a for-profit company formerly known as Health Net, operates in the Kansas City Metropolitan Area and 90 counties in Kansas and Missouri. Mid America Health has over 356,000 members in its HMO and PPO plans and participates in Medicare.

BACKGROUND

Kansas and Missouri have uninsured rates of 12% and 13% respectively, which are well below the national average of 18%. Part of this low uninsured rate may be attributed to the tight labor market in the Kansas City area as well as to an exhortation by the Greater Kansas City Chamber of Commerce to private insurance companies to market products for small mom-and-pop stores not previously offering insurance. Since 1994, several private insurance companies have targeted health plans to small groups of up to 50 employees, including Mid America Health and Blue Cross Blue Shield of Kansas City.

Mid America Health regularly conducts focus groups and market research to refine its products according to the pricing and benefit needs of the market. Mid America Health Choice in its latest version was launched on April 1, 1998. The design of the product is also tailored to the local market. Mid America Health Choice provides comprehensive benefits at a market price level.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Small businesses with up to 50 full-time employees; 75% of eligible employees must purchase the plan.
<i>Location</i>	16 counties in Kansas (includes Anderson, Atchison, Brown, Coffey, Douglas, Franklin, Jefferson, Johnson, Leavenworth, Lyon, Miami, Osage, Pottawatomie, Shawnee, Wabaunsee, and Wyandotte) and 7 counties in Missouri (includes Cass, Clay, Clinton, Jackson, Lafayette, Platte, and Ray).
<i>Target Enrollment</i>	The target growth rate is between 10% to 15% per year.
<i>Potential Market</i>	1,515,994 uninsured in the Kansas City Metropolitan Area with 1,076,356 with incomes above 250% FPL.
<i>Actual Enrollment</i>	Approximately 15,000 members as of September 1, 2001. Twenty-five percent of the enrollees were previously uninsured.
<i>Retention</i>	More than 75% of enrollees remain in Mid America Health Choice which is above the current industry average.
<i>Staffing</i>	Staffing for Mid America Health Choice is the same staff as used for other small group products, including five permanent employees.

APPENDIX

BENEFITS AND SERVICES

Mid America Health Choice provides comprehensive health benefits including: preventive services such as well-baby care, immunizations, and routine physical exams; physician care including laboratory and x-ray procedures, office visits, in-office surgery, allergy care; annual eye exams; prescription drug coverage; inpatient and outpatient hospital services including diagnostic tests; emergency services; 30 home health care visits per year; 60 days of skilled nursing facility visits per year; DME, prosthetic and orthotic benefits; physical, occupational and speech therapy; organ transplant; chiropractic services; infertility diagnosis; and inpatient and outpatient mental health, drug and alcohol treatment. Copayments range from \$10 to \$25 for preventive services and \$50 to \$75 for emergency services.

PROVIDERS

The providers for Mid America Health Choice are the same as for other products. The PPO network is significantly larger geographically than the HMO network, which is limited to the Kansas City Metropolitan area. Reimbursement for Mid America Health Choice providers is the same as for other products.

FINANCING

The product is financed by employer-employee contributions, with employers responsible for 50% of the cost. The monthly premium is industry-, age-, and gender-rated, and the cost of the product does not differ significantly from other similar products. The premium rates in the Kansas City area are extremely competitive as all health plans are vying for the same small group market.

MARKETING

The health plan uses a variety of methods to market Mid America Health Choice, but is primarily broker driven. Much of Mid America Health's marketing is focused on establishing a relationship with its customers through community sponsorships and events, targeted direct mail, one-on-one meetings with customers, and television and print advertisements. The health plan's desire to reach out to the community is key to marketing to the small family-run shops in Kansas City as many customers are referred to Mid America Health Choice by current enrollees.

PROGRAM ANALYSIS AND LESSONS LEARNED

- 1) *State Regulation*. Mid America Health encountered problems creating a product with similar features in both Kansas and Missouri. The states differed in underwriting requirements and other regulations.
- 2) *Benefits Design*. The comprehensive benefits design at market price is attractive to small group employers.
- 3) *Relationship with Community and Providers*. The health plan attributes much of Mid America Health Choice's success to its close relationship with the community and providers. Unlike many national carriers in the area, Mid America Health designs its products according to the needs and characteristics of the local market.
- 4) *Replicability*. Mid America Health staff believe this plan is replicable in other areas. The company's relationship with providers and understanding of the community's needs may be unique components necessary to ensure success with such a product.

SOURCES

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Lagnado, Lucette. "Small Firms Offer Health Benefits To Lure Workers in Kansas City." *The Wall Street Journal*, 14 April 1999.

PLANSCAPE AND FLEXSCAPE

WellPoint

Location: California

PlanScape and FlexScape are two products designed to address the large number of uninsured in California. Offered by WellPoint, PlanScape, an individual plan, and FlexScape, a plan for small businesses with 2 to 50 employees, each provide an array of PPO and HMO options. Benefits range from basic catastrophic coverage to high deductible, comprehensive packages depending on the pricing alternative. PlanScape's and FlexScape's goals are "to increase both small-group offer rates and employee take-up rates, expand the individual market, allow for transitions for people who are locked out back into the system, and overcome means and motivation barriers." WellPoint, a for-profit, publicly traded health plan, has more than 13 million members and 22% of the market share in California. WellPoint participates in Medicare, Medi-Cal, SCHIP, AIM, and MRMIP.

BACKGROUND

A quarter of its nonelderly residents lack health insurance, ranking California fourth among all states in the number of uninsured. Over 85% of the uninsured have at least one family member who is employed. But, only 58% of Californians receive health benefits from their employers. This places California 49th in the percentage of the nonelderly population with employer-based insurance.

WellPoint launched PlanScape in January 2001 and FlexScape in April 2001 to help address the growing problem of the uninsured in California. Also, WellPoint has been advocating for changes in the health insurance system including: (1) transitioning high-risk pools into short-term incubator programs; (2) creating a broader waiver platform to use SCHIP to subsidize private purchases; (3) devising joint marketing/outreach with public programs; and (4) bringing people into private/public alternatives.

WellPoint's senior management believes that there is a market for the nonpoor uninsured. The health plan cites the expansion of private insurance to 5.5 million nonpoor from 1998 to 1999 as evidence that the private market can help reduce the number of the uninsured. But, products must be tailored to the population's needs.

The design and marketing of PlanScape and FlexScape were based on various studies including a California HealthCare Foundation survey that found that nonpoor Californians perceived insurance as more costly than in reality. WellPoint's past experience shows that price is a key factor in attracting people to health plans. In 1998, half of all small groups and three-quarters of all individuals who left WellPoint did so due to price changes. Previously, WellPoint designed plans around benefits. Therefore, PlanScape and FlexScape were created to fit into three price categories — low, medium, and high — to tailor the market. The low- to medium-priced products are geared to the uninsured with incomes at or above 200% FPL.

APPENDIX

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

	PlanScape	FlexScape
<i>Population</i>	Individuals; includes the nonpoor uninsured with incomes at or above 200% FPL for the low- and medium-priced plan options.	Small businesses with 2 to 50 employees. Employees under the defined contribution plan are slightly younger and tend to buy lower-priced products. At least 75% of eligible employees must participate.
<i>Location</i>	California; WellPoint plans to roll out the product in other states in 2002.	All WellPoint states except Georgia.
<i>Target Enrollment</i>	The joint target is 3 million members by 2004.	
<i>Potential Market</i>	More than 1.9 million Californians have incomes of at least 200% FPL and lack insurance. ¹	
<i>Actual Enrollment</i>	815,000 as of January 2002.	797,000 as of January 2002.
<i>Retention</i>	N/A	
<i>Staffing</i>	The staffing for these products is the same for all other products at WellPoint.	

BENEFITS AND SERVICES

FlexScape offers 10 PPO, EPO, and HMO product arrangements that range from basic catastrophic coverage to comprehensive packages. The four lower priced plans cover office visits, professional services such as maternity, diagnostic laboratory and x-ray procedures, hospital stay and outpatient services, \$10-\$25 two-tiered prescription drug coverage, annual health screenings at \$25 to \$75 per visit, and well-baby immunizations and check-ups. Employers may also offer dental benefits.

FlexScape's EmployeeElect option allows each employee to choose different plans within the array. The FamilyElect option allows each member of a family to have different plans.

PlanScape offers 12 PPO, EPO, and HMO plans with variations in member cost sharing mechanisms as well as benefits. The most basic plan offers preventive care, inpatient and outpatient hospital care, x-ray and laboratory procedures, anesthesia and surgeon fees, office visits, and a 24-hour nurse hotline. Ten out of the 12 plans offer maternity, prescription drug coverage, and physical and occupational therapy on top of the basic services.

PROVIDERS

For the FlexScape and PlanScape plans, WellPoint uses the same provider panel as other WellPoint and Blue Cross of California products. Providers fall into two groups — one which is high-priced and another which is low-priced. A member using services at a higher priced facility will encounter higher cost sharing mechanisms. The health plan will be adding more providers for the FlexScape provider panel in the coming year.

FINANCING

FlexScape is financed by employer contributions and member cost sharing. The products make very limited use of fixed-dollar copayments and more extensive use of conventional deductibles and percentage cost sharing. While the products offer first dollar coverage for routine care, out-of-pocket costs are higher for catastrophic care (\$2,000 to \$4,500 annual out-of-pocket maximums in-network and \$2,000 to \$10,000 maximums out-of-network). FlexScape products have \$5 million lifetime maximums.

Within FlexScape, employers choose among four financing options:

- *Defined Contribution 80* in which the employer pays \$80 per employee towards the monthly premium;
- *Defined Contribution 100* in which the employer pays \$100 per employee towards the monthly premium;
- *Defined Contribution Select* in which the employer pays a fixed amount (over \$100) per employee towards the monthly premium; and
- *Traditional Contribution* in which the employer pays at least 50% of the monthly premium.

Once the employer chooses a financing option, employees select one of the health plans within the FlexScape array, which differ in member cost sharing levels and benefits. WellPoint does not allow employees under Defined Contribution 80 to purchase the most expensive plan. The assumption is that people under Defined Contribution 80 who want to buy the most comprehensive plan are sicker and want more coverage for their condition.

PlanScape is financed by member cost sharing mechanisms. Like FlexScape, PlanScape offers first dollar coverage for routine care. Annual deductibles range from \$1,000 to \$3,000. PlanScape has a lifetime maximum of \$5 million. In the lowest priced plan, premiums can start from as little as \$21 per month for an individual with an average of \$65 to \$75 per month per individual or \$250 to \$300 per month for a family of four. The average monthly premium across all of the product offerings is \$116. Both FlexScape and PlanScape are age-rated and medically underwritten.

MARKETING

WellPoint launched an extensive marketing campaign to the uninsured focusing on the affordability of health care coverage and the importance of insurance in averting financial disaster. Television and print advertisements emphasize the price of its products. The health plan's campaign also includes radio advertisements and direct mail. Print advertisements in foreign language newspapers target large Hispanic, Chinese, and Korean populations in California. As a result of the campaign, WellPoint has been receiving between 7,000 to 9,000 inquiries each month.

PROGRAM ANALYSIS AND LESSONS LEARNED

WellPoint has been very successful in reaching the uninsured. Based on enrollment numbers, senior management estimates that 63% of FlexScape and 49% of PlanScape enrollees were previously uninsured. Fifteen percent of enrollees transitioned into PlanScape from employer-sponsored coverage or Medi-Cal through Blue Cross. Part of the success may be attributed to the following:

- 1) *Marketing*. Although the first round of marketing emphasized price since employers base 90% of their decision on price, the health plan found that it needed to stress other aspects of the plan such as benefits. The marketing team also advertises to the large Hispanic and Asian populations in

APPENDIX

California. These two groups have a greater risk of being uninsured than white or African-American populations.

- 2) *Financing.* PlanScape and FlexScape both address consumer price sensitivity by offering several lower-priced plans each with different benefit options. Also, all plans are younger-age spouse rated. FlexScape goes further in making insurance attractive to the uninsured. Key elements of the product include Defined Contribution, EmployeeElect, and Family Elect options, which make health insurance more affordable for small businesses. WellPoint found that members enrolled in Defined Contribution plans tend to purchase lower priced options than those under Traditional Contribution. In addition, evaluation of data shows that more employee only, employee + child(ren), and younger members (under age 40) are enrolled in Defined Contribution plans. In contrast, a greater percentage of employee + spouse, employee + spouse + child(ren), and members aged 50 to 64 are in Traditional Contribution options.
- 3) *Population Needs.* WellPoint has implemented several features in FlexScape and PlanScape in order to break down the barriers that young adults and the near-elderly face in obtaining insurance. According to a Commonwealth Fund report, near-elderly adults between the ages of 55 to 64 are uninsured due to premium hikes that make insurance unaffordable. Also, a large proportion of people between the ages of 19 and 29 are uninsured because they are no longer considered dependents or are not offered insurance through work. To address these issues, WellPoint allows PlanScape members a 30-day “open window” to make plan changes when a birthday moves the member from one premium age band to the next. PlanScape also allows dependents over the age of 23 to be automatically enrolled in their own policies, with premiums based upon age. Both PlanScape and FlexScape allow dependents over age 18 to stay on their parent’s policy through at least age 23.
- 4) *State Regulation.* In California, the health plan had some difficulty rolling out FlexScape because California regulators thought that the defined contribution idea might have some problems. But regulators could not identify any issues with FlexScape.
- 5) *Replicability.* WellPoint believes that PlanScape and FlexScape are replicable. But, these plans should not be offered simultaneously with conventional, high option plans and treated as experimental or demonstration projects. Instead, a company interested in implementing plans such as PlanScape and FlexScape needs to take the risk in overhauling its entire system. Management must also be supportive of a product design that requires members to increase their level of cost sharing.

SOURCES AND ENDNOTES

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Brewster King, Director, Business Development, Individual and Small Group, Blue Cross of California

Melissa Mehring, Health Policy Analyst, Health Policy and Analysis, WellPoint

¹ Kaiser Family Foundation, “50 State Comparisons: Distribution of Nonelderly Uninsured by FPL, 1999-2000,” *State Health Facts Online*, <www.statehealthfacts.org> (25 February 2002).

SMALL BUSINESS HEALTH INSURANCE

Group Health Incorporated
Location: Parts of New York City

Small Business Health Insurance (SBHI) is a low cost product designed to reduce the number of the working uninsured in parts of New York City. Begun in 1999 as a two-year demonstration project by Group Health Incorporated (GHI) with support from New York City Health and Hospitals Corporation (NYCHHC) and the Office of the Mayor, SBHI provided comprehensive coverage for small firms with 2 to 50 employees. GHI is the largest private, not-for-profit health plan in New York State serving 3.5 million people, including the Medicare population, in all 62 counties of the state. GHI also participates in SCHIP. The goal of SBHI was to enroll 3,000 lives, thereby decreasing the number of working uninsured, improving the health status of those enrolled, and increasing their access to care.

BACKGROUND

Approximately one in four people residing in New York City lack health insurance. While 75% of New York's uninsured population are working adults with 63% in full-time positions, 90% of uninsured workers are not offered insurance through their employer.

In 1998, Mayor Rudolph Guiliani announced a plan to develop an insurance product for the working uninsured in New York City, as a collaborative effort through the Office of the Mayor and NYCHHC, the public hospital system of the City of New York, and a health insurer. Through an RFP process, GHI was chosen as the insurer for SBHI, which was to be duplicated as a model city- and statewide.

Prior to implementation, NYCHHC conducted extensive market research to evaluate the potential market and product design. Research revealed that owners wanted to legitimize their businesses, increase employee retention, and decrease sick time. Employers were interested in plans with emergency room coverage and open access. Plans with monthly premiums of \$100 tested optimally. Regulations influenced product design, as New York is a guaranteed issue state with community rating in parts of New York City. Also, products sold to group sizes smaller than 50 must meet state mandates and other guidelines. In January 1999, GHI and NYCHHC launched SBHI in East Harlem, South Bronx, and Northern Brooklyn. The demonstration project ended in July 2001.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Small businesses with 2 to 50 employees.
<i>Location</i>	Sections of the Bronx, Brooklyn, Manhattan, and Queens.
<i>Target Enrollment</i>	3,000 lives.
<i>Potential Market</i>	Approximately 30,000 small businesses are located in target areas; 70%–80% have less than 10 employees. Fifty percent of these businesses have no health insurance, so over 100,000 lives would be able to enroll in SBHI. In Brooklyn, 78% firms have 2-9 employees; 43% of residents are African-American, 37% Hispanic, 16% white, 3% Asian, and 1% other.
<i>Actual Enrollment</i>	515 lives were covered, with 269 people enrolled when SBHI ended.
<i>Retention</i>	10% attrition rate due to members moving or inability to pay monthly premium. GHI did not believe that dissatisfaction was a factor.
<i>Staffing</i>	Staff was similar to other products, along with GHI department heads and staff from the Mayor's Office who participated in product development.

APPENDIX

BENEFITS AND SERVICES

SBHI provided comprehensive care with copayments for selected services: ambulatory surgery; emergency room treatment; preventive care including annual physicals, prenatal and well-baby care, immunizations, pap smears and mammography screenings; unlimited office visits with some restrictions for allergy, speech, and physical therapy; chiropractic care; lab, pathology, and radiology; 30 inpatient days and 20 outpatient visits per year for mental health services; substance abuse services; 100 visits per person per year for home health care; home infusion therapy; durable medical equipment; 210 days of hospice care; 210 days for skilled nursing facility; and prescription drug coverage by NYCHHC facilities.

PROVIDERS

The provider panel was limited to NYCHHC facilities and their more than 750 affiliated physicians through the two PPO networks listed below. The NYCHHC network was augmented as required, such as for durable medical equipment.

- Generations Plus Network, which includes Lincoln Medical and Mental Health Center, the Metropolitan Hospital Center, Morrisania Diagnostic and Treatment Center, and Segundo Ruiz Belvis Diagnostic and Treatment Center; and
- North Brooklyn Network, which includes Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center.

FINANCING

While employer-employee contributions averaged approximately 65%–35% of premiums respectively, the product was subsidized by GHI, providers, and NYCHHC. After reaching the \$50,000 threshold, risk was shared in full between providers with Group Health Incorporated. NYCHHC assumed all drug and medical transport costs, and provider networks agreed to deep discounts averaging 40% of commercial rates. The system as a whole took a 40% discount. Although 15% was allocated to administrative costs, GHI expended “unquantifiable soft costs” in implementation, marketing, and ongoing program support.

The premiums were 50% less than comparable plans in the market area and were rated in the following four-tiered manner:

- Individual, \$99.80/month
- Employee and Child(ren), \$161.29/month
- Employee and Spouse, \$224.02/month
- Employee, Spouse, and Child(ren), \$235.22/month

MARKETING

Group Health Incorporated marketed SBHI to target communities in a variety of ways. Channels included direct mail, media, letters to brokers, lunch with community leaders, and print advertising. To address the city’s large Spanish speaking population, SBHI materials were printed in both English and Spanish.

East Harlem Chamber of Commerce contacted business owners with a cover letter about SBHI, a brochure, and an invitation to hear GHI’s presentation at one of the Chamber’s regular meetings. GHI marketed to individuals through door-to-door canvassing and health fairs. The idea behind this approach was to educate individuals who would then inform their employers about the availability of

affordable coverage. GHI worked with only a few brokers who were hand-selected due to their involvement with the community. Commissions, based on a percentage of the product's price, were smaller than they would have been for conventional products due to SBHI's lower premiums.

PROGRAM ANALYSIS AND LESSONS LEARNED

Evaluations by Group Health Incorporated and outside sources such as Pricewaterhouse Coopers revealed that Small Business Health Insurance achieved its goals of improving access to care and health status. Primary care visits increased while emergency room visits and hospitalizations decreased. Case managers were successful in helping enrollees navigate their way through the health care system. In focus groups, employers and employees gave positive feedback on SBHI and the treatment they received. More than half of the enrollees had no coverage prior to SBHI. Businesses experienced an increase in employee retention indicating that health insurance may be a recruiting tool for small firms. But, Small Business Health Insurance had limited success in meeting its goal of decreasing the number of working uninsured, as the pilot attracted only 17% of targeted enrollment. Several reasons were cited:

- 1) *Marketing*. Despite all of the efforts, marketing was not perceived as being effective, broad, or sophisticated enough to reach the target audience. Group Health Incorporated believes that it should have spent additional funds to market SBHI. Broker compensation was considered too low to provide an incentive to refer potential clients to SBHI in comparison to other standard products, since SBHI's low price meant that brokers would realize about half the usual commission.
- 2) *Cost*. Although SBHI's premium was 50% of commercial insurance, it was still unaffordable for many employees and employers who had previously used the same providers for free.
- 3) *Target Area*. By broadening the target location, GHI believed enrollment could have been greater since many businesses interested in SBHI were located outside of the catchment area based on business.
- 4) *Provider Network*. By including more provider networks and increasing choice, Group Health Incorporated may have been able to attract more members.
- 5) *Documentation*. Many businesses in New York City are small "mom-and-pop" stores, and some applicants for SBHI did not have proper documentation such as tax filings.
- 6) *Tax Issues*. Group Health Incorporated believed it should have been exempt from an 8.18% surcharge on health care services for an uninsured pool and a covered lives assessment for graduate medical education levied by New York State, because of its funding of SBHI.

SOURCES

Sharon Schmerzler, Vice President, Group Health Incorporated
Lori Metz, Manager of Special Projects, Group Health Incorporated

APPENDIX

SPECIAL CARE

Highmark Blue Cross Blue Shield, Capital Blue Cross, Blue Cross of Northeastern Pennsylvania, Independence Blue Cross, Pennsylvania Blue Shield

Location: Pennsylvania

Special Care is a low-cost indemnity plan targeted to uninsured with incomes at or below 185% FPL. Eligible individuals are those with incomes exceeding the cap for public assistance, but too low to purchase other commercial health insurance alternatives. Through a coordinated effort between the Blue Cross Blue Shield (BCBS) plans¹ in Pennsylvania to reduce the number of the uninsured in the state, Special Care was launched in 1992 at half the price of other commercial plans. Special Care provides physician, hospital, medical, and surgical coverage with first dollar coverage and limited out-of-pocket costs. Highmark BCBS, a private, not-for-profit plan, serves 3.66 million members in 30 counties in western Pennsylvania and has 69% of the market share in the six-county Pittsburgh metropolitan area. Highmark BCBS participates in Medicare, Medicaid, and SCHIP.

BACKGROUND

The rate of the uninsured in Pennsylvania in 1990 (11%) was below the national average (16%)², yet the Pennsylvania BCBS plans still decided it was necessary to work together to further reduce the number of people lacking coverage. The Pennsylvania BCBS plans include Highmark Blue Cross Blue Shield, Independence Blue Cross, Capital Blue Cross, and Blue Cross of Northeastern Pennsylvania. The four health plans decided to target young adults, working adults whose employers did not offer coverage, early retirees, and other segments of the population who were unable to afford commercial plans and were ineligible for public assistance.

While considering the development of affordable small group and individual products for the uninsured, the BCBS plans commissioned Widener-Burrows & Associates to conduct four focus groups. The goals of the focus groups were to assess small employers' attitudes towards offering health insurance, perceptions of reasonable health care coverage costs, and reactions to the proposed low-cost insurance product.³ Results indicated that employers were interested in offering coverage. But, difficulty in securing affordable products and constant rate increases prevented them from paying for their employees' health benefits. While respondents stated that \$100 to \$125 was a "reasonable" cost per employee per month, they remarked that they would be willing to pay only \$75 to \$100 for a product like Special Care since it lacked coverage for prescription drugs and substance abuse. The BCBS plans based Special Care on these findings and sold the product in the individual market.

In 1994, Kaagan Research Group conducted a study on behalf of the BCBS plans to determine the "true nature" of the uninsured problem in order to refine Special Care and target additional programs to those in need. The income criteria was changed from 150% FPL to 185% FPL. In June 2001, the state passed a bill creating a new insurance plan that provides basic care to 40,000 adults with incomes up to 200% FPL at \$30 per member per month. Approximately \$76 million of Pennsylvania's tobacco settlement money will be used to subsidize this program, called adultBasic, slated to begin in July 2002. Keystone Health Plan East (owned by Independence Blue Cross), Capital Blue Cross/Pennsylvania Blue Shield, Highmark's Western Pennsylvania Caring Foundation, and First Priority Health were selected by the Pennsylvania Insurance Department to provide adultBasic. The BCBS plans may alter eligibility to make it compatible with adultBasic, allowing the following groups to enroll in Special Care: (1) those ineligible for adultBasic due to income; and (2) those placed on the state program's waiting list.

ELIGIBILITY, ENROLLMENT, AND OPERATIONS

<i>Population</i>	Uninsured Pennsylvanians at or below 185% FPL not eligible for public insurance or private group insurance.
<i>Location</i>	Pennsylvania
<i>Target Enrollment</i>	60,000 covered lives.
<i>Potential Market</i>	Approximately 470,000 uninsured Pennsylvanians who are at 200% FPL or below. In Highmark BCBS' market area, 33.9% of the population have incomes less than \$20,000. Nearly 83% are white, 10% are black, 2.7% are Hispanic or Latino, 1.8% are Asian, and 2.8% are multiracial. Pennsylvania ranks second nationally in the percent of population age 65 or older.
<i>Actual Enrollment</i>	61,000+ (as of June 2001). A significant number of enrollees are young adults just out of school or unemployed.
<i>Retention</i>	Retention is relatively high. Some enrollees may transition out of the program because they qualify for more comprehensive government programs or because they buy into the commercial market.
<i>Staffing</i>	Two staff members handle the plan operations for Special Care. Highmark's marketing, membership, and customer service departments which serve all subscribers also work on Special Care.

BENEFITS AND SERVICES

Special Care is a low-cost indemnity plan with benefits including: four doctor visits per year with a \$10 copayment; 21 inpatient days; emergency medical and accident; surgery (inpatient and outpatient surgery, doctor visits while in the hospital, and anesthesia for covered surgical procedures); diagnostic x-ray and laboratory services up to \$1,000 per person per year; chemotherapy; radiation therapy; annual mammograms after age 40 or when recommended by a physician; annual routine gynecological exam and PAP test; pediatric preventive services including immunizations; and maternity and newborn care. Nonemergency services must be rendered at Special Care participating hospitals in order to receive full payment. Some procedures, including elective procedures or hospital admissions, require precertification.

PROVIDERS

Special Care uses the same provider network as other Highmark BCBS products. Providers are reimbursed in full for preventive services, but take a significant discount of 70% for surgery for Special Care members. Eight out of 10 providers in the state participate in the product.

FINANCING

Monthly premium rates depend on the plan in which the member is enrolled. The discrepancies between the rates are due primarily to the different levels of subsidization from each plan. Highmark finances Special Care through the following sources:

- 20%, or \$8 million, from a heavy rate subsidization;
- 15% from lower reimbursement levels to providers;
- 15% from the limited benefits design; and
- 50% from member cost sharing.

APPENDIX

Monthly Rates by Plan and Subscriber	Highmark BCBS	Independence BC/ PaBS	Capital BC/ PaBS	BC of Northeastern PA/ PaBS
Individual	\$62.30	\$90.30	\$83.90	\$70.35
Parent/Child	\$91.95	\$128.50	\$135.40	\$104.00
Husband/Wife	\$124.65	\$180.55	\$167.90	\$140.65
2 Parents/Child(ren)	\$154.25	\$218.85	\$218.35	\$155.40

MARKETING

Special Care is advertised at doctors' offices, job fairs, and at schools through flyers and brochures. Applicants may call a toll-free customer services number for any of the BCBS plans in Pennsylvania to obtain more information about Special Care. The BCBS plans are working with Pennsylvania's Maternal and Child Health Division in the Department of Health to coordinate an effort to enroll children in SCHIP and offer Special Care coverage to parents who do not qualify for medical assistance.

PROGRAM ANALYSIS AND LESSONS LEARNED

- 1) *Marketing.* While more aggressive marketing was cited as a method to achieve higher enrollment, Special Care was successful in surpassing the target enrollment by 1997. Highmark BCBS representatives indicated that exceeding the target enrollment may require potentially greater subsidies from the plans as well as generate concerns from providers who would have to serve more Special Care members at the negotiated reimbursement level.
- 2) *State Regulation.* Although SCHIP and the new adultBasic program are exempt from the guaranteed renewability provision of HIPAA, Special Care is not. The provision allows an enrollee to stay in Special Care even if his income exceeds 185% FPL or if an individual reaches the age of 65. The BCBS plans are struggling with this provision as they would like to keep Special Care affordable for those who need it most. In addition, elderly members can potentially affect premium rates because of higher utilization. This has led to the creation of a "second tier" premium. In the past, self-declaration of income was allowed. Since January 2002, plans require annual reverification of income to determine which enrollees exceed the income criteria. The creation of the second tier and the income reverification process has increased the cost of administration and planning.
- 3) *Financing and Benefit Design.* The BCBS plans' high market share was instrumental in negotiating discounts with providers as well as in discussions with regulators about the creation of an affordable, limited benefits product for the uninsured. The plans sought exemptions from mandates for covering diabetes, mental health, and substance abuse services. A diabetes component alone would have raised the premiums by \$9. High market share also enables the plans to provide heavy subsidization of the rates.
- 4) *Public/Private Coordination.* Collaboration between the Department of Health and the BCBS plans allows for smoother transitions between public and private insurance coverage.
- 5) *Replicability.* Implementing a program like Special Care may not be possible without a high market share, heavy plan subsidization, and cooperation from state regulators and providers.

SOURCES AND ENDNOTES

Barbara Dubs, Director, Community and Social Programs, Highmark Blue Cross Blue Shield
 Kathy Holder, Project Manager, Highmark Blue Cross Blue Shield

¹While the four BCBS plans offering Special Care include Highmark BCBS, Independence BC/Pennsylvania BS, Capital BC/Pennsylvania BS, and BC of Northeastern Pennsylvania, this description focuses on Highmark's experiences.

²From *State-Level Data Book on Health Care Access and Financing*, 1993.

³From Widener-Burrow & Associates, *Results of Focus Group Research Among Small Employer Groups Which Do Not Offer Health Insurance to Employees*, 1991.