

Profiles in Coverage: Arizona Healthcare Group

Overview

Healthcare Group of Arizona (HCG) was created by the Arizona State Legislature in 1985 to provide affordable and accessible health care coverage to sole proprietors, small businesses with 50 or fewer employees, and Arizona political subdivisions. Initial operations began in 1986 with a grant funded by the Robert Wood Johnson Foundation. Since inception, HCG has undergone several significant changes, the most notable occurring in 2004 when the Arizona State Legislature eliminated the state subsidy that had supported the program since 1999. Beginning in fiscal year 2005, the program has operated entirely from premiums paid by subscribers. Enrollment has continued to grow, more than doubling between 2004 and 2006, with March 2007 enrollment reaching 26,062 medical plan members. HCG also offers a dental and a vision plan that brings total enrollment in all plans to 45,521, making HCG one of the largest state initiatives to provide health insurance for small businesses nationwide.



The State Coverage Initiatives Program (SCI) recently spoke with Anthony Rodgers, Director of the Arizona Health Care Cost Containment System (AHCCCS) about HCG.

buying power in the health care market to offer small businesses affordable managed care coverage benefits. The benefits were similar to AHCCCS Medicaid benefits except this was to be a self-funded health care coverage plan. HCG hit a high enrollment mark in 1998, but then managed care plans, whose core business was Medicaid, started to withdraw from the program because they did not have the expertise to market HCG and medical losses started to mount. HCG plans were being adversely selected as a result of minimal group participation requirements in concert with community rating and guarantee issue. Many low risk group members obtained coverage in the commercial market, leaving HCG as the only option for high risk enrollees.

Program Overview

1. Please discuss the origin of HCG. Senate Bill 1166 (2004) made significant changes to the program. Please describe the changes and their impact.

HCG has undergone a number of evolutions since 1985 when the Arizona Legislature authorized AHCCCS, Arizona's Medicaid Agency, to implement a health care coverage program for small businesses and political subdivisions within the state. The concept was to use AHCCCS health plans and their

To revitalize HCG, AHCCCS management went to the legislature to get additional program benefit design and provider contracting flexibility. Unfortunately, with the additional flexibility came new restrictions



Robert Wood Johnson Foundation

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including: 1) a requirement that employers must be uninsured for six months (the “bare period”) before they can obtain insurance from HCG (the bare period only applies to the business itself and not to individual employees); 2) a restriction upon using AHCCCS (Medicaid) rates as default rates for hospital reimbursement; 3) limitations on contracting with insurance brokers and paying broker commissions; and 4) restrictions on dollars that could be spent on marketing and administration.

The six-month bare period before HCG can cover a small business has continued to be a point of frustration for the small businesses who want to join HCG. Additionally, those small businesses that meet the six-month bare period requirement tend to have employees with pent up medical care needs. This pent up demand creates additional adverse selection for HCG.

The legislature also eliminated the state subsidy to HCG; this has required HCG to change the way premiums are priced and to create a fund reserve to cover the ups and downs of the medical cost cycle. Additionally, the limitation on HCG to use AHCCCS Medicaid rates to pay the hospitals has required HCG health plans to negotiate separate contracts with hospitals.

These challenges have really slowed the progress of HCG in growing membership over the last two years. Limitations on dollars available for marketing and infrastructure have required HCG management to be very creative in the approach to the small business market. Most of the marketing is done through community events and word of mouth.

You might ask why the Arizona legislature placed so many challenges in the way of success of HCG. There is no one answer to that question. However, it is obvious that this was an important compromise to gain acceptance from the commercial health plans in the state and to assure that HCG would

not compete directly with them for the small business employer market, at least not in the most desirable portion of the market.

2. Please describe how HCG operates today. Can you describe the vision and business model?

The vision of HCG is to reduce the number of businesses not offering insurance. We have set as a goal to grow the membership to 100,000 subscribers. We referred to our business model as the “ABC’s” of small business health care coverage: A = Administrative Ease; B = Budget-Ability; and C = Choice.

HCG management has streamlined employer enrollment and member service processes to make it easy for businesses to enroll and re-enroll. HCG management is also developing new ways to improve employer and subscriber satisfaction and customer care.

To make premiums affordable to employers and their employees, HCG has tried to develop a premium for every employee income level and health care coverage budget. We do not require the employer to contribute to the employee’s premium, so we need to offer an attractive health plan option to fit the many income levels of employees and their employer.

HCG provides a cafeteria plan of benefit choices and options to the small business employer. That is probably the most attractive aspect of the HCG coverage. Each employee, as well as the employer, can individually choose from a comprehensive, medium, or basic benefit plan. There are several deductible options that allow employees to choose based on price, deductible, and benefit coverage. Additionally, there are four different health plan networks from which to choose.

This business model has worked well in the small business market. Enrollment has grown over 90 percent since we started to offer the new benefit plans and enhanced networks.

3. What makes HCG different from other state approaches to providing coverage for small businesses?

The biggest difference with HCG is that it is not state or federally subsidized. HCG is self-funded and relies solely on the attractiveness of health plan benefits and business plan to achieve success. HCG is a small business health care coverage laboratory. Because of AHCCCS management expertise in managed care, it has been possible to leverage that expertise to create innovative health benefits and manage the financial and medical risk associated with providing health care coverage to the small business market.

HCG’s business plan is based on the belief that, to attract and retain small businesses, HCG must offer the “right products at the right price.” To accomplish membership goals, HCG has refined the business model into several important components.

A. Provider Network Strategy

Currently HCG contracts with three managed care network contractors and a third party administrator contracting with the well-respected, statewide network, Arizona Medical Care Foundation, for the Preferred Point of Service (PPOS).

B. Premium Pricing and Community Rating Strategy

Implementing multiple benefit options with community-rated premiums (and no medical underwriting) is the best way to keep premiums affordable in the long run.

C. Member Out of Pocket Cost

Small businesses are extremely sensitive to employer group premium increases. Using co-pay and co-insurance, HCG has passed on a larger portion of the first dollar financial responsibility to employees/subscribers. First dollar out of pocket charges help keep premium increases between 6 percent and 10 percent.

D. Sales and Marketing

HCG will use a combination of sales staff and enrollment producers (brokers) to meet its enrollment targets. Bilingual sales staff have been hired to market to the large segment of Hispanic small businesses. Producer relations staff will continue to expand the number of Arizona insurance producers enrolling small businesses into HCG.

E. Medical Cost Risk Management and Long Range Financial Stability

To remain financially viable as a self-funded health care coverage program requires significant attention to medical cost (which is expected to rise 6 percent to 10 percent annually), financial risk management, and membership growth. Long-range financial forecasts have been established to evaluate performance against forecast and provide an early indication of financial problems for the HCG health plans. These forecasts are used to manage financial risk and determine when adjustments to the premiums or benefits are necessary. HCG forecasts revenues, expenditures, fund disbursements, and reserves for each health plan network and benefit product line.

F. Health Plan Benefit and Product Development

Benefits are designed to be offered as a cafeteria plan rather than as a single product. Member education and clear and concise health plan information materials and collaterals are critical to assure subscribers understand benefit plan choices.

G. Employee Wellness and Chronic Illness Management

HCG is partnering with existing public and private programs to create a care management program. This program will include a comprehensive wellness program for small business and political subdivision employers, as well as disease management for members with chronic illness.

4. HCG has grown significantly since the 2004. To what do you attribute the growth in enrollment?

The growth of HCG has been fueled mostly by word of mouth. The community-rated premiums are attractive to small business employers because they spread their medical risk across a larger cohort of subscribers. It is the same concept as an association plan, but communities are used as the common pool of subscribers rather than business associations. Governor Janet Napolitano is very supportive and includes HCG when she is talking to small businesses.

Who is covered by HCG?

5. Please describe the eligibility criteria for the program.

To be eligible for HCG coverage, a small business must:

- A. Be a small business employer with 50 employees or fewer at the time of initial enrollment (businesses can grow to greater than 50 employees and remain enrolled); a sole proprietor is considered a business;
- B. Have an Arizona business address (although employees can work in other states); and
- C. Meet the employee participation requirement (employees working 20 hours or more cannot opt out; however employees covered by other insurance can be waived from participation).

6. How is HCG reaching the target population? What marketing and outreach has the state done to draw employers into the program?

HCG has a small staff of sales associates who enroll small businesses. Most of the sales leads come from individuals who were told by another small business about HCG. Also, HCG sales staff provides outreach to organizations such as local chambers of

commerce and other business associations in the state as well as community meetings and events that attract small businesses. HCG also contracts with insurance brokers who are paid an enrollment fee if they sign up a business. The marketing and outreach process is resource intensive, but has shown effectiveness in raising awareness about HCG.

7. How does an employer apply to participate in HCG?

Employers may call HCG directly, use a contracted broker, and/or receive a personal onsite visit from sales staff. Most of the enrollment paperwork involves providing employee names, health plan choices, and a copy of a business tax return. Employees must complete a health assessment form. The employer is responsible for paying the first month's premium in advance; from then on they get a monthly bill for their premium. They can even pay premiums online. That is all there is to it.

8. You mention that agents and brokers play a role in marketing the program. Are agents and brokers paid a commission?

HCG does use Arizona-licensed brokers to enroll small businesses. Brokers are paid a one-time enrollment fee that ranges from \$90 to \$140 per subscriber they enroll. Because it is a one-time fee rather than a commission (commissions are usually 4 percent to 6 percent of premium in the small business market), many brokers are hesitant to enroll larger groups with HCG. Brokers are normally paid a commission by commercial health plans. This was a concession to the commercial insurers to avoid competing for broker referrals in the market place.

What services are covered by Healthcare Group?

9. Senate Bill 1166 (2004) allowed AHCCCS to change benefit packages. How does this new flexibility help HCG market the product to small employers?

HCG offers three primary Health Maintenance Organization (HMO) benefit

options and two Preferred Point of Service (PPOS) options.

- A. Classic (HMO):** A comprehensive product, which includes comprehensive medical, prescription, behavioral health, and preventive care. This benefit has deductibles as low as \$500 and up to \$5,000. Comprehensive benefits do not include some transplant procedures.
- B. Secure Advantage (HMO):** A medium range product, which includes medical, prescription, and preventive care, but has no pregnancy benefits or behavioral health benefits, has limits on inpatient days paid, and higher co-pays on diagnostic services. This product also has \$500 to \$2,000 deductible options. It was designed for the “thirty-something” individual who is generally in good health but wants to be able to see the doctor and have a good pharmacy benefit.
- C. Active (HMO):** A basic product, with emergency medical and hospitalization, outpatient, primary and specialty care, and prescription benefits. This product was designed for the “young and invincibles” who are hedging their bets when it comes to health care coverage.
- D. Platinum:** HCG’s comprehensive medical PPOS product (similar to HMO Classic) designed for employers or employees that want open access to a statewide network of physicians and hospitals.
- E. Gold:** Is a product similar to the HMO Active product with access to the statewide PPOS provider network.

Each of the health coverage products are designed to address the health care coverage needs and budgets of small business employers and their employees.

10. Recently HCG began offering a statewide PPOS as an option. Can you describe the rationale for offering a PPOS product? What were the challenges or lessons from the experience?

HCG management met with a number of small business employers who said they did not mind offering the HMO options to their employees, but they wanted PPOS network options for themselves if they were going to join the plan. Many employers live in other parts of the state from where their business is located, or their employees may be spread throughout the state. The HMO networks were county specific. The PPOS option gave HCG a statewide and national provider network to offer to employers who had employees in other surrounding states or who themselves lived outside the state.

Getting the PPOS started required additional infrastructure and expertise and definitely added to the complexity of the program. We have had to fund the start-up costs with some of our HCG reserves. The only way that the PPOS will be cost effective is to achieve membership of 3,000 subscribers or more. Today, we have grown to 2,000 subscribers over the last 12 months. We project to break even with the PPOS within the first 24 months. One lesson learned regarding the PPOS is to cap the maximum benefit in the first year to avoid adverse selection.

11. Please describe HCG’s wellness programs and how they are being implemented?

HCG is still in the process of designing a comprehensive wellness program for small businesses. The initial planning stage involves collecting health status information on employees and using this information to design a program geared around the unique challenges of small businesses. HCG plans to request proposals from wellness program companies some time in 2007 to provide a comprehensive wellness benefit. Getting a critical mass of membership is important

to having a successful wellness program. In the meantime, HCG-contracted managed care organizations are responsible for disease management.

12. How do the benefit packages, premiums and cost sharing compare to commercial products also available to the HCG eligible groups?

Our market research shows that HCG benefit packages and premiums are comparable and very competitive for groups under five employees. For larger groups, especially with younger, low-income employees, HCG plans to revamp its premium schedule to be more in line with what is available in the market.

Delivery and Financing

13. How are premiums charged to HCG participants calculated?

Premiums are community rated by age and gender cohorts. The HCG actuaries use both medical loss trend factors and size of the group to determine the premium. For example, a group with only one subscriber has one set of community premiums; groups of two or more subscribers have another set of premiums. HCG has determined specific geographic regions of the state on which to base its community-rated premiums. Premiums are analyzed based on medical loss experience within that geographic area.

14. How is the program financed?

The HCG program is self funded by premiums collected from enrolled small businesses and public employers.

15. How is the product delivered?

HCG’s HMO benefits are provided by contracted Managed Care Organization (MCOs) which also manage Medicaid lines of business. Commercial health plans can also participate, but to date none have chosen to do so. The PPOS benefits are administered through a contracted third-party administrator.

16. Does the state hold any risk for the costs of HCG? If so, how does the state manage risk? What is the role of reinsurance in managing risk?

The state has risk only for the PPOS product which is managed directly by HCG. Contracted MCOs are at risk for the medical losses from their enrolled members and they must maintain adequate financial equity to cover short term losses. HCG reduces the medical loss risk of the contracting MCO by providing commercial reinsurance coverage for single occurrences above \$125,000. Reinsurance per member per month (PMPM) is allocated from each premium to pay the commercial reinsurance carrier. HCG also allocates a portion of the premium of each member to a financial stability reserve that is used to reconcile significant aggregate medical losses by the PPOS and MCO plans. The financial stability reserve is a self-funded reserve maintained by HCG to reconcile the health plans for medical losses above an aggregate medical loss ratio of 86 percent annually.

17. HCG has invested in data collection. Are there specific data sources that are particularly useful in program management? What major types of data would you recommend that other state policymakers collect?

HCG maintains its own data warehouse for management decision support, actuarial analysis, and performance monitoring. Electronic files are submitted by MCOs monthly to HCG with claims data, pharmacy benefit manager (PBM) data and pricing, eligibility data, and provider data. These data sets are critical to HCG to properly price premiums, evaluate medical loss trends, and evaluate MCO performance and provider performance. The third-party administrator contracted to deliver the PPOS product also submits this information.

In addition to the data listed above, policy makers need enrollment income for enrollees, business and industrial sector classifications, and business employer size, employee age, and gender information.

18. How does AHCCCS oversee other aspects of HCG? For example, does HCG have a role in overseeing network adequacy or the reimbursement rates paid to providers?

HCG provides administrative support and oversight of the MCO and PPOS health plans. This includes marketing and sales, premium pricing and collection, enrollment and membership management, network analysis, performance monitoring, contractor reimbursement, and compliance and financial oversight.

HCG administrative oversight is based on contract requirements negotiated with the health plan contractors. Many of the same financial and performance requirements required of AHCCCS Medicaid health plans are required of the HCG contractors. These include financial equity requirements, operational performance requirements, and network adequacy requirements.

19. Without a state or federal subsidy, HCG has operated on premiums only. How can HCG remain an affordable option if there is no subsidy?

To date, HCG has been able to remain solvent as a self-funded program by pricing premiums to cover medical losses and offering customer choice options that keep premiums affordable to employers and employees. Unless HCG reaches its membership goals of 50,000 members enrolled by July 2008, remaining self-funded without subsidy may not be possible.

The policy question we are trying to answer is, “what will it take to maintain HCG financial solvency and community rated premiums while keeping benefits affordable?” If we find that it is not possible to attract enough of the small business market to grow membership, to keep our premiums affordable, and manage aggregate medical cost through effective care management, it may be necessary for the state to subsidize the HCG premiums in future years. The Governor is supporting the elimination of the six-

month bare period mandate on HCG which would broaden the membership base, dilute adverse selection due to pent-up demand for medical services from the uninsured, and more rapidly increase enrollment.

Moving Forward

20. What role does HCG play in reducing the number of uninsured in Arizona?

HCG has been particularly successful in enrolling sole proprietors and employer groups under five employees. These smallest of small businesses are the most vulnerable to being uninsured. Most of the state’s non-Medicaid-eligible uninsured adults are working in small businesses. HCG’s market-driven approach is not only reducing the number of uninsured directly, but is also stimulating the commercial small business health insurer in the market to offer more innovative and price competitive health care coverage options for this market segment.

21. Do you see any challenges or major changes for HCG moving forward?

There are a number of challenges for HCG in the next two-to-three years:

- A. Grow membership to 50,000—this means not only adding more new members but retaining employers currently enrolled in HCG by assuring high member satisfaction and premium price stability.
- B. Assure that community-rated premiums are priced correctly.
- C. Manage the pent up demand of uninsured employees who have been without a normal source of health care.
- D. Assure adequate provider networks and network coverage by paying reasonable reimbursement rates.
- E. Manage pharmacy cost, especially with new high cost drug therapies.

22. What lessons or advice do you have for other states considering similar insurance initiatives for small businesses?

Some of the lessons we have learned for the last three years are:

- A. To compete in the small group market you must offer attractive benefit options, have adequate funding for marketing and member education, and have the core competencies to manage care.
- B. Strong actuarial and management decision support, reporting, databases, and analytical tools are critical to pricing and benefit management strategies.
- C. Deciding which business model works for your state is key, e.g., Managed Care HMO, PPO, limited provider network, etc.
- D. Determining whether the program will be a market-driven program competing with the private sector or a subsidized program—with or without commercial health plan participation—is another key decision point.
- E. Setting reinsurance stop loss levels that are low enough to protect health plans against adverse selection is integral.
- F. Treating contracted health plans as valued business partners is important for success.
- G. Having aligned political support is a necessary component to a successful state program such as HCG.