INTRODUCTION

In 2008, the Kansas Legislature’s Joint Committee on Health Policy Oversight requested the Kansas Health Policy Authority conduct a number of studies. Two of the studies requested, #13 - Young Adult Policy Options, and #15 – Small Business Health Reform Options, are addressed here. We have provided the Committee with excerpts from KHPA’s 2008 Legislative Recommendations that are relevant to the topics addressed here in order to provide the Committee with the continuum of policy development from 2008 to 2009.

Review of the 2008 Legislative Session – KHPA Discussions on Health Care Reform Options

To place the 2009 Legislative studies in perspective, it is important to review the analyses completed in preparation for the 2008 Legislative Session. In advance of the 2008 Legislative Session, KHPA had undertaken a comprehensive health reform analysis, designed to examine the most effective ways to fundamentally improve the health of all Kansans. KHPA produced a comprehensive set of health reform recommendations. The third set of reform recommendations, Providing and Protecting Affordable Health Insurance are most relevant to this discussion.

P3 (1) Providing and Protecting Affordable Health Insurance: Access to Care for Kansas Children and Young Adults

Policy
For children, target and enroll the children up to 200% FPL currently eligible but not enrolled in HealthWave 19 and 21. For young adults, change Kansas insurance law to allow parents to keep young adults (through age 25 years) on their family insurance plan and develop specific Young Adult Plans (YAPs) that provide health care insurance options with limited benefit packages and lower premiums. (Note: In the United Methodist Health Ministry Fund report, YAPs are discussed within the third initiative describing voluntary insurance market reforms.)

The policy would include specific targets and timelines for the improved enrollment for children and young adults that if not met, would trigger additional review by the KHPA Board. This trigger mechanism will initiate the KHPA Board’s review of further policy options, including the consideration of mandating health insurance coverage for children in Kansas.

Background
States that have been successful at increasing enrollment penetration for eligible but not enrolled in government-funded health care have extended their outreach programs operationally and included web-based enrollment, public-program coordination/collaboration, school-based outreach programs, and out-stationing eligibility workers with culturally competent community partners. Each of these efforts entails moving the point of engagement with the child or family into the family’s everyday life through a known contact, local geography or both.

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1 The recommendations contained in P3 Providing and Protecting Affordable Health Insurance are part of the Kansas Health Policy Authority (KHPA) Board Updated Health Reform Recommendations, released January 30, 2008. This has been included to add perspective to the topics presented in the 2008 Legislative Session and give insight into the selection process of reform options that have been modeled since that time in preparation for the 2009 Legislative Session.
Just as with the broader uninsured population, there are many reasons young adults lack health care coverage, but key differences of the young adult population can be capitalized upon. First, young adults are more likely than their uninsured older counterparts to live at home, be supported by their parents, or be enrolled in secondary education institutions. Secondly, young adults typically enter the workforce in lower paying jobs and are more likely to work in jobs where health insurance is not offered. Third, young adults are, in general, healthier than their older counterparts and may see less benefit in paying top dollar for comprehensive health insurance plans. A change in Kansas insurance law to allow parents to keep young adults on their family insurance plan through age 25 would assist in providing transitional insurance to young adults as they leave home, enter the workforce, and gain employer-sponsored coverage. Development of YAPs – health insurance products specifically designed for adults aged 19-24 years old – would be a voluntary program aimed at offering a market specific insurance product with a limited benefit package and correspondingly lower premiums. These plans would be developed by the state in conjunction with private health insurers. This again would require changes to Kansas insurance law. Kansas would need to develop regulations covering areas such as who could sell the product, minimum coverage standards, and rating requirements for the product.

Stakeholder Input
Stakeholder input and KHPA Board deliberations focused on increasing access to health services by maximizing the use of existing health insurance coverage. The KHPA Board voiced strong support for polices to insure all children in Kansas have access to health insurance. Aggressive outreach and web-based enrollment is seen as a first step in ensuring access. The KHPA Board focused on developing strategies for children and young adults encouraging them to enroll in existing insurance currently available to them. Another important consideration discussed by the Board was to begin to develop a culture of valuing insurance early on in all Kansans. The Board felt it important to have children and young adults experience the value of health insurance starting an early age.

Population Served
15,000 additional children would enroll in Medicaid and approximately 5,000 additional children would enroll in SCHIP as a result of an extremely visible and effective outreach, web-based enrollment and facilitated enrollment processes specifically targeting uninsured lower income children eligible for public programs. Developing Young Adult Plans (YAPs) with limited benefits targeted at young adults ages 19-24 years old would insure 15,000 additional young adults.

Cost Estimate
Children and Young Adults
- $22 million All Funds (AF)
- $14 million State General Funds (SGF)

Financing Considerations
For the child-focused targeted outreach and web-based enrollment, effective new enrollment rates are projected to be high compared to the typical range of take-up rates assumed for public programs. Also, to employ these innovative strategies, the outreach costs per additional enrollee for these currently eligible but not enrolled children will be greater in comparison to Kansas’ historical outreach costs per additional enrollee. For the creation of affordable YAPs, the challenge for Kansas health policy-makers is to develop the regulations so that they balance affordability with comprehensive coverage.
P3 (2) Providing and Protecting Affordable Health Insurance: Expanding Insurance for Low-Income Kansans

Policy
Expand population for the Premium Assistance program to include adults (without children) earning up to 100% FPL ($10,210 annually).

Background
This voluntary program was aimed at integrating the poorest childless adults into the health care system by providing them with subsidized access to health care insurance. Adults without children do not fit within Medicaid’s traditional eligibility categories, although the Centers for Medicare & Medicaid Services (CMS) have provided states with additional options within the Deficit Reduction Act (DRA). States have taken a variety of approaches to covering childless adults, typically either through state-only programs like Connecticut’s State Administered General Assistance (SAGA) program or by pursuing waiver authority through the federal government and the CMS waiver process. The structure for this initiative would be an expansion of the covered population eligible for Premium Assistance as specified in SB 11. The newly eligible individuals could be served within the same administrative structure that is being developed for the current SB 11 Premium Assistance program.

Stakeholder Input
Stakeholder input focused on leveling the playing field to assist low income Kansans’ to getting access to health insurance.

Population Served
The population served are adults (without children) earning up to 100% FPL ($10,210 annually). 39,000 low income Kansans would become insured.

Cost Estimate
Low Income Kansans
- $119 Million AF
- $56 Million SGF

Financing Considerations
The model allowed for joint financing between the state and federal governments, however stand-alone State financing is also an option. If the Governor and the Kansas Legislature made the policy decision to implement a state-only program, Kansas could implement a state-only program fairly quickly by building upon the existing Kansas public program infrastructure. However, if the policy decision is to pursue federal matching funds for childless adults, significant challenges may exist depending upon whether the State could pursue approval using flexibility through the Deficit Reduction Act (DRA) or whether the State would be required to pursue a waiver. If required to pursue a waiver, Kansas would need to determine the appropriate waiver vehicle to use. Regardless of the waiver vehicle and strategy selected, the second and perhaps the more vexing challenge would be meeting budget neutrality.

If Kansas chose to pursue a state-only program for childless adults, the price tag would be $140 million for a fully implemented program (at the current take-up rates). Alternatively, to achieve CMS budget neutrality for a federal program waiver, the state would need to find reductions in federal spending on the order of approximately $63 million annually (once the childless adults hit full enrollment).

P3 (3) Providing and Protecting Affordable Health Insurance: Affordable Coverage for Small Business

Policy
Help small employers better access health insurance by developing a voluntary health insurance clearinghouse to assist small employers to access health insurance and tax-preferred health insurance premiums through Section 125 plans. Stabilize and lower health insurance rates for the smallest and newest businesses by creating a new "micro-market" for sole proprietors and very small employers (VSG - one to ten employees) within the small group market. Establish a reinsurance program to spread the risk of this new micro-market among all carriers and the State.

**Stakeholder Input**
The KHPA Board received a tremendous amount of input describing the need to make coverage more accessible and affordable for small businesses. The input directed the KHPA Board to consider ways to further segment the small employer population into smaller sub-populations and to consider a Kansas-specific adaptation of a health insurance connector/exchange. The Board described this as a voluntary insurance clearinghouse to provide administrative functions to the small employer market.

**Population Served**
Overall, the new VSG market would insure 5,900 working Kansans and their families prior to the impact of the reinsurance program. The introduction of the reinsurance program and the subsequent drop in premium would result in an additional 6,000 working Kansans and their families insured. The newly established voluntary insurance clearinghouse will be available to assist all of Kansas’ small employer groups but has no direct population impact.

**Cost Estimate**
**Small Businesses**
- -$5 Million AF*
- $1 Million SGF

(*Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above. Practically, however, at the program level, the State of Kansas will not change the state’s Disproportionate Share Hospital reimbursement methodology.)

**Marketplace Considerations**
During the numerous discussions with the KHPA Board surrounding potential insurance market reforms, the concept of “Do No Harm” was introduced. In the context of health insurance market reform, “Do No Harm” conveyed the KHPA Board's desire to ensure that the market reforms being considered would only improve the workings of the admittedly complex health insurance market. To ensure the reforms “Do No Harm,” substantial review of Kansas insurance law will need to take place to ensure a level-playing field exists in the context of the new markets proposed here for VSGs and YAPs. Due to the complex and interrelated nature of the health insurance market, equally as importantly is the need to consider the proposed reforms in the context of the larger health insurance market in Kansas.

**Summary of the Updated Sequential Plan**
The individual components of the Updated Sequential Model, as fully implemented, each decrease the number of Kansans without health care insurance. Modeling results indicate the total effect of the Updated Sequential plan would be a 30% decrease in the number of uninsured Kansans (non-elderly).

**Population Served**
The number of uninsured Kansans would drop by 86,000, from 260,000 to 174,000 (Figure 12).

**Children and Young Adults**
- 20,000 more children would be insured through public program outreach.
- 15,000 more young adults would be insured due to new products being offered at the Insurance
Clearinghouse.

Low Income Kansans
- 39,000 more childless adults with incomes below 100&% FPL would be insured through an expansion of the Premium Assistance SB 11 Program.

Small Businesses
- 12,000 more very small groups (sole proprietors and 1 to 10 employees) would be insured through the market combination and reinsurance efforts.
- Section 125 assistance would encourage small businesses to offer tax-preferred health insurance premiums.

After full implementation of the Updated Sequential option, Kansas will have one of the lowest uninsurance rates in the country with only 7% of Kansans lacking health care coverage.

Cost Estimate
While the individual components of the Updated Sequential Model, as fully implemented, each decrease the number of Kansans without health care insurance, the impact upon All Funds and State General Funds varies substantially (Figures 13 and 14).

Children and Young Adults
- $22 Million AF
- $14 Million SGF

Low Income Kansans
- $119 Million AF
- $56 Million SGF

Small Businesses
- -$5 Million AF*
- $1 Million SGF

(*Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above. Practically, however, at the program level, the State of Kansas will not change the State’s Disproportionate Share Hospital reimbursement methodology.)

The net cost of the Updated Sequential plan is an increase in expenditures (AF) for non-elderly Kansans of $136 million. After full-implementation of all three initiatives that make up the Updated Sequential plan, State General Fund expenditures would increase by $71 million.
NEXT STEPS

The analyses discuss above were used to construct the 21 recommendations for health care reform presented by KHPA during the 2008 Legislative Session as part of SB 81. Of these recommendations, nine of the 21 were included in an Omnibus appropriations bill, and only one of the nine was funded by the Legislature. From this it was determined further discussion was needed regarding reform options present in the Updated Sequential Plan, particularly those addressing health insurance issues specific to the small business community. As a result, KHPA formed the Small Business Health Insurance Steering Committee (SBHISC) and tasked with Committee with representing the stakeholders in the small business market and working collaboratively with KHPA to provide recommendations for small business health insurance reform options to be presented in the 2009 Legislative Session.

Preparations for the 2009 Legislative Session – KHPA Discussions on Health Care Reform Options

The dialogue with the SBHISC yielded a plethora of recommendations from various stakeholders within the small business market; Kansas Insurance Department, health plan administrators, independent agents, and advocates. From the start, there were common themes in the responses from all participants, focusing primarily on affordability and cost containment. Both of these issues are interrelated, as in order for affordability to be sustained for any significant period of time, pressure from increasing costs must be relieved. The process considering various options for reform was comprehensive, but the feedback from the SBHISC as well as direction from the 2008 Legislative Session was for KHPA and its recommendations to be more focused for 2009. As a result, KHPA and srHS crafted the following reform options2 to model for the 2009 Legislative Session:

- Section 125 – Mandate Section 125 Plans for all Small Employers
- Business Health Partnership (BHP) – Expand roles and responsibilities of BHP in leading Small Employer Reforms
- Reinsurance – Estimate cost of Subsidized Reinsurance to reduce cost and volatility of Small Employer Health Insurance Market
- Mini-Med – Estimate cost and enrollment due to offering Mini-Med policies
- Young Adults – Allow all Dependent Young Adults from 19-25 remain on Parent’s Insurance Coverage

2009 Legislative Studies – Joint Committee on Health Policy Oversight

As part of those deliberations and analyses conducted by KHPA in support of the SBHISC, in addition to the reform options listed above submitted to the KHPA Board, KHPA also completed the following analyses in response to the Joint Committee on Health Policy Oversight request for 2009 Legislative studies by KHPA:

13) A study allowing insurers to offer young adult policies with limited benefits and reduced premiums to expand access to affordable coverage; and
15) Study health policy options to reduce the rate of uninsurance at Small Businesses, including the creation of a Small Business Health Policy Committee to assist small employers secure health insurance, allowing very small employers to obtain health insurance and making health insurance more affordable for small businesses and employees to expand affordable commercial insurance.

The results of our studies are presented below.

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2 For more information on the reform approaches considered and modeled, please the presentation to the KHPA Board on November 18, 2008 entitled “Small Business Health Reform Proposal.”
13) Study allowing insurers to offer young adult policies with limited benefits and reduced premiums to expand access to affordable coverage

Purpose of this Study
The purpose of this study was to examine the impact on the number of uninsured young adults (ages 18-25) in Kansas by allowing insurers to offer policies specific to young adults with limited benefits and reduced premiums. In collaboration with the Small Business Health Insurance Steering Committee and the Kansas Health Policy Authority, schramm=raleigh Health Strategy (srHS) priced out a “Mini-Med” plan design with limited benefits. Premiums calculated reflected both the limited benefits and the underlying health risk for young adults. Based on the lower monthly premium and subsidies from the State srHS estimated how many additional young adults would purchase health coverage.

Insurance Status of Young Adults in Kansas
As an age group young adults have the highest rate of uninsurance in the state. According to an average of the 2006 and 2007 Current Population Surveys (CPS), there are an estimated 310,000 young adults living in Kansas as shown in Table 1. Of this amount, 229,000 currently have health insurance, while 81,000 are uninsured.

Table 1

Table 2

Mini-Med: Young Adult Limited Benefit Health Coverage
In contrast to the majority of products seen in the health insurance market, Mini-Med is not and should not be considered health insurance, but rather health coverage. In this instance Mini-Med is intended to provide an
affordable alternative for access to coverage through traditional sources in the private market. In order to prevent crowd-out from the private market and to target the uninsured srHS is assuming a 6 month “go-bare” provision, making a requirement for eligibility that enrollees have been uninsured for 6 months prior to enrollment. The Mini-Med plan has the following service specific dollar amount and service limitations:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Limit (for a 12 month period)</th>
<th>Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Visits</td>
<td>12 Visits</td>
<td></td>
</tr>
<tr>
<td>• PCP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Generic Only $2,000 Maximum</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$15,000 Maximum</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>2 Visits</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>1 Visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient Other (includes Lab/Radiology and PT/ST/OT services)</td>
<td>4 Services</td>
<td></td>
</tr>
<tr>
<td>DME</td>
<td>$1,000 Limit</td>
<td></td>
</tr>
<tr>
<td>Maximum Annual Benefit</td>
<td>$25,000</td>
<td></td>
</tr>
</tbody>
</table>

**Access and Affordability**

The Mini-Med product is able to offer coverage at approximately $122 per month, which is roughly 20% less than the cost of the typical insurance product purchased on the individual market, however with no deductibles or coinsurance. When comparing the premiums of Mini-Med and employer sponsored insurance (ESI), ESI is less expensive due to the employer typically covering 70%-80% of premium expense. Despite the economic advantage of purchasing ESI, young adult participation in ESI is low for two reasons:

1. The transient nature of employment seen in the young adult population typically does not allow them to be eligible for coverage through an employer; and
2. Many do not have employers who offer insurance or are willing to contribute its cost.

Even though in comparison to other policies Mini-Med is more affordable, it is not likely there will be a large portion of the uninsured young adults purchasing a Mini-Med program at full price. This can be explained by the large number of young adults that are considered either low income or are living under the Federal poverty level (FPL). People with lower income place more value to each dollar relative to their higher earning counterparts, therefore a 20% decrease in premium does not increase their propensity to purchase coverage if the resulting premium is still a significant portion of their monthly income. To address this issue srHS modeled the effects of a state subsidy for the premiums in this plan. Assuming state subsidization, enrollee contributions would range from $5 to $45 depending on income. srHS used an elasticity of demand function in an attempt to estimate how many of the uninsured young adults would purchase the Mini-Med product based on:

1. The current purchasing decisions of this population; and
2. The out of pocket expenditures associated with Mini-Med (includes both premium contribution and cost sharing).

Due to the factors listed above regarding the unlikely nature of uninsured young adults to purchase coverage, their demand was assumed to be relatively inelastic. The majority of studies done regarding elasticity of demand as it relates to health insurance state the average figure to be between -.500 and -.600, which would be considered inelastic. These studies have typically not targeted young adults, but the limited information available suggests this group to be more inelastic than their older counterparts, so to be conservative we assume a base elasticity of -.100.
Findings
The results showed that the number of uninsured young adults could be reduced using state subsidies. Due to the inelastic nature of young adults as it relates to purchasing health coverage, a significant reduction in price is necessary to provide enough incentive to purchase coverage. Assuming state subsidization as stated above, it is estimated over 8,000 previously uninsured young adults would purchase Mini-Med coverage, showing a 10% uptake of the eligible population. In addition, approximately 25% of new enrollment would come from those under the poverty level, and almost 70% would be those making less than 300% (FPL). State subsidization of this program would cost the state $7,000,000 or about $70 per enrollee, which, in relation to typical state subsidized coverage, is cost effective.

Feedback and Recommendations
This product operates under the principle that some coverage is better than no coverage. An individual who is uninsured seldom has regular access to a physician; this situation has the potential to lead to more serious health conditions. Mini-Med addresses this by making access to coverage affordable, allowing people to receive medical treatment as needed. An additional benefit to this policy would be showing young adults the value of health coverage, which can be useful in educating young adults new to the health insurance market. Taking a long-term approach is necessary in teaching future generations the importance having and utilizing health coverage. However, there is not universal agreement on the effectiveness of Mini-Med. The fact that there are limited benefits exposes enrollees to bear the risk of claims over $25,000, which could leave them without coverage when the most serious medical conditions occur.
15) Study health policy options to reduce the rate of uninsurance at Small Businesses, including the creation of a Small Business Health Policy Committee to assist small employers secure health insurance, allowing very small employers to obtain health insurance and making health insurance more affordable for small businesses and employees to expand affordable commercial insurance.

Purpose of the Study
The purpose of this study is to examine current health policy nationally for potential small group reform approaches that could be successful at reducing the rate of uninsurance for small employers in Kansas. In collaboration with the Small Business Health Insurance Steering Committee and the Kansas Health Policy Authority, schramm=raleigh Health Strategy (srHS) examined the issues critical to small employers in Kansas. We examined the small employer health insurance market from the perspective of the key players in the market:

- Regulator
- Employer
- Employee
- Carrier

Based on that review, srHS examined potential strategies used nationally to increase the insurance rate in the small employer market and their applicability to Kansas.

Small Employer Health Reform Experience Nationally
The issue of uninsurance at small employers is not unique to Kansas. Over the past decade, States have been deliberated and implemented a wide range of health insurance reforms the small employer health insurance market. Their reforms have typically covered four major areas:

1. Regulation – Review Small Group Insurance Market Laws and/or Structure
   a. Laws - Rating Bands, Community Rating
   b. Administration – Connector/Exchange
2. Affordability – Improve thru Targeted Intervention
   a. Stability – Reinsurance, Hi-Risk Pools
   b. Funding – Tax Credits, Subsidized Reinsurance
3. Plan Design – Develop Targeted Products
   b. Populations – Young Adult Populations/Plans (YAPs)
4. Education/Outreach
   a. Communications Strategy – Information on Market/Reform

Options Modeled for Kansas
As a result of the Steering Committee process, srHS modeled multiple potential approaches to addressing the problem of uninsurance at Kansas’ small employers:

- Administration – modeling and results described below
- Reinsurance Options – see 11/18/08 KHPA Board presentation
- Benefits Changes – see 11/18/08 KHPA Board presentation
- Population Specific Plan Design – see 11/18/08 KHPA presentation

Administrative Reform for Kansas
As part of this study, we examined the existing Kansas statutes governing the small employer insurance market and previous attempts to reform the small employer health insurance market in Kansas. In a notable previous move to address uninsurance in the small employer market in Kansas, the Legislature created the Business Health Partnership. As an existing statutory vehicle, the Partnership, could provide a ready vehicle for any reform efforts and potentially shorten the time to implementation for any reform proposals.
The Business Health Partnership
The Business Health Partnership (BHP) does offer stakeholders an existing legislative vehicle that could support several of the proposed reforms in the small group market without change; however some of the propositions do require amendments to the current statute.

As noted by the stakeholders, it would be desirable to utilize the BHP as a vehicle allowing multiple employers and funding sources to contribute to an employee’s health insurance costs. The BHP is currently authorized to combine funds from the federal government and the state, with contributions from employers and their employees to purchase health insurance. In addition to being authorized to accept funds, the BHP also has the ability to offer Mini-Med policies, and it would not be subject to all of the health insurance benefit mandates in Kansas, however there are mandates in the BHP legislation that mandate preventive and screening services, which must be included in any policy offered.

Potential Changes to BHP Statute
There are some slight changes needed if the BHP were to offer the Mini-Med policy as currently proposed.

- The Mini-Med proposal includes a 6-month “go-bare” provision, essentially stating to be eligible for enrollment one would have had been without insurance for the previous 6 months. In the statute the BHP cannot offer its products to any business that has offered health insurance, or contributed to the cost of coverage for its employees for the previous 2 years.
- The second area of difference between proposed policy and current statute regards what is considered a full-time employee in order to be eligible for policies offered by the BHP. While the statute currently requires an employee work at least 30 hours per week to be eligible for coverage, the Mini-Med proposal requires only 20 hours per week, to allow workers who may work part time at two or more jobs to still have the opportunity to participate.

Potential Additional Roles of the BHP
In addition to offering health insurance policies to small employers, the BHP has the potential to serve multiple purposes in serving the small group market.

The BHP can take an active role in product design, ensuring quality affordable products for small employers. There are many components to this role, such as developing benefits and pricing for new products, and the development, marketing, and evaluation of RFP’s for carriers to provide pricing on BHP products. The BHP could also develop service specifications for Section 125 vendors, and facilitate the development, marketing, and evaluation of RFP’s for Section 125 services.

In an administrative capacity the BHP could act as a resource for small employers purchasing health insurance, regardless if the policy being purchased is offered by the BHP or not. In this situation the BHP would provide a Seal of Approval for certain products and carriers they have deemed quality affordable insurance products, as well as play a similar role as it relates to Section 125 services. The BHP could also coordinate the receipt and distribution of money from different funding sources on the employer’s behalf.

Feedback and Recommendations
There are numerous potential approaches that Kansas could consider to reform the small employer health insurance market in Kansas. The BHP as it is currently written into statute is able to facilitate most of the reform proposals for the small group market, being able to offer insurance products and combine subsidies from state and federal funding sources. However, there may need to be changes made to the statute concerning the eligibility requirements for employers and employees that would more closely align with the goals of the reform proposals considered. These changes were generally favored by the stakeholders that participated in the Small Business Health Insurance Steering Committee. Additionally, potential regulatory roles of the BHP would have to be examined much more closely to ensure there is no overlap with the proposed duties and those currently being performed by other state agencies.