

HealthHub RI

Options to Consider

January 29, 2009

This study was funded by Robert Wood Johnson's State Coverage Initiative program (SCI) to evaluate options for a health insurance exchange in Rhode Island. Lieutenant Governor Roberts led the project, with expert participation by the Office of the Health Insurance Commissioner. The study was performed jointly by three consultants – Deborah Chollet (Mathematica), Deborah Faulkner (Independent Consultant), and Amy Lischko (Tufts University).

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Executive Summary

Early in 2008, Lt. Governor Roberts filed legislation entitled the “*Healthy RI Reform Act of 2008*.” This legislation included the establishment of an insurance exchange called HealthHub RI. Ultimately that legislation did not pass but the bill began a public discussion about the merits of establishing a HealthHub in Rhode Island. Recognizing the need for additional expertise and deliberations on this topic, the Lt. Governor initiated this study, and outlined two primary objectives:

- To continue the public dialogue around the challenges of sustaining and increasing health insurance coverage for all Rhode Islanders; and,
- To identify and evaluate the options for a future HealthHub RI.

With these objectives in mind, Lt. Governor Roberts convened a working group, with expert participation by the Office of the Health Insurance Commissioner. External funding for this project supported the team in hiring outside consultants to provide both national context to the deliberations and expertise regarding the viability of an insurance exchange for Rhode Island.

Various constituents were convened during a stakeholder process including three public meetings in the Fall/Winter of 2008-2009. Carriers, brokers, employers, consumers, legislators and other interested parties were invited to participate in a dialog around their goals and vision for a HealthHub RI. Information regarding various options and the merits and challenges of each option created an environment of lively discussion and debate culminating in this report.

The range of options proposed for HealthHub RI were carefully crafted to consider the following four Rhode Island specific characteristics:

- **Small market size**
With only approximately 115,000 small group lives, any added administrative infrastructure requires careful scrutiny of added cost versus added value.
- **Small number of carriers**
With the addition of Tufts Health Plan, beginning in January 2009, there are three small group carriers in Rhode Island.
- **Erosion in employer sponsored coverage**
Consistent with national trends, employer sponsored health insurance in Rhode Island has eroded considerably over the past few years. In Rhode Island, this trend coincides with substantial shift in the composition of jobs, with fewer jobs in professional services and manufacturing and more jobs in retail industries. Retail industries rely more heavily on part time workers and are much less likely to offer health insurance to their employees.
- **Substantial state budget deficit**
With a current State budget deficit of over \$400 million, HealthHub RI options must be designed to allow incremental steps toward clear goals, with little or no immediate investment.

Exchanges in three other states, Connecticut, Massachusetts and Washington, were used as examples of the various forms and functions of existing exchanges. Experience in these states provided valuable “lessons learned” for the purpose of developing a plan for Rhode Island, as described in Section II of this document.

The first step in the public discussion was to identify and prioritize score goals for HealthHub RI. Participating stakeholders identified five primary goals, as described in section III and summarized below:

1. Organize the Market: Transparency and standardization (“Travelocity Lite”)

In the context of HealthHub RI, this was defined as a web-based tool providing product descriptions, pricing across carriers, and actuarially defined categories of insurance products such as illustrated by the Massachusetts Connector’s “gold” “silver” and “bronze” choices.

2. Organize the Market: Simplify purchase, improve choice and portability (“Travelocity Plus”)

This goal was characterized by a broader definition of market organization. Here the HealthHub would not just inform consumers about options, but would actually enroll individuals and/or employers. With this type of functionality in the HealthHub, employers could contribute to health insurance via the Hub, which would allow employees to choose among Hub product options, and pay the additional premium amount or pocket the difference. In addition, employees could combine contributions from multiple employers (a particularly important feature for part-time employees), to purchase coverage through the Hub. In this way, the Hub would achieve increased employee choice and portability. It also would simplify the purchasing process for employers, as they could simply specify a contribution amount and allow their employees to choose the carrier and product that best fit their needs. This new purchasing model would involve substantial additional administrative infrastructure.

3. Access: Establish benefit standards and incentives (Individual Mandate)

Establishing a minimum benefit standard for all Rhode Islanders through a public process, was important to many stakeholders for two reasons. First, they were concerned that existing standards were established through legislation and, therefore, were not regularly reviewed and modified to address current market needs. Second, existing standards do not apply to self-insured employers, who account for approximately one-third of the commercial market (and growing).

In Massachusetts, the Connector board is responsible for establishing a minimum benefit standard, which defines “creditable coverage” for the purpose of satisfying the individual mandate. HealthHub RI could also have a board responsible for establishing a minimum benefit standard. Consistent with the Massachusetts model, this standard could be linked to an individual mandate requiring all Rhode Islanders (for whom affordable options are available) to have health insurance coverage. The HealthHub board would therefore have responsibility for both defining a minimum benefit standard (“creditable coverage”), as well as setting a standard of what level of premium relative to income constitutes affordability for Rhode Island residents.

4. Access: Location for Subsidies

Subsidies would be required to move Rhode Island toward (if not to) universal coverage. Conceptually, if an individual mandate included standards for affordability, then those Rhode Islanders for whom no options were deemed “affordable” could be eligible for subsidized coverage.

Although stakeholders rated this goal as a lower priority, that was due only to timing and the current state budget difficulties. Stakeholders felt strongly that whatever HealthHub structure was established now should be capable of evolving into an entity that could provide a location for subsidies.

5. Cost Containment:

Establishing a HealthHub that could drive system affordability was an important goal for many members of the working group. Discussion centered on the mechanisms were needed to drive system affordability and whether the HealthHub could be a vehicle and location for this activity.

At the second stakeholder meeting, these goals were reviewed and prioritized as the basis for evaluating different HealthHub models. **Cost containment and improving access through the establishment of benefit standards and incentives were the group’s highest priorities.** Discussion focused on how best to meet these goals – that is, what core characteristics and functions of HealthHub RI would be needed to achieve these goals? The group considered many different characteristics and functions, but focused on three primary dimensions:

1. What are the minimum structural requirements needed to meet the goals of the HealthHub?

The group agreed that a public board with some analytic capacity would serve most goals. However, it was not recommended that Rhode Island pursue the establishment of a new administrative structure at this time. Nevertheless, stakeholders did not preclude the establishment of a new entity in the future.

2. Will any mandates be needed to support the HealthHub goals as defined?

High priority was placed on the goal of “improving access through benefit standards and incentives.” Consequently, an individual mandate became a key element of most options considered. The group recognized that any benefit standard would be most meaningful in the context of a mandate requiring all Rhode Islanders to have health insurance coverage that meets the standard, as long as it is deemed “affordable.” These are difficult policy discussions to have during hard financial times. However, as more employers and individuals drop coverage insurance premiums in Rhode Island could become ever less affordable for those who remain covered. It was therefore recommended that some form of a mandate be pursued in Rhode Island.

3. Target Population: Who should the HealthHub serve?

The stakeholders acknowledged that, because Rhode Island is a small state, any new policies will have the most influence if they are broadly applied. Small employers seem to have difficulty navigating the health insurance marketplace. A targeted approach to simplifying the small group market seems possible. The goals of cost containment and access, however,

are broader goals. Therefore, any policies to pursue these goals through the HealthHub should be broadly targeted, applying to as many Rhode Islanders as is feasible.

The project consultants considered many combinations of characteristics and functions for the HealthHub, but ultimately narrowed them down to four options, which were presented to the stakeholder group for discussion. ***All four options take incremental steps toward reform, recognizing Rhode Island's unique starting point and goals for a HealthHub.*** They are arrayed below from the least to the most aggressive reform option; a more detailed assessment of each can be found in the text of the report.

Option 1: Mandate Only

This option would establish a minimum benefit standard applicable to all Rhode Islanders. It would set this standard through an individual mandate, which would apply only to Rhode Islanders who have access to “affordable” coverage. This option requires a quasi-public HealthHub board with some analytic capacity. The Board would be responsible for deciding benefit standards, creditable coverage, and affordability.

Assessment: Small but important step toward reform

Option 2: Travelocity Lite + Mandate

In addition to the individual mandate described in option 1 above, this option would create a new source of market information for individuals and small employers. The Health Hub would organize and post all carrier/product options on a single web site. This option would require a quasi-public HealthHub board. The HealthHub could be a virtual entity responsible for developing and maintaining a website and also organizing standard product options.

Assessment: A helpful addition for small employers. But, would employers sufficiently value the “Travelocity Lite” functionality (without the full exchange features) to justify this option?

Option 3: Full Exchange + Mandate (Pilot)

In addition to the other features noted in options 1-2 above, this option assumes that all small employers (under a certain size to be determined) purchase insurance through the HealthHub. It would therefore require the establishment of a new administrative structure and begins to restructure how health insurance is purchased in Rhode Island.

Assessment: Logical pilot for new purchasing model – but will it provide sufficient volume to justify administrative investment?

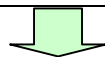
Option 4: Full Exchange + Mandate

This option assumes all the features of option 3 above except that it would change the purchasing model for all individuals and small employers if not in self-insured firms. This option would require infrastructure investments similar to option 3 but is likely large enough to be financially viable.

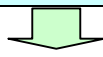
Assessment: Addresses all goals – represents an aggressive leap from current model

Summary: Recommended Set of Options

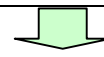
	Option 1 Mandate Only	Option 2: Mandate + Travelocity Lite	Option 3: Full Exchange (Pilot)	Option 4: Full Exchange
Target Pop:	All Rhode Islanders	Individuals + Small Employers	Individuals + Small Employers (<15?)	Individuals + Small Employers (all)
Min Structure:	Public Board Only	Public Board + Virtual Entity	New Administrative Structure	New Administrative Structure
Mandates:	Individual Mandate	Individual Mandate	Individual Mandate	Individual Mandate
Goal 1a: Organize Market Travelocity "Lite"	-	✓	✓ -	✓
Goal 1b: Organize Market Travelocity "Plus"	-	-	✓ -	✓
Goal 2a: Access: Benefit Standards and Incentives	✓	✓	✓	✓
Goal 2b: Access Location for Subsidies	✓	✓	✓	✓
Goal 3 Cost Containment	✓ -	✓	✓ -	✓



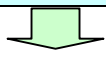
*Small but important
step toward reform*



*Do employers value
the "Travelocity lite?"*



*Logical pilot for new
purchasing model –
but sufficient
volume?*



*Addresses all goals
with aggressive
leap from current
model*

I. Introduction

This study was funded by the State Coverage Initiative (SCI) program of the Robert Wood Johnson Foundation to evaluate options for a health insurance exchange in Rhode Island. Lt. Governor Roberts led the project, with expert participation by the Office of the Health Insurance Commissioner (OHIC).

Early in 2008, Lt. Governor Roberts filed legislation entitled the “Healthy RI Reform Act of 2008.” This legislation included the establishment of an insurance exchange called HealthHub RI. Ultimately that legislation did not pass but that bill began a public discussion about the merits of establishing a HealthHub in RI. The work described here was initiated by the Lieutenant Governor to continue a public dialogue around the challenges of sustaining and increasing health insurance coverage for all Rhode Islanders and to identify and evaluate the options for a future HealthHub.

Various constituents were convened during a stakeholder process including three public meetings in the Fall/Winter of 2008-2009. Carriers, brokers, employers, consumers, legislators and other interested parties were invited to participate in a dialog, discussing their goals and vision for a HealthHub RI. Information regarding various options and the merits and challenges of each option created an environment of lively discussion and debate culminating in this report.

The feasibility of establishing a HealthHub RI was guided by the following core goals:

- 1) to better organize the health insurance market to make it more transparent and accessible to small employers and individual consumers;
- 2) to provide access to affordable health insurance for all Rhode Islanders; and,
- 3) to drive system affordability.

The external funding for this project supported the team in hiring outside consultants to provide both national context to the deliberations and expertise regarding analysis of the viability of an insurance exchange for Rhode Island; and to develop related legislation.

This report summarizes the work conducted under this study. It is organized into four sections. Section II provides brief background material including: A) lessons learned from other states with an existing exchange model, and B) context for Rhode Island’s insurance markets, population, and carrier characteristics. Section III outlines the goals and priorities for a HealthHub in Rhode Island and Section IV presents the options that were evaluated during this process and includes a discussion of how each of the options fulfills the goals and priorities that stakeholders put forth.

II. Background

A. Lessons from other Markets

Exchanges have been conceptualized and developed as platforms to improve access for small employers and individuals. Exchanges can be attractive alternatives for small employers, part-time employees who work for large employers, temporary and seasonal employees, and people purchasing in the non-group market. Lessons can be learned from three current case studies of exchanges – Connecticut, Massachusetts and Washington State. Each state model is briefly discussed below and lessons learned from these models and implications for the development of a HealthHub in Rhode Island are presented.

1. Connecticut

The Connecticut Business and Industry Association Health Connections is a private-sector purchasing mechanism. Operated as a division of the Connecticut Business and Industry Association for more than 12 years, Health Connections was one of the first statewide, multi-vendor health insurance purchasing alliances in the country. It serves employers with three to 100 employees and provides choice among plans offered by four participating health insurance carriers. Currently, more than 6,000 businesses with 88,000 covered lives participate.

Health Connections offers a range of benefits to participating employers. These include a menu of employee choices for health insurance policies. For participating businesses, administration is consolidated and employer contributions are managed across plan options, with employees paying the difference between the premium for the option they choose and the employer contribution. In addition, Health Connections offers small employers full-service human resources capability, which includes payroll services and assistance in complying with federal laws like COBRA.

To mitigate the potential for adverse selection, Health Connections uses the same rating rules (age, gender, geographic area, family tiers) as those in the small group market and has established a floor of benefits which each of four participating carriers must meet. As a condition of group enrollment, at least 75 percent of eligible full-time employees must participate. Health Connection's has maintained a good relationship with businesses, insurers, and brokers; it is small enough to be nimble; and it is willing to adapt to marketplace changes. Health Connection executives report that developing and maintaining a role for brokers was essential in order to gain market share, and that use of the same underwriting, rating, and eligibility rules inside Health Connections as outside has been critical to avoiding adverse selection.

2. Massachusetts

The Commonwealth Health Insurance Connector Authority (the Connector) was established in 2006 as an important part of system-wide reform in Massachusetts intended to cover most uninsured residents. The Connector is an independent, quasi-governmental entity designed to

help eligible individuals and small groups purchase health insurance at affordable prices. The law allows residents in certain circumstances to purchase insurance through the Connector as shown in Table 1.

The Connector makes it easier for all businesses to offer insurance to part-time employees and contractors, as well as full-time employees, on a pre-tax basis. The Connector administers premium assistance for individuals between 150 percent and 300 percent of the federal poverty levels (FPL), and free coverage for those who earn less than 150 percent FPL, but who are not eligible for Medicaid. To facilitate purchase of coverage with pre-tax dollars, employers (with 10 or more employees) must offer all employees a Section 125 plan whether the employees are part-time or full-time.

Beginning in December 2008, employer groups with 50 or fewer employees could purchase insurance via the Connector. Employers are required to choose a level of product offering for their employees (gold, silver or bronze) and then employees are free to choose a product within that level of coverage. Alternatively, employers can continue to purchase as a group, either through the Connector or outside of it, selecting a single product for eligible employees.

3. Washington

E2SHB 1569 created the Washington Health Insurance Partnership (HIP) in 2007 to help small businesses provide affordable health plan options to their employees. HIP anticipated opening enrollment in 2009 but due to severe state budget problems the launch date has been delayed indefinitely. HIP is governed by a seven-member board. HIP is narrowly targeted for start-up. It is a market organizer similar to the Connector in Massachusetts, and CBIA in Connecticut. As such, it does not negotiate rates for any product. Twelve plans (in four tiers) will be available in HIP. Current small-group rating rules apply inside the HIP as outside.

Only employers with a low-wage workforce will be eligible to purchase HIP coverage, and only if they do not currently offer coverage.¹ Employers must contribute at least 40 percent of the single premium for the plan they select, but there are no minimum participation requirements or requirements for dependent coverage. Employers will choose the plan that they offer to their workers; employees will have no choice among plans. The HIP will offer a premium subsidy to employees with family incomes below 200 percent of the federal poverty level (FPL).

Estimates prepared by Mathematica Policy Research (MPR) found that as many as 16,500 workers will enroll in the HIP (2010 estimate), less than 2 percent of all uninsured small-firm workers in Washington State. Most of those projected to enroll have incomes below 200% of the FPL. Thus, although HIP enrollment is projected to be low, without the availability of (a) a low minimum employer contribution; and (b) subsidies to offset higher employee contributions to coverage, virtually no one would enroll in the HIP.

¹ Low-wage firm is defined as one in which at least 50 percent of workers earn no more than the equivalent of 200 percent of the federal poverty level (FPL) for a single-person household.

Table 1: Key Features of the Connecticut (CBIA), Massachusetts (Connector), and Washington State (HIP) Models

Key Feature	Connecticut	Massachusetts	Washington HIP
Eligibility	<ul style="list-style-type: none"> Employers with 3-100 employees 	<ul style="list-style-type: none"> Small groups (2-50) Sole proprietors Individuals working for non-offering companies Individuals working for offering companies but not eligible (part timers) Non-working individuals 	Low wage firms (2-50) currently not offering
Governance	<ul style="list-style-type: none"> Private entity 	<ul style="list-style-type: none"> Quasi-public/private entity with a 10-member board 	<ul style="list-style-type: none"> Quasi-public/ private entity with a 7- member board
Product Choice	<ul style="list-style-type: none"> Employer chooses from 2 suites of plans. Employees choose among 4 carriers with varying cost sharing, within the suite. 	<ul style="list-style-type: none"> Employer chooses one of 3 plan types (gold, silver bronze). Employees choose among carriers and plan designs within that plan-type. 	<ul style="list-style-type: none"> Employer chooses one of 12 plans. No employee choice
Alternative market(s)	<ul style="list-style-type: none"> CBIA competes in the small-group market. Association plans (Chambers of commerce, etc) are rated the same as small groups (each employer within the association is rated individually) 	<ul style="list-style-type: none"> The Connector operates side-by-side with blended small group and individual market. Any firm may self-insure. Association plans are rated the same as small groups (each employer within the association is rated individually) 	<ul style="list-style-type: none"> Operates side-by-side small group market Association plans continue to operate outside the HIP Any firm may self-insure.
Contribution participation requirements for employers	<ul style="list-style-type: none"> 75 percent of full-time employees must participate. Employer must contribute 50 percent of premium for the lowest-cost plan in the suite. 	<ul style="list-style-type: none"> 75 percent of full-time employees must participate. No employer contribution is required. Employers with more than 10 employees must sponsor a Section 125 plan. 	<ul style="list-style-type: none"> Employer must contribute 40 % of employee premium for some available plan, All employers must sponsor a Section 125 plan.
Other features	<ul style="list-style-type: none"> Provides full-service human-resources 	<ul style="list-style-type: none"> Operates premium assistance for low-income 	<ul style="list-style-type: none"> Operates premium assistance

4. Lessons Learned

As demonstrated by the discussion above, the concept of a HealthHub can take a variety of different forms and perform a variety of functions. As such, it is important to consider the lessons learned from efforts in other states in developing a plan for Rhode Island. Preliminary lessons that have emerged from the three state models presented above are discussed here.

Goals

It is important that goals and objectives are clearly articulated and that all parties participating in the development of the exchange understand them. If the exchange has multiple goals, it may be necessary to prioritize them.

Governance/decision-making

In both Massachusetts and Washington, a multi-disciplinary board makes decisions regarding the functions and policies of the exchange. Some decisions may be better situated in specific state agencies or the within the administrative infrastructure of the exchange, but this model appears to be working well.

Size

The models developed in Connecticut, Massachusetts, and Washington were designed to serve different populations—variously, all or some small or large employers and individuals. Any state considering an exchange must first consider which populations to target. The financial success of the model depends on sufficient enrollment. In addition, the size of the exchange is important if affecting the delivery of healthcare is a goal.

Mandates

By themselves, exchanges developed thus far have done little to increase the offer or take-up of health insurance. To ensure that the risk pool remains healthy, it may be necessary to require the offer and/or purchase of some level of health insurance. In Massachusetts, the individual mandate increased take-up of both individual and employer-based coverage.

Cost Containment

Exchanges developed in the states discussed above have done little to constrain the growth of health care costs. They have had little role regarding product pricing and the rate determination process is quite similar to what occurs in the outside markets. It is conceivable that a large exchange could help drive system affordability through creative benefit design and product standards.

B. Rhode Island Context

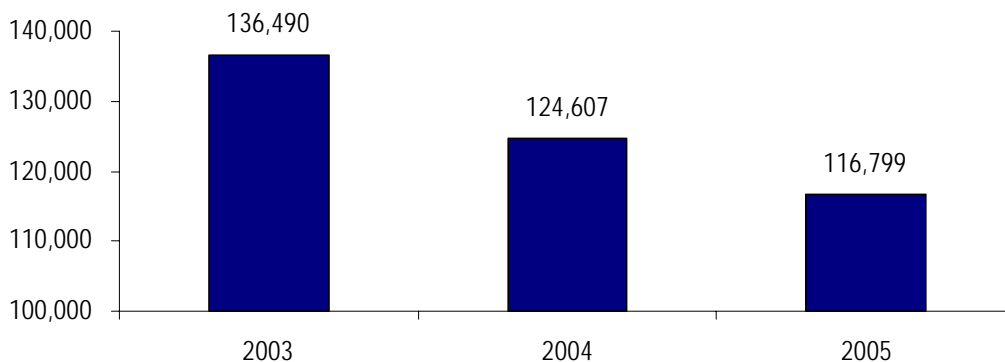
Development of the HealthHub must consider Rhode Island's unique circumstances. This section briefly describes the small group and individual markets in Rhode Island and profiles the population that is uninsured.

1. Small Group Market

The plans offered to small groups in Rhode Island are heavily weighted toward rich benefit designs with modest cost sharing. Typical plans have no deductibles or coinsurance—cost sharing is limited to office visit and pharmacy co-payments. Three carriers currently offer products in this market: Blue Cross Blue Shield of RI, Tufts, and United Health Care.

Enrollment in the small group market currently stands at approximately 115,000 enrollees. As of 2007, United HealthCare (UHC) had approximately a 21% share of the market; Blue Cross Blue Shield of Rhode Island (BCBSRI) controlled the other 79%.² A third carrier, Tufts Health plan, entered the Rhode Island market in late 2008.

Table 2: Total Rhode Island Small Group Membership



Source: OHIC, Rhode Island Small Group Market Conduct Study, 2007

Enrollment in the small group market has declined in recent years, largely reflecting a decline in the number of workers eligible for coverage.³ While small employers are much less likely to offer health insurance to employees than larger employers, this gap has not changed over time. Small employer premiums and trends are about 11% higher than large employer premiums.⁴ When Rhode Island small employers do offer insurance, they contribute a greater share of the premium than the average in surrounding states or the nation.

² Source: Carrier financial filings

³ Source: MEPS-IC data, OHIC analysis

⁴ Source: MEPS-IC 2006 data, OHIC analysis

2. Individual Market

For Rhode Islanders who purchase through the individual market, coverage is available exclusively through BCBSRI. Because a single carrier covers the entire market, it has been easier for the state to exercise oversight of medical underwriting, and to ensure that coverage is high quality and premiums are affordable. Rhode Island's regulations limit the extent to which insurers can penalize less healthy individuals in the individual market. Similar to the small group market, health plans cannot deny applications for insurance.

A substantial number of the subscribers who purchase non-group coverage are high-risk, meaning their predicted or actual medical costs are higher than average due to their age or medical conditions. However, almost half of the individuals who purchase in this market are relatively low risk—younger, healthier people, who see a value in (and have the means to purchase) health insurance. BCBSRI has been allowed to use medical underwriting to accommodate both types of individuals in the risk pool without setting prices so high that the healthier subscribers will forego coverage.

Individual premiums also vary according to plan design and benefit coverage (in addition to health status). While the array of available plans allows a choice of coverage types and premium levels, it is heavily weighted toward products with significant cost sharing (such as deductibles and coinsurance). More than half of the products offered to individuals have a deductible of \$2,000 or more. However, the most popular plan has the lowest deductible: \$400 for individuals.

The membership mix in the non-group market has not substantially changed over the last several years. The percentage of healthy subscribers has increased slightly, from 42.6 percent in 2003 to 48 percent by the middle of 2007. Non-group membership, in total, also has remained stable over the past four years, between 12,000 and 15,000 members.

3. The Uninsured

In Rhode Island, the rate of uninsured among residents under age 65 was 13.3 percent in 2005—similar to the rate of uninsured across New England and lower than the national average (18 percent). Rhode Island's rate of uninsured has grown rapidly in recent years, up from 6.9 percent in 2000. Loss of coverage was apparent among adults and children alike, and among employed and self-employed workers. However, much of the increase in the rate of uninsured is a result of the erosion of employer-based coverage. More than 60 percent of the uninsured population is employed in some capacity.

The erosion of employer-based coverage coincides with employment changes in Rhode Island. Between 1999 and 2006, there was a substantial shift in the composition of jobs in Rhode Island, with fewer jobs in professional services and manufacturing and more jobs in retail industries. Retail industries rely more heavily on part time workers and are much less likely to offer health insurance to their employees. In addition, premiums have been rising steadily, far outpacing wage growth in Rhode Island.

III. HealthHub RI: Goals

A. Description of Goals

Three broadly defined goals were identified early in the strategic HealthHub process: 1) organize the market to improve transparency and accessibility, 2) provide access to affordable health insurance for all Rhode Islanders; and 3) contain cost. Detailed discussions around each of these goals occurred during the stakeholder process and several sub-goals were identified, resulting in a final set of five goals as described below.

1. Organize Market: Transparency and standardization: “Travelocity Lite”

Transparency and standardization can be achieved in a number of different ways – in the context of HealthHub RI, it can be achieved via the development of a web- based tool providing product descriptions and pricing across carriers within actuarially equivalent categories of insurance products (such as the Massachusetts Connector’s “gold” “silver” and “bronze” product choices). The travel industry provides a helpful analogy. In the travel industry, consumers can view various websites that provide information on all carriers offering flights to their destination. They can compare benefits (time of trip, number of stops) and price and can then purchase their ticket through an agent or the carrier. They do not need to purchase their ticket through the web-based venue but it provides a level of transparency and access that had not existed before and encourages consumers to shop for the product that best meets their needs.

2. Organize Market: Simplify purchase, improve choice and portability: “Travelocity Plus”

A broader definition of organizing the market might be termed “Travelocity plus.” Here the HealthHub would not just inform consumers of options, but would actually enroll individuals and/or employers. With this type of functionality in the HealthHub, employers could contribute to health insurance via the Hub, allowing employees to choose among the Hub’s product options, and pay the additional premium or pocket the difference if the premium is lower. In addition, employees could combine contributions from multiple employers (a particularly important feature for part time employees) when they purchase coverage through the Hub. In this way, the Hub would achieve increased employee choice and portability. It also would simplify the purchasing process for employers, as they could simply specify a contribution amount, and allow their employees to choose the carrier and product that best fit their needs.

In order to achieve this goal, Hub would be responsible for all the functions involved in this transaction including billing, marketing, and collection of premiums. This would involve substantial additional administrative infrastructure.

In concept, this “Travelocity Plus” model of insurance would substantially change the purchasing model, with the potential for significant advantages, as described above. However, this model is just now being tested in Massachusetts. Having first focused on providing subsidized coverage through the Commonwealth Care program, the Massachusetts Connector has just begun to support employer-based options in line with the “Travelocity

Plus” concept, effective February 1, 2009. Even so, not all of the functionality described above is yet available.

3. **Access: Establish benefit standards and incentives (Individual Mandate)**

Establishing a minimum benefit standard for all Rhode Islanders through a public process was important to many stakeholders for two reasons. First, they were concerned that existing standards were established through legislation, and therefore were not regularly reviewed and adjusted to address current market needs. Second, existing standards do not apply to self-insured employers, who account for approximately one-third of the commercial market (and growing).

In Massachusetts, the Connector board is responsible for establishing a minimum benefit standard; however, it is important to recognize that this standard is inextricably linked to an individual mandate: All Massachusetts residents (for whom affordable options are available) must purchase health insurance coverage that meets, at minimum, the benefit standards as defined by the Connector. In this way, the individual mandate provides the “glue” that holds both individuals and employers to the minimum benefit standard.

HealthHub RI could also have a board responsible for establishing a minimum benefit standard. Consistent with the Massachusetts model, this standard could be linked to an individual mandate requiring all Rhode Islanders (for whom affordable options are available) to have health insurance coverage. The HealthHub board would then have two primary responsibilities:

- To establish a definition of “creditable coverage,” or minimum benefits standards,
- To set standards around what constitutes affordability for Rhode Island residents.

Affordability standards could be based on the maximum premium Rhode Islanders can reasonably afford to pay at various income levels. Some lower-income Rhode Islanders might still have affordable options available to them via public programs or generous employer contributions to group insurance. Thus, the mandate could capture a larger share of the uninsured – not only those over a specified poverty level (e.g., 400% FPL) but also Rhode Islanders with incomes below this standard, but who are offered employer sponsored coverage with the employer paying a substantial share of the premium. Since the average employer contribution in Rhode Island is 80%, there may be many Rhode Islanders with income is below 400% FPL, for whom health insurance is made “affordable” by generous employer contributions.

There is early evidence from Massachusetts that the individual mandate has, in fact, held employers to the minimum benefit standard without unintended, negative effects. To the contrary, it has provided employees with an incentive to begin and/or continue participation in their employer-sponsored plans and individuals with an incentive to either purchase private coverage or enroll in subsidized programs for which they are eligible. All of this has increased coverage dramatically in Massachusetts.

4. Access: Location for Subsidies

Subsidies would be required to move Rhode Island toward universal coverage. In concept, if an individual mandate included an affordability standard, then Rhode Islanders for whom no commercial options were deemed “affordable” could be eligible for subsidized coverage.

Stakeholders rated this goal as a lower priority due to timing and current state budget difficulties, but deemed it a longer-term goal. Stakeholders felt strongly that whatever HealthHub structure was established now should be capable of evolving into a location for subsidies.

5. Cost Containment

Cost containment was an important goal for many members of the working group. There was extensive discussion about what cost containment means and how it could be accomplished through a HealthHub.

Because none of the exchanges established to date have focused on this as a primary goal, there is little evidence regarding how a HealthHub can help with cost containment. Requiring all products sold through the exchange to meet specified standards might help to control costs. Enrolling a large pool of covered lives in the HealthHub could change the delivery of care in Rhode Island and in turn affect health care cost trends.

B. Summary of Priorities

Because there are multiple goals and sub-goals for the HealthHub it was important to prioritize these goals both in terms of what is feasible in the short-term vs. longer term, and what is most important to various stakeholders. Depending on how these goals are defined and prioritized, a somewhat different model can be envisioned for the HealthHub.

At their second meeting, stakeholders reviewed and prioritized goals and used this prioritization to evaluate different HealthHub models. The discussion was iterative: a set of priorities was considered, the “best” HealthHub model to meet those priorities was determined, and then the priorities were reconfirmed. The priorities for Rhode Island, as confirmed at the stakeholder meeting, are summarized below in Table 2.

Table 3: Prioritization of Goals (*high priority goals are shaded*)

Goals	Priority	Stakeholder Comments
Goal 1a: Organize Market: Travelocity "Lite"	Medium	Some small employers expressed a significant need for this information, and support for decision-making. Some stakeholders viewed this as a lower priority, as brokers currently provide this service for small employers, and any web based tool would be inadequate Many expressed support for the concept – consistent with the travel insurance analogy – and the need to "just get started."
Goal 1b: Organize Market: Travelocity "Plus"	Low	Reactions of the group were mixed: <ul style="list-style-type: none"> ▪ Some considered this to be a critical transition, away from employer-defined benefits, toward individual purchasing. This was seen as critical to reigning in cost – giving individuals more of a role, and financial incentive, to make responsible health care choices ▪ Others viewed this goal as an important step toward more centralized purchasing, as the Hub could ultimately become the mechanism for all state purchasing of health insurance ▪ Still others were against this goal – expressing the opinion that there was no pressing need for changing the existing purchasing model
Goal 2a: Access: Benefit Standards and Incentives	High	There appeared to be general agreement around this goal from all stakeholders
Goal 2b Access: Location for Subsidies	Low	There appeared to be general agreement around the importance of this goal in the longer term, as well as the "lower priority" designation due to current budget constraints
Goal 3: Cost Containment	High	Importantly, all stakeholders agreed that cost containment was a critical, and primary goal. However, there was mixed perspectives on the HealthHub as the vehicle for cost containment.

Cost Containment and improving access through benefit standards and incentives (individual mandate) were the group’s highest priorities. While organizing the market was important to some members, there was considerable discussion about what this meant and how it could be achieved. There was a desire to increase the transparency of prices and benefits for available products so that consumers could more easily make comparisons across carriers and products. That goal was deemed a medium priority.

While the group did not believe that it was a high priority for the HealthHub to immediately change the way employers and/or individuals purchase insurance, they wanted to keep that option on the table for the future. In addition, most believed that ultimately subsidies would be necessary to truly improve access to health insurance in Rhode Island for low-income residents, but given budget constraints, that goal was not a high priority for now.

IV. HealthHub Options

A. Three Key Decisions

The HealthHub model may differ based on numerous characteristics and functions but it was important to focus the discussion first on three basic dimensions:

- **Structure:** What are the minimum structural requirements needed to meet the goals of the HealthHub? (New administrative entity, virtual)
- **Mandates:** Will any mandates be needed to support the HealthHub goals as defined?
- **Target Population:** Whom should it serve? (Individuals, small employers)

1. Minimum Administrative Structure

This decision relates to whether the HealthHub requires the establishment of a new entity. We considered two broad options, a virtual entity and a new administrative structure. The virtual model (like a new administrative structure) could include some analytic capacity and an advisory board for decision-making. The primary functions of this entity are in three key areas:

- Policy decision-making around product and benefit standards;
- Incentives for the purchase of insurance; and (possibly)
- The development and maintenance of a website to help organize the market.

This model could achieve most of HealthHub’s stated goals only with a public board as noted below in Table 3.

Table 4: Minimum Administrative Structure

Goals	Minimum Structure Needed	Role
Goal 1a Organize Market: Travelocity “Lite”	Public Board + Virtual Entity	Set product standards Structure product “template” for carrier small group offerings
Goal 1b Organize Market: Travelocity “Plus”	Public Board + New Administrative Entity	Support “defined contribution” model Handles enrollment/billing, link to payroll, combines employer contributions
Goal 2a Access: Benefit Standards and Incentives	Public Board Only	Establish product/benefit standards
Goal 2b Access: Location for Subsidies	Public Board + Virtual Entity	Determine eligibility Link to existing RiteCare/Medicaid enrollment processes
Goal 3 Cost Containment	Public Board Only	Establish product/benefit standards

* High priority goals are shaded

If the establishment of a new purchasing model was a high priority, then a new administrative structure would be required with the capacity to accomplish an extensive list of tasks -- including (but not limited to) processing applications, confirming eligibility, billing premiums, monitoring employer contribution, reconciling payments, developing and maintaining a website, payment of commissions, broker training, ongoing marketing and outreach, and electronic interface.

Recommendation:

A public board with some analytic capacity could serve most goals. Consequently, at this time it is not recommended that Rhode Island pursue the establishment of a new administrative structure due to current state budget constraints. However, this does not preclude the establishment of a new entity in the future.

2. Mandates

An important consideration for the HealthHub is whether to require the offer or purchase of insurance. A mandate would entail developing benefit standards and incentives for employers to continue to offer insurance, and for employees and individuals to purchase it.

The HealthHub board could develop a minimum standard for creditable coverage and set standards of affordability based on what Rhode Islanders can reasonably afford to pay at different income levels. The mandate would then be the "glue" holding employers and employees accountable to the standard. This method has worked well in Massachusetts, holding employers and employees accountable to a minimum benefit standard and encouraging them to offer and/or purchase insurance when it is affordable.

As shown in Table 4 below, an individual mandate would facilitate other goals as well. Rhode Island is concerned about cost containment and affordability of its insurance products. Although it does not affect health care cost trends, requiring the provision of health insurance by employers and the purchase of health insurance by individuals would keep the risk pool healthier and insure that everyone is in the pool. In addition, if Rhode Island decides to move toward a new purchasing model with a new administrative entity, it would be advisable to implement an individual requirement to obtain and maintain insurance coverage, in order to ensure that individuals purchasing insurance directly continue to purchase health insurance coverage.

Table 5: Mandates

Goals	Mandates Needed	Role
Goal 1a: Organize Market: Travelocity "Lite"	No	
Goal 1b: Organize Market: Travelocity "Plus"	Maybe	Individual mandate may be needed to provide incentives for individuals to continue participation in employer based coverage options
Goal 2a: Access Benefit Standards, Incentives	Yes	Individual mandate holds employers, employees accountable to minimum benefit standards
Goal 2b: Access Location for Subsidies	Yes	
Goal 3 Cost Containment	Helpful but not necessary	Everyone in the pool provides one time cost advantages, eliminates free riders

* High priority goals are shaded

Recommendation:

Although these are difficult policy discussions to have during hard financial times, if employers and individuals begin to drop coverage insurance premiums in Rhode Island could become ever less affordable for those who remain covered. It is therefore recommended that some level of a mandate be pursued in Rhode Island.

3. Target Population

Because of the size of Rhode Island’s markets, consideration of the target population for a HealthHub is important. For most of the goals noted above it is important that HealthHub’s reach be broad. Only the first goal of organizing the market and providing greater transparency of price and benefits could be envisioned for a narrow target population of small employers. The other goals would necessitate that they apply to a larger number of Rhode Islanders (in some cases all Rhode Islanders) as shown in Table 5 below.

Table 6: Target Population

Goals	Target Population	Explanation
Goal 1a:Organize Market Travelocity "Lite"	Small Employers and Individuals	Small employers typically don't have the resources to facilitate product selection
Goal 1b:Organize Market Travelocity "Plus"	Large Segment	Large segment needed to sustain operations, support portability. Most likely individuals and all/most small employers.
Goal 2a:Access Benefit Standards and Incentives	All Rhode Islanders	If affordable
Goal 2b:Access Location for Subsidies	All Rhode Islanders	Subsidies available to ensure affordability
Goal 3 Cost Containment	Large Segment	No specific segment but need a large market segment to be meaningful

* High priority goals are shaded

Recommendation: Because Rhode Island is a small state, the stakeholders acknowledged that any new policies would have the most influence if they were broadly applied. As small employers seem to have the most difficulty navigating the health insurance marketplace, a, targeted approach to achieve this goal seems possible. The cost containment and access, however, are broader goals. Therefore, and policies the HealthHub develops around these goals should be broadly targeted and apply to as many Rhode Islanders as is feasible.

B. Summary of Options

As discussed earlier, there are numerous options that could be considered for a RI HealthHub. Table 6 below summarizes the options that were discussed by the stakeholder group, linking the various options to specific goals.

Option 1: Mandate Only

This option establishes a minimum benefit standard, applicable to all Rhode Islanders, through an individual mandate. The mandate would apply only to those Rhode Islanders with access to “affordable” coverage. This option would require a quasi-public HealthHub board, with some analytic capacity, responsible for deciding on policies for implementing the mandate--including minimum benefit requirements and standards of affordability.

This option is specifically focused on goal number three, establishing a minimum benefit standard. It would likely improve insurance coverage in Rhode Island (thereby achieving one of the higher priority goals), but it would do nothing to help organize the market and would provide little relief regarding cost containment. There might be a one-time cost savings to those currently insured if healthier lives are brought into the risk pool via the individual requirement.

Assessment: Small but important step toward reform

Option 2: Travelocity Lite + Mandate

In addition to the health insurance access improvements described in option 1 above, this option would create a new source of market information for individuals and small employers, by organizing and posting all carrier/product options on a single web site. It would require both a quasi-public HealthHub board, and a virtual entity to develop a website and organize/standardize the product options.

This option would move Rhode Island further along with regard to its stated goals by providing some opportunity for cost containment and market efficiencies due to greater transparency in the marketplace.

Assessment: A helpful addition for small employers. But, do employers sufficiently value the “Travelocity Lite” functionality (without the full exchange features) to justify this option?

Option 3: Full Exchange + Mandate (Pilot)

In addition to the other features noted in options 1-2 above, this option assumes that all small employers (under a certain size to be determined) purchase their insurance through the HealthHub. It therefore would require a new administrative structure. It would begin to restructure how health insurance is purchased in Rhode Island.

In addition to the access and transparency advantages described in options 1 and 2 this option would encourage choice and portability for employees of smaller firms. It would target very small employers whose employees have the least choice and for whom health insurance is the most unaffordable.

Moving insurance purchase to a defined contribution with employee purchase and choice could make sense for the smallest of employers. This option might not cause much disruption in the marketplace although there might be some opposition from carriers and brokers. A key challenge to this option is scale: establishing this new purchasing structure entails some significant additional costs, and it is unclear whether there is sufficient volume in any pilot segment to maintain viability.

Assessment: Logical pilot for new purchasing model – but will it provide sufficient volume to justify administrative investment?

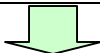


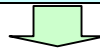
Option 4: Full Exchange + Mandate

This option would assume all the features of option 3 above, except that it would change the purchasing model for most individuals and employers. Larger firms that are self-insured would continue to purchase insurance as they do now. This option would require infrastructure investments similar to option 3, but is likely large enough for financial viability.

A key challenge to this option is political in nature. There would likely be strong opposition from carriers and brokers to moving so dramatically to another purchasing model. In addition, this model is just now being tested in Massachusetts. Having first focused on providing subsidized coverage through the Commonwealth Care program, the Massachusetts Connector has just begun to support employer-based options in line with the “Travelocity Plus” concept, effective February 1, 2009. Even so, not all of the functionality described above is yet available.

Table 7: Recommended Set of Options

	Option 1 <u>Mandate Only</u>	Option 2: <u>Mandate + Travelocity Lite</u>	Option 3: <u>Full Exchange (Pilot)</u>	Option 4: <u>Full Exchange</u>
Target Pop:	All Rhode Islanders	Individuals + Small Employers	Individuals + Small Employers (<15?)	Individuals + Small Employers (all)
Min Structure:	Public Board Only	Public Board + Virtual Entity	New Administrative Structure	New Administrative Structure
Mandates:	Individual Mandate	Individual Mandate	Individual Mandate	Individual Mandate
Goal 1a: Organize Market Travelocity "Lite"	-	✓	✓ -	✓
Goal 1b: Organize Market Travelocity "Plus"	-	-	✓ -	✓
Goal 2a: Access: Benefit Standards and Incentives	✓	✓	✓	✓
Goal 2b: Access Location for Subsidies	✓	✓	✓	✓
Goal 3 Cost Containment	✓ -	✓	✓ -	✓

Small but important step toward reform
Do employers value the "Travelocity lite?"
Logical pilot for new purchasing model – but sufficient volume?
Addresses all goals with aggressive leap from current model

The workgroup discarded a number of options that were not presented to stakeholders because they were deemed to not meet the priorities for Rhode Island. These options are described below and presented in Table 7.

Option 1a: Minimum Benefits with No Mandate

This option would establish a HealthHub Board to make decisions about benefit standardization. However it would not be coupled with a mandate for coverage so would have no regulatory “glue” to help enforce standards. Large self-insured employers, protected by ERISA, could continue to offer barebones policies to their employees.

Assessment: Insufficient impact. Do not pursue

Option 2a: Travelocity Lite with No Mandate

This option would require establishing a virtual entity that could develop a website to improve the transparency of insurance products’ cost and benefits. This option would entail some functionality regarding organization of the market. It would move Rhode Island further along with regard to its stated goals by providing some cost containment and market efficiencies due to greater transparency in the marketplace. However it doesn’t seem to fit well with the priorities for Rhode Island.

Assessment: Does not sufficiently address either high priority goal. Do not pursue

Option 3a: Full Exchange (Pilot) with no Mandate

In addition to the other features noted in options 1a-2a above, this option would require the establishment of a new administrative structure and would begin to restructure how health insurance is purchased in Rhode Island. This option assumes that all small employers (under a certain size to be determined) would purchase insurance through the HealthHub and would allow other small employers to purchase through the HealthHub on an optional basis.

On the plus side, this option would encourage choice and portability for employees of smaller firms. It would target very small employers whose employees have the least choice and for whom health insurance is the most unaffordable. Moving insurance purchase to a defined contribution with employee purchase and choice could encourage the smallest of employers to offer coverage. This option would not cause much disruption in the marketplace although there might be some opposition from carriers and brokers.

However, this option entails some significant additional costs in establishing this new purchasing structure and it is questionable whether there is sufficient volume to maintain viability. Importantly, without an individual mandate, younger, healthier employees may opt out of insurance coverage when it is no longer a pass-through benefit from their employers causing problems for the risk pool in Rhode Island, creating affordability problems and further eroding coverage over time.

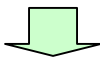


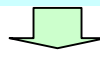
Assessment: New purchasing model, without a mandate, would risk young/healthies dropping out. Do not pursue

Option 4a: Optional Exchange + Mandate

This option assumes all the features of option 4 above except that it would provide the new purchasing model as an option for individuals and employers except for self-insured larger firms. Employers could continue to purchase insurance in the traditional way, through their broker or directly from carriers, or they could choose to enroll through the new HealthHub model. The key challenge for this option would be scale. This option would require a substantial infrastructure investment, which would be difficult to sustain in an optional model, particularly given the small size of the Rhode Island marketplace. In addition, here “the devil is in the details.” Substantial design efforts would be required to mitigate insurer incentives to select risk.

Assessment: Insufficient scale to justify investment. Do not pursue.

Table 7: Options Rejected by Working Group

	Option 1a Minimum Benefits with No Mandate	Option 2a: Travelocity Lite with No Mandate	Option 3a: Full Exchange (Pilot) with No Mandate	Option 4a: Optional Exchange + Mandate
Target Pop:	All Rhode Islanders	Individuals + Small Employers	Individuals and Small Employers (<15?)	Individuals + Small Employers (optional)
Min Structure:	Public Board	Virtual Entity	New Administrative Structure	New Administrative Structure
Mandates:	No Mandates	No Mandates	No Mandates	Individual Mandate
Goal 1a: Organize Market Travelocity “Lite”	-	✓	✓ -	✓
Goal 1b: Organize Market Travelocity “Plus”	-	-	✓ -	✓ -
Goal 2a: Access: Benefit Standards and Incentives	-	-	-	✓
Goal 2b: Access Location for Subsidies	✓	✓ -	✓	✓
Goal 3 Cost Containment	-	✓ -	✓ -	✓ -
				
	<i>Why bother?</i>	<i>Doesn't fit with priorities</i>	<i>Risk young healthies drop out – need mandate to encourage/maintain ESI</i>	<i>Will there be sufficient volume?</i>