

HealthHub Rhode Island

Options Discussion
Friday, December 19th, 2008



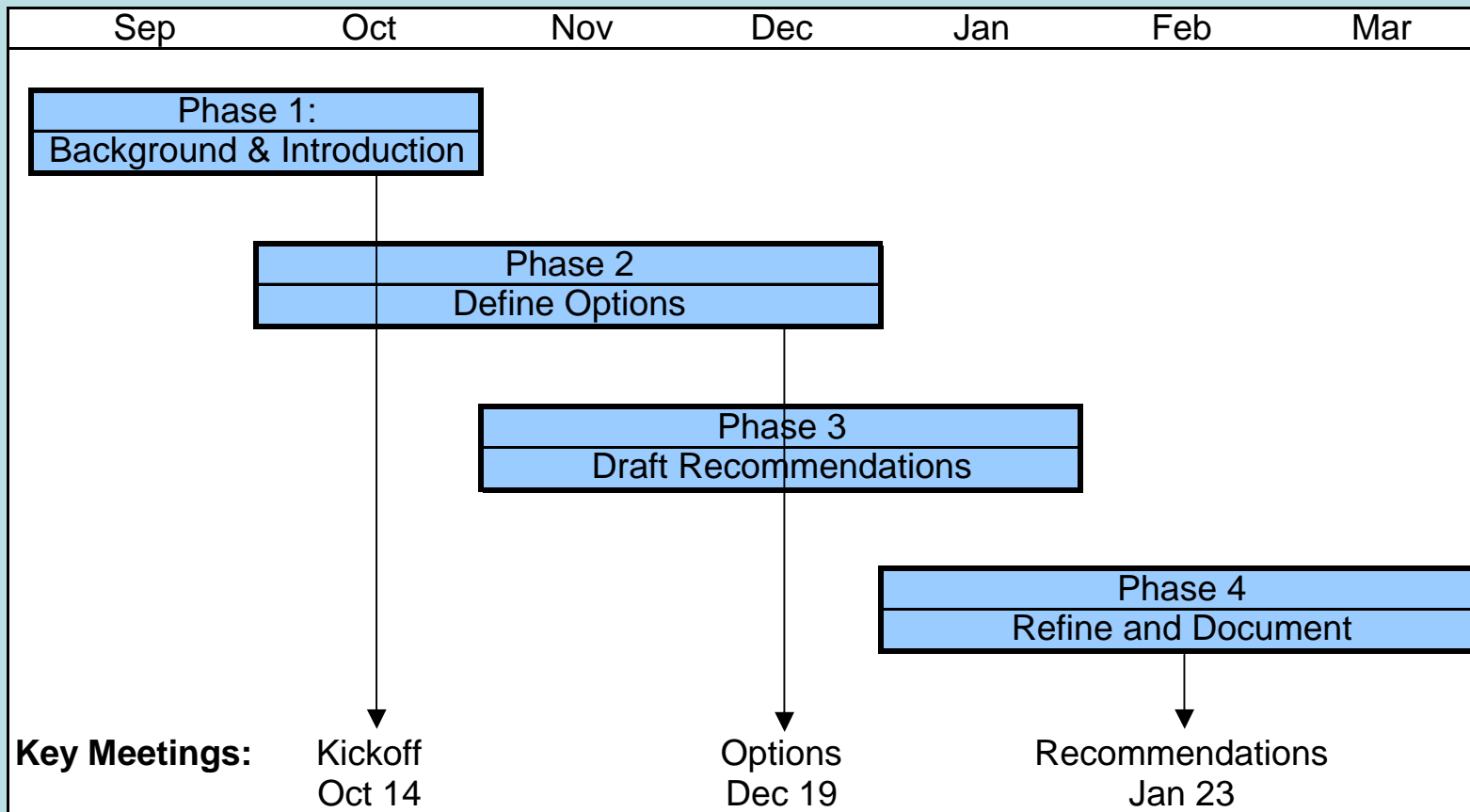
Today's Agenda

- ❖ **Reminder: Project Overview**
 - Project Objectives and Workplan
 - Lessons from Other Markets
- ❖ **Options for Rhode Island: How best to meet our goals**
 - Minimum Structure
 - Mandates Needed?
 - Target Populations
- ❖ **Next Steps**

Project Goals

- ❖ **Assess and confirm the goals of HealthHub Rhode Island**
- ❖ **Assess best options for achieving these goals; specifically,**
 - ✓ **Minimum structure needed**
Virtual entity? New administrative structure
 - ✓ **Will mandates be needed to support this model?**
Individual mandate? Employer mandate?
 - ✓ **Target populations**
Individuals? Small employers? What size?
Required or optional?
 - ✓ **Other Issues**
Standard products? Product Choice? Rating rule revisions?

Workplan: Four Phases



Lessons Learned (Summary)

❖ **Goals**

Clearly articulate goals of project and focus on establishing entity that will accomplish goals

❖ **Governance/Decision-making**

A multi-disciplinary board can work together to make difficult decisions regarding coverage and affordability but business decisions should remain separate.

❖ **Size**

The HealthHub needs to be large enough to make it sustainable

❖ **Individual Mandate**

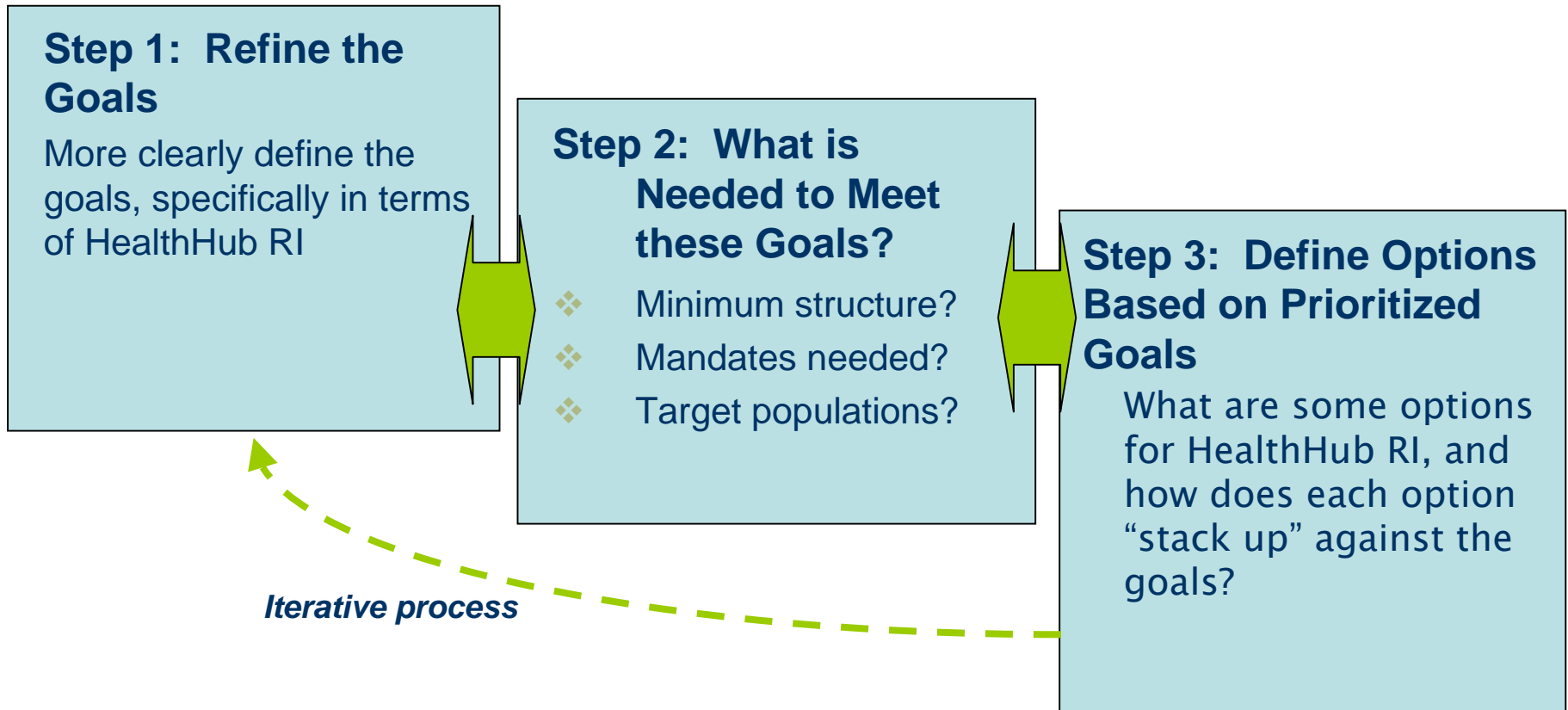
Increases coverage not only for individuals purchasing in non-group market but take-up of employer sponsored health insurance.

❖ **Cost Containment**

A HealthHub alone does little to constrain the growth of health care costs.

Determining the Options

We defined a set of options for HealthHub RI based on a three step process described below:



Step 1: HealthHub Potential Goals

In order to assess our options we first defined our potential goals with more detail.

1. Organize the Market

- ❖ Transparency & Standardization: Web based tool providing product descriptions, pricing across carriers. Clear product choices in actuarially defined categories (gold, silver, bronze)
- ❖ Simplification: Travelocity of Health Insurance. On-line enrollment, payment -- “no phone calls, no meetings, just go on line and get it done”
- ❖ Choice: Provide broader employee choice
- ❖ Portability: Combine employer contributions thru multiple family members or part-time jobs and use combined contributions to purchase insurance. Maintain this coverage when switch employers

2. Provide Access to Affordable Health Insurance for All Rhode Islanders

- ❖ Minimum Coverage Levels: Set a minimum standard for affordable, creditable coverage for all RI'ers
- ❖ Incentives: Create and enforce incentives for individuals to purchase insurance when they can afford it (individual mandate)
- ❖ Location for Subsidies: Longer term, provide location for subsidies for those who cannot afford coverage

3. Cost Containment

More on an Individual Mandate

What do we mean?

- ❖ **Set a minimum standard of creditable coverage**
What is the minimum level of coverage that is required in Rhode Island
- ❖ **Set a minimum standard of affordability**
What is the maximum premium Rhode Islanders can “afford” to pay, at different income levels?
- ❖ **Enforce the standards**
Require that all individuals be enrolled in a plan that offers benefits that meet or exceed the minimum standard – as long as the premium is “affordable”

Why a mandate?

- Make good coverage and good health a priority in Rhode Island.**
- ❖ Hold employers, employees accountable to minimum benefit standard
- ❖ Provide incentives for continued participation in employer based coverage options
- ❖ Provide incentives for individuals (above a certain income level) to purchase insurance when they can afford it

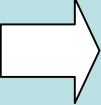
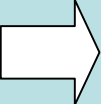
Step 2: Key Defining Characteristics

We then linked each specific goal to the structural requirements/how best to meet them

Goal	Minimum Structure	Mandates Needed?	Target Populations?
Organize Market: Transparency/ Standardization	Virtual Entity Sets product standards	No	Small Employers who typically don't have resources to facilitate product selection
Organize Market: Choice, Simplification, Portability	New Administrative Structure <ul style="list-style-type: none">❖ Needed to support "defined contribution" model❖ Handles enrollment/billing, links to payroll, combines employer contributions	Yes: Individual Mandate To provide incentives for continued participation in employer based coverage options	Large Segment to sustain ops, support portability. (Most likely, individuals and all/most small employers)

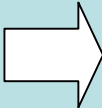
Step 2 (Continued)

We then linked each specific goal to the structural requirements/how best to meet them

Goal	Minimum Structure	Mandates Needed?	Target Populations?
Access: Benefit Standards and Incentives 	Public Board Set minimum benefit requirements, standards of affordability	Yes: Individual Mandate Holds employers, employees accountable to minimum benefit standard	All Rhode Islanders (if affordable)
Access: Location for Subsidies (Longer-term) 	Public Board Virtual Entity: Determine eligibility, link to existing RC/Medicaid enrollment process	No	All Rhode Islanders (subsidies available to ensure affordability)

Step 2: Continued

The cost containment goal was the most challenging – how best to tackle cost containment through the Hub? What defining characteristics/structures are required to do so?

Goal	Minimum Structure	Mandates Needed?	Target Populations?
Cost Containment 	Public Board: Establish product/benefit standards	Helpful but not necessary “Everyone in pool” provides one-time cost advantage, eliminates “free riders”	No Specific Segment BUT Need large market segment to be meaningful

Key Conclusions:

- ❖ Exchanges established so far have been mostly vehicles for access + simplicity/transparency, not cost containment
- ❖ However, a Hub can use product standards and benefit design to
 - ✓ Give providers consistent incentives to follow established medical protocols
 - ✓ Give consumers consistent incentives to use care appropriately
 - ✓ Improve the value of care

Step 3: Defining Options

We then translated the structural requirements into options for Rhode Island linking options specifically to individual goals. To do this we needed to prioritize our goals, based on your feedback at our last meeting

1. Organize the Market

- ❖ Transparency & Standardization..... **Medium Priority**
- ❖ Choice, Simplification, Portability..... **Low Priority**

2. Provide Access to Affordable Health Insurance for All Rhode Islanders

- ❖ Benefit Standards & Incentives..... **High Priority**
- ❖ Location for Subsidies (longer-term)..... **N/A** (*works with all options*)

3. Cost Containment **High Priority**

Structural Implications:

- ❖ **Minimum Structure:**
A public board, without administrative structure, may be sufficient
- ❖ **Mandates:**
Individual Mandate may be required
- ❖ **Target Populations:**
HealthHub RI must apply to large segment of market



Step 3. Defining Options

We then translated the structural requirements into options for Rhode Island, linking options to specific individual goals

	Option 1	Option 2	Option 3	Option 4
Definition:	No specific segment	Individuals + Small Employers	Individuals (all) Small E'ers <15 (all) Small E'ers 15+ (optional)	Individuals (all) Small E'ers (all)
	Public Board Only	Public Board, Virtual Entity	New Admin Structure	New Admin Structure
Impact on Goals:	Individual Mandate (affordability based)	Individual Mandate (affordability based)	Individual Mandate (affordability based)	Individual Mandate (affordability based)
Organize Market: Transparency, Standardization	--	✓	✓-	✓
Organize Market: Choice, Portability, Simplification	--	--	✓-	✓
Access: Benefit standards & incentives	✓	✓	✓	✓
Access: Subsidies	✓	✓	✓	✓
Cost Containment:	✓-	✓	✓-	✓
	<i>Small, but important step toward reform</i>	<i>Do employers value added transparency/standardization?</i>	<i>Logical "pilot" for new purchasing model – sufficient volume?</i>	<i>Addresses all goals with aggressive "leap" from current model</i>

Step 3. Defining Options: Rejected ideas

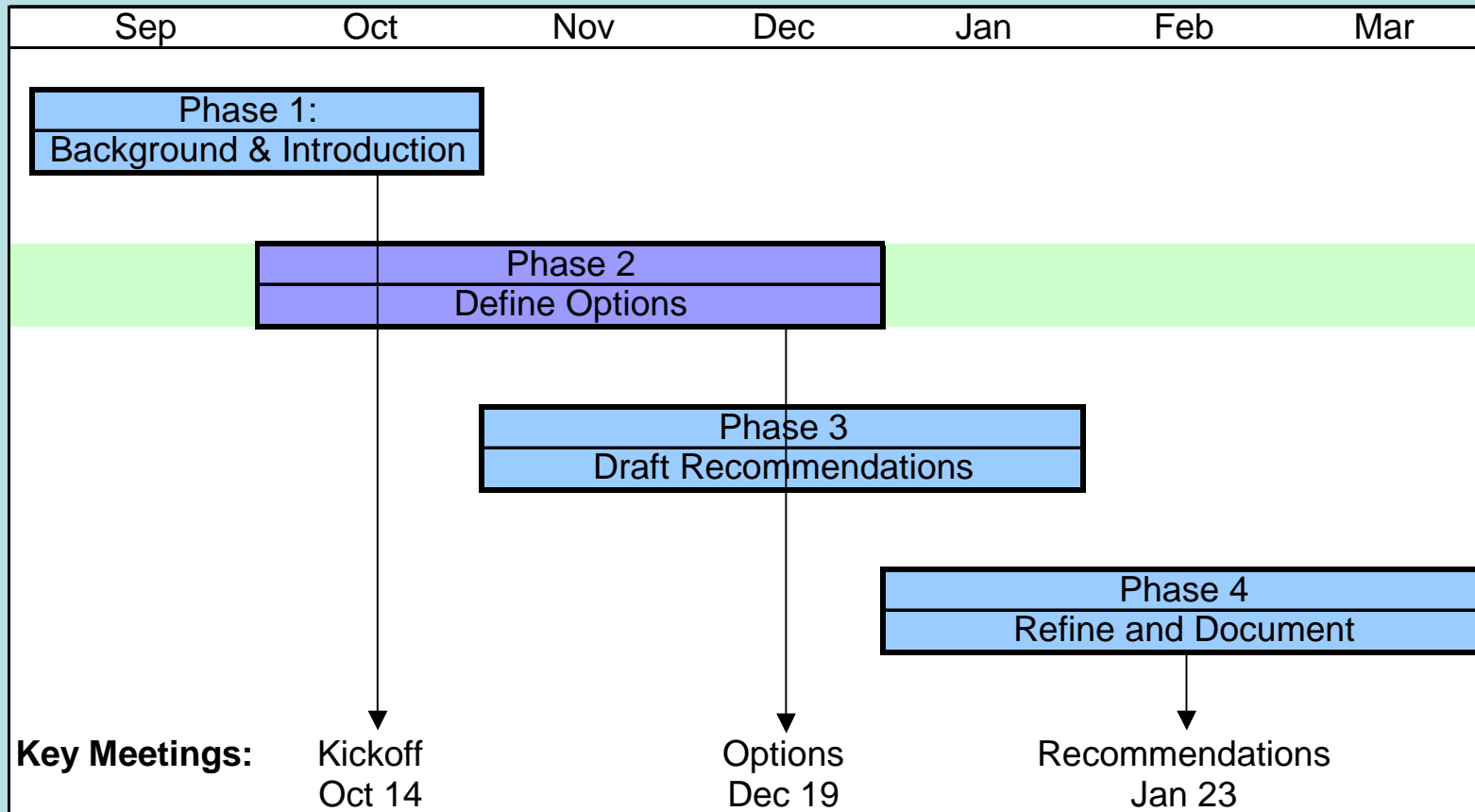
Options rejected – due to sustainability, feasibility or fit with high priority goals

	Option 1a	Option 2a	Option 3a	Option 4a
Definition:	No specific segment	Individuals + Small Employers	Individuals (all) Small E'ers <15 (all) Small E'ers 15+ (optional)	Individuals (all) Small E'ers (optional)
	Public Board	Virtual Entity	New Admin Structure	New Admin Structure
Impact on Goals:	No Mandates	No Mandates	No Mandates	Individual Mandate (affordability based)
Organize Market: Transparency, Standardization	--	✓	✓-	✓
Organize Market: Choice, Portability, Simplification	--	--	--	✓
Access: Benefit standards & incentives	--	--	--	✓
Access: Subsidies	✓	✓	✓	✓
Cost Containment:	--	✓	✓-	✓
	<i>Why bother?</i>	<i>Fit with priorities?</i>	<i>Risk young healthies drop out – need mandate to encourage /maintain ESI take-up</i>	<i>Sufficient volume/ Sustainable?</i>

Next Steps

Phase 3: Draft Recommendations

Based on a more detailed assessment of a narrow set of options



Backup

Connecticut (CBIA)

- ❖ **Overview**
Private sector purchasing mechanism: a division of the Connecticut Business and Industry Association (CBIA)
- ❖ **Target Population**
Serves employers with 3-100 employees, targets 3-25. In operation for 12 years, serves over 6,000 employers and 88,000 members
- ❖ **Value Proposition**
Provides choice to employees of small businesses and full service HR shop for employers, flexible and nimble, strong employer and broker relationships
- ❖ **Questions/Challenges that remain**
 - What goals does this serve?
 - Would this model meet RI's primary objectives?

Massachusetts Connector

❖ **Overview**

Established in 2006 as key element of system-wide reform. Independent, quasi-governmental entity – separate from the state, governed by a 10-member board

❖ **Target Population**

Began offering subsidized products in October 2006, private products to individuals in April 2007, private products to employers in February, 2009

❖ **Value proposition**

Connector designed to help eligible individuals and small groups purchase health insurance at affordable prices

- Administers premium assistance program for those under 300% FPL
- Makes it easier for businesses to offer pre-tax contributions to part-timers, contractors
- Improves transparency and choice for small employers (Gold/silver/bronze)
- Facilitates affordable, portable individual insurance coverage

❖ **Questions/Challenges that remain**

- Markets exist side-by-side, carrier and broker resistance remain
- Most of “sales” have been of subsidized product
- Has not addressed health insurance cost trends

Washington Health Insurance Partnership

❖ **Overview**

Governmental organization established by law in 2007 with a seven member board

❖ **Target Population**

Narrowly targeted for start-up, small employers who do not currently offer coverage and have low-wage workers (low-wage workers get subsidy from state)

❖ **Value proposition**

Market organizer, offers 12 plans in four tiers. Employers required to contribute 40% of single premium and no minimum participation requirements

❖ **Questions/Challenges that remain**

- Markets exist side-by-side, carrier and broker resistance remain
- No mandate and narrow target population = very little impact on uninsured. Increased take-up are mostly of low-income, subsidized employees
- Initial goals unclear, policymakers evaluating options for expansion