

HealthHub RI

Background on Health Insurance Exchange Models in Other Markets

Exchanges have been conceptualized and developed as platforms to improve access for small employers and individuals that do not have access to coverage that is portable, choice-based, tax-advantaged, and easy to access. 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 of these states has made different choices regarding the priorities and goals of their model. In this brief, each state model is presented and discussed and lessons learned from these models and implications for the development of a HealthHub in Rhode Island are presented.

A. 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 companies. 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 choices for health insurance policies with employee choice among the options. Enrollees need not switch coverage when they change jobs if the new employer also participates in Health Connections. 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 (described further below). 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. This particularly appeals to smaller firms without in-house human resources departments; Health Connection has been particularly successful in the three to 25 employee market. This turnkey approach allows small businesses to offer coverage with relatively low administrative burden.

The Health Connections model is intended to stimulate price competition as well as competition among alternative network designs and formularies. 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.

Small employers that participate in Health Connections must select either of two suites of plan design options (one more comprehensive than the other) to make available to their employees.

Each employer must establish a minimum premium contribution level, equal to at least 50 percent of the premium for the lowest cost plan in the suite. Typically, employers identify a “benchmark” plan of benefits within the suite; that benchmark plan becomes the basis for their premium contribution and monthly premium budget. Employees may choose to enroll in the “benchmark” plan or opt to “buy up” or “buy down” to an alternative level of benefits within the suite offered. This concept allows employers to establish their premium budget while providing employees the opportunity to choose a plan that best meets their needs. In the general market, employee choice is precluded by insurer requirements that a minimum percentage of employees participate in any one plan offered by the employer.

Health Connection’s success is attributed to having learned lessons from earlier models and focusing on implementation of best practices. It 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.

B. 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. Through a comprehensive law, Massachusetts restructured both how private insurance is purchased, sold, and administered, and how public subsidies are delivered.

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, including:

- Small businesses with 50 or fewer employees.
- Sole proprietors.
- Individuals working for non-offering companies of any size.
- Individuals working for offering companies of any size who are not eligible for benefits (part-timers, contractors, new employees).
- Non-working individuals.

The Connector is a self-governing, legal entity; it is separate from the state and governed by a 10-member board consisting of private and public representatives. The Connector certified for sale seven plans offered by six carriers, signaling to consumers that the approved plans were both comprehensive and affordable. It began offering subsidized products in October 2006 and private products to individuals in April 2007. It will begin offering private products to small employers in October 2008. After an initial infusion of \$25 million in state appropriations, its operations are funded through retention of a percentage of premiums collected on the subsidized and non-subsidized (private) products sold through the Connector.

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 facilitates pro-rata employer contributions for individuals working for more than one employer. It 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 (described later in this report), whether the employees are part-time or full-time.

In addition, the Connector enables individuals to purchase health insurance which meets their needs and which is portable. Portability—that is, the ability to keep one’s coverage after leaving a job—is important to consumers, and it is also desirable for the system overall: carriers are encouraged to manage member health proactively because members can stay with carriers longer. In addition, easy consumer access to alternative coverage options offers an incentive for carriers to be more responsive to consumers in order to maintain their market share.

The Connector also improves choice for the small employer. Beginning in February 2009, employer groups with 50 or fewer employees can 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. Importantly, rating factors are the same both inside the Connector and outside in the marketplace, and for the most part products sold in the Connector can also be sold outside.¹

The health care reform act required that the non-group market be phased out and merged with the small-group market. As in most states, Massachusetts’ non-group market was relatively small. However, the Massachusetts non-group market differed notably from other states regarding the health status of its members. Although rating factors were almost identical to the small group market, the risk in the small group market was much better. In fact, non-group market premiums were 40 percent higher than for similar products in the small group market, primarily reflecting the health of the individuals who bought coverage and the provision requiring carriers to offer guaranteed issue in the non-group market.

The decision to merge markets and allow the Connector to offer products in both markets was made somewhat easier by the fact that both markets already had guaranteed issue and rating factors that were nearly identical. Both markets had adjusted community rating, prohibiting underwriting of any kind based on health status; and rates were compressed within a fairly tight 2:1 overall band with age and geography as the primary rating factors.

Small group rates could (and still can) be adjusted modestly for industry-type and group size; group size rate factors were increased slightly when the markets were merged to help accommodate the higher cost of administering plans for smaller groups. The 2006 reforms also changed rating rules to allow insurers to rate individuals and small groups based on smoking

¹ Young Adult Products (offered to 19-26 year olds) can be sold only in the Connector.

status and for participation in wellness programs. The health care reform act imposed a moratorium on any new legislative health insurance mandated benefits through 2008.

C. 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 anticipates opening enrollment in 2009.

HIP is governed by a seven-member board. Because a number of issues were raised during the legislative session that could not be fully addressed, the HIP is narrowly targeted for start-up. However, the board is currently studying the feasibility of expanding the HIP to other groups and individuals and allowing greater flexibility around product choice. This paper will only discuss the operations of HIP as it was established by E2SHB.

HIP 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 which allow rates to vary on age within a band of 3.75:1.

Only employers with a low-wage workforce will be eligible to purchase HIP coverage, and only if they do not currently offer coverage.² 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 as currently exist in the small group market. 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), if they take up their employer's offer of a HIP plan.

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. Nearly half (49 percent) of those projected to enroll have incomes below the poverty level, and 80 percent have incomes below 200 percent 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.

² 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 CT (CBIA), MA (CONNECTOR), AND WA (PHIP) 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

D. LESSONS LEARNED

As demonstrated by the table above, the concept of HealthHubRI can take a variety of different forms. As such, it is important to consider the lessons learned from efforts in other states in developing a plan for Rhode Island. A preliminary list of lessons that have emerged from the three state models presented above and from earlier attempts at exchanges in other states is discussed here.

Goals

It is important that the exchange's goals and objectives are clearly articulated and that all parties participating in the development of the exchange understand them. The goals may evolve during the development process and therefore it is important to discuss goals early and revisit them frequently. In addition, if the exchange has multiple goals, it may be necessary to prioritize them. Although this seems obvious, the development of an exchange involves a number of complex decisions that should clearly conform to its stated goals and objectives.

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.

Size

The models developed in Connecticut, Massachusetts, and Washington are designed to serve different populations—variously, all or some small or large employers and individuals. Any state considering similar models must consider which populations to include in the exchange, and whether participation is optional or mandatory. 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.

Individual participation

By themselves, exchanges do little to increase the offer or take-up of health insurance. As employers increase employee contributions to coverage and/or more employees transition to multiple (part-time) employers that do not offer coverage, employees are increasingly called on to buy their own coverage. Those who are healthy may go uninsured, increasing the likelihood that the insured risk pool will become a sicker population. To ensure that the risk pool remains healthy, it may be necessary to require the purchase of some level of health insurance. In Massachusetts, the individual mandate increased take-up of both individual and employer-based coverage.

Cost Containment

To date, the models developed in Connecticut, Massachusetts, and Washington have done little to constrain the growth of health care costs. The three entities discussed have had little no significant role regarding product pricing and the rate determination process is quite similar to what occurs in the outside markets. In Massachusetts, the Connector is under intense public scrutiny and this puts some downward pressure on product pricing but medical cost trends have not largely been affected. The rating rules are the same in all three states both in and outside the exchanges; this is a necessary condition to avoid risk selection. It is conceivable that a large exchange could help drive system affordability through creative benefit design and product standards. Both Massachusetts and Washington recognize the need to begin thinking about their exchanges in those terms.

Employer Participation

No state policies to date have significantly increased small employers' offer of health insurance to their employees. Any new policy that would entail an employer requirement would involve decisions about which employers might be exempted from the requirement, what the level of the requirement would be, and what level of employer effort would satisfy the requirement.

Massachusetts requires employers who do not offer a "fair and reasonable" contribution towards health insurance to pay a \$295 per employee per year fee towards the care of the uninsured. This is not widely viewed as an employer pay-or-play requirement, and the employer offer rate in Massachusetts has remained flat since the law passed. The new federal Administration may consider this feature in planning for national health reform.

E. IMPLICATIONS FOR RHODE ISLAND

The goals for the HealthHub in Rhode Island, as confirmed at the October, 2008 stakeholder meeting, are:

- 1) to better organize the health insurance market;
- 2) to provide access to affordable health insurance for all Rhode Islanders; and,
- 3) to drive system affordability.

Because there are three stated goals for the HealthHub it is important to prioritize these goals both in terms of what is feasible in the short-term vs. longer term, and what is most important. Depending on how these goals are defined and prioritized, a somewhat different model can be envisioned for the HealthHub. This model may differ based on the following key questions:

- What are the minimum structural requirements needed to meet the goals of the HealthHub? (new administrative entity, virtual)
- Will mandates be needed to support this model? (individual, employer)

- What is the target population for the HealthHub? (individuals, small employers)

At the next stakeholder discussion, we will review/prioritize these goals, and use this prioritization to evaluate different HealthHub models. The discussion will be iterative, considering a set of priorities, determining the “best” HealthHub model to meet those priorities, then reconfirming the priorities.

We look forward to this ongoing discussion.

DRAFT