



INSURANCE MARKET MERGER TASK FORCE

RHODE ISLAND INSURANCE MARKET “PRIMER”

*BACKGROUND MATERIAL FOR FIRST TASK FORCE
COMMITTEE MEETING*

SEPTEMBER 26, 2007

Introduction

This primer includes background material prepared for the Insurance Market Merger Taskforce. Data used in this report are excerpted from two primary sources: (1) The recent market conduct study report prepared by Hinckley, Allen & Trengale, LP, on behalf of OHIC; and (2) the recent application for a high risk pool grant, prepared by the Office of the Health Insurance Commissioner (OHIC). Additional data and reports from other states and federal agencies are cited as necessary. While not intended to be comprehensive, this summary provides some background for members to review before addressing the key policy questions specified in the legislation and project charter.

The following materials have been included in this document for your review and information:

- I. Overview of the market
- II. Small Group Market Primer
 - a. Characteristics of the Small Group Market
 - b. Governing Statutes and Regulations
- III. Direct Pay Market Primer
 - a. Characteristics of the Direct Pay Market
 - b. Direct Pay Membership and Product Mix
 - c. Trends, Future of the Direct Pay Market
- IV. Summary, Implications for this Study

I. Overview of Market: By the Numbers

Rhode Island has a population of 1.1 million people. Approximately 600,000 of these residents are commercially insured, 400,000 are insured through Medicare/Medicaid, and 100,000 are uninsured.

TOTAL POPULATION	NUMBER OF RHODE ISLANDERS	PERCENT OF RHODE ISLANDERS
Total Commercially Insured	600,000	55%
Total Medicare or Medicaid	400,000	36%
Total Uninsured	100,000	9%
Total Population	1,100,000	100%

The commercially insured market can be divided into three market segments: large group (471,000), small group (115,000) and direct pay (14,000), as shown below.

COMMERCIALLY INSURED	NUMBER OF COMMERCIALLY INSURED RHODE ISLANDERS	PERCENT OF COMMERCIALLY INSURED RHODE ISLANDERS
Total Large Group (50 +)	471,000	79%
Total Small Group (< 50)	115,000	19%
Total Direct Pay	14,000	2%
Total Commercially Insured	600,000	100%

Large Group

Large employers, defined as those with over 50 employees, comprise the “large group” market. This group is the least regulated component of the market. Their rates are set based on their specific population and cost experience. Although large *employers* comprise only 6% of Rhode Island employers, the majority of *employees* in Rhode Island work for large employers. “Large group” employers, as large purchasers, have the lowest, most stable health insurance premium rates.

Small Group

Small group employers are defined as those with between 1 and 50 employees. The General Assembly reformed the laws governing small group insurance regulations in 2000 to promote greater stability in this market.

Direct Pay

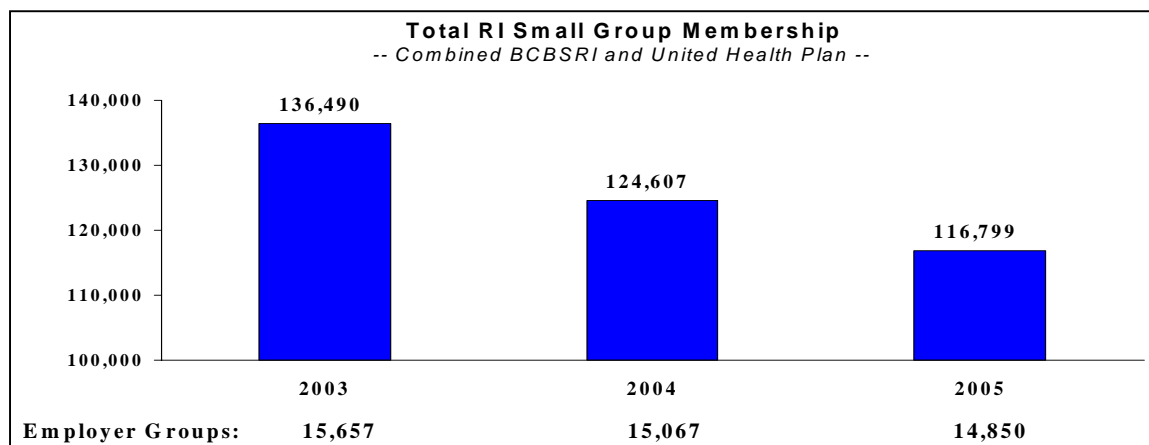
For years, BCBSRI has been required by Rhode Island law to offer health insurance to anyone who is not eligible for coverage in the small group or large group market. This includes workers and their dependents whose employers do not offer coverage, part time workers who may not be eligible for their employer coverage, and individuals who work for themselves, such as individual contractors or consultants.

II. Small Group Market Primer

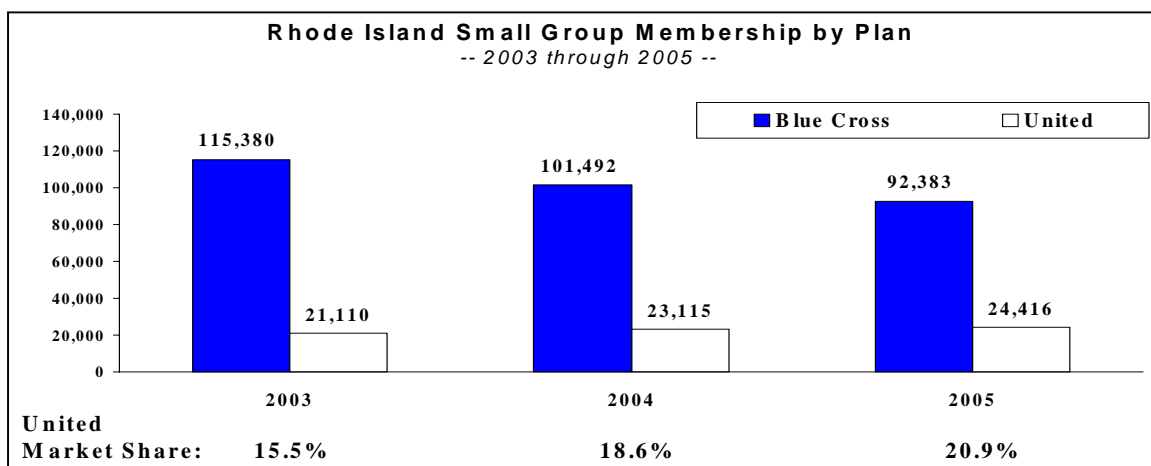
Small group employers are defined as those with between 1 and 50 employees. The General Assembly reformed the laws governing small group insurance regulations in 2000 to promote greater stability in this market.

A. Characteristics of the Small Group Market

Enrollment in the small group market currently stands at approximately 115,000 enrollees. As of 2005, United HealthCare (UHC) had approximately a 21% share of the market with Blue Cross Blue Shield of Rhode Island (BCBSRI) controlling the other 79%. The small group market is characterized by declining overall enrollment in recent years.



However, this decline masks a slightly different experience when you examine enrollment changes by for each insurer. Between 2003 and 2005, UHC's membership and market share has actually increased; however, this increase has been more than offset by membership declines at BCBSRI, as shown below.



Small group enrollment is heavily weighted toward rich benefit designs with modest cost sharing, as shown below. Typical plans have no deductibles nor coinsurance – cost sharing is limited to office visit and pharmacy copays. United’s most popular plan designs do have a modest deductible (\$300/600) with limited coinsurance, indicating a somewhat different market positioning by the two carriers.

Most Popular Small Group Plan Designs, by Carrier

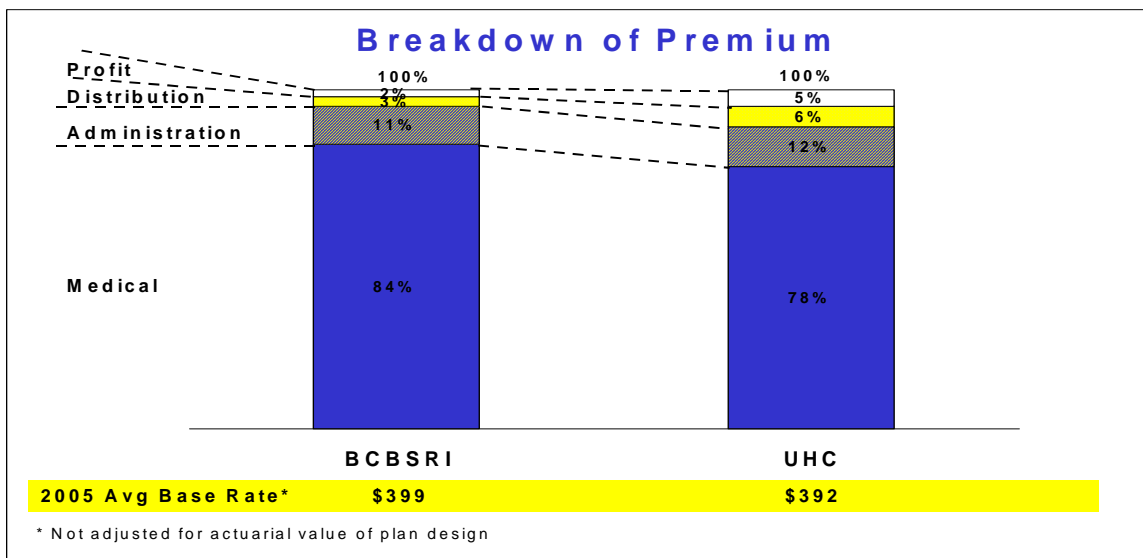
	BCBSRI	United
Deductible	\$0¹	\$300/600²
Coinsurance	N/A¹	20%^{2,3} (for certain services)
Office visit copay	\$10	\$15
ER copay	\$25	\$50
Pharmacy copays	\$7/25/40	\$10/30/50

1. In network only. There is an OON deductible of \$200 I/\$600 F, with 20% coinsurance and an OON OOP max of \$3000/9000

2. In network only. There is an OON deductible of \$350/700, with 30% coinsurance and an OON OOP max of \$4000/8000.

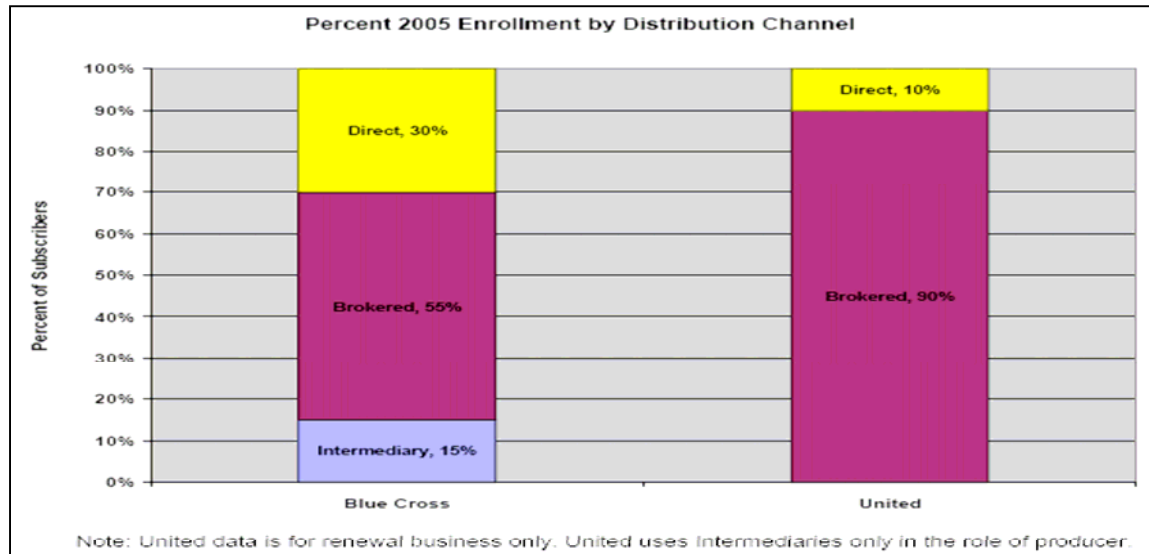
3. In network coverage is 80% for certain services, including home health, OP therapy, DME, prosthetic devices,accidental dental, infertility, spinal treatments, ambulance.

Small group premiums averaged approximately \$392-399 per month in 2005. Premiums are established by each carrier to include four key elements: Medical costs, administration, distribution costs and profit. The breakdown of premiums across these categories are similar across the two carriers, with some notable differences as shown below.



Between 78% and 84% of the premium amount covers medical expenses. The remaining premium dollar is captured by administration, distribution costs, and profit for the insurance carriers.

Finally, the small group market is heavily reliant on brokers as a distribution channel, as shown below. For both insurance carriers, brokers serve as the primary distribution means of health insurance products to small group subscribers.



B. Governing Statutes and Regulations

The Small Employer Health Insurance Availability Act went into effect on July 13, 2000 and currently governs the small group market. There are five key elements of the Act that are relevant to the Merger Task Force’s work.

1. Eligibility. The law requires that eligible small group employees must be permanent, full-time workers who work at least 30 hours during normal work week. A small employer is given the option to lower the 30 hour requirement to as low as 17.5 hours per week provided that this change applies to all employees uniformly. Under the law, temporary employees are not eligible for coverage through their small group employer. Additionally, every small employer interested in insurance must be offered all small employer health plans that are available from the quoting insurer as long as the small employer meets the carrier’s minimum participation requirement, which can be no higher than 75%. The participation requirement is based on the percent of eligible individuals who actually enrolling coverage, excluding any employees who have other creditable coverage.

2. Guaranteed Issue. The Rhode Island small group market has what is called guaranteed issue. This simply means that no small group employer can be denied renewal of coverage based on

prior claims experience. This prevents an insurer from dropping coverage to employers with high-risk employees.

3. Adjusted Community Rating. Insurers are required to develop rates based on an adjusted community rating system. This means that rates are determined according to the combined experience of all the small employers that the carrier insures and this “community rate” can only be raised or lowered for each individual employer based on age of the enrolling employees, the sex of the enrolling employees, and the health status of the enrolling employees. However, an important limitation on the health status rating factor is that it can only impact an employer’s rate by no more than plus or minus 10%. Thus, the health status of all enrollees at an employer can only lead to at most a 10% increase or a 10% decrease in what that employer’s rate would have otherwise been.

4. Family Composition: Four Tier Composite Rating. Carriers must offer four different types of insurance coverage to all small employers: employee only, employee and spouse, employee and children, and employee, spouse, and children. This is called “four tier composite rating.”

5. Rate Band: 4:1 Compression. The Act places an overall limit on the different rates within the small group market: the highest rate charged to any small employer can be only four times as great as the lowest rate charged to any other small employer. This limit is referred to as a “4:1 compression.”

The National Association of Insurance Commissioners (NAIC) has model legislation that recommends guaranteed issue, adjusted community rating, a 2:1 composite rate band, and allowable rating factors such as geography, family composition, and age. Overall, Rhode Island appears to be closer to a pure community rating system than most states but is less closely regulated than many nearby states.

State	Guaranteed Issue	Community Rating	Rate Band	Rating Factors	Health Status Factor (Y/N?)	Health Status Factor (Specify)
NAIC	Yes	Adjusted	2:1 Composite	Geography, Family Composition, Age	No	N/A
RI	Yes	Adjusted	4:1 Composite	Age, Sex, Family Composition	Yes	+/-10%

III. Direct Pay (Individual) Market Primer

For years, BCBSRI has been required by Rhode Island law to offer health insurance to anyone who is not eligible for coverage in the small group or large group market. This includes workers and their dependents whose employers do not offer coverage, part time workers who may not be eligible for their employer coverage, and individuals who work for themselves, such as individual contractors or consultants.

A. Characteristics of the Direct Pay Market

There are five key characteristics of the direct pay or individual market in Rhode Island.

1. “Guaranteed Issue”. Rhode Island has public policies that limit the extent to which direct pay insurers can penalize less healthy individuals in the health insurance market. Similar in principle to the small group market, health plans cannot deny applications for insurance. However, it should be noted that individuals in Rhode Island can currently be required to wait until an annual open enrollment period to obtain coverage. This, combined with regulation of rates in the small group and individual markets, helps ensure access to the market for all individuals, regardless of their health status.

2. A Single Carrier. Health insurance coverage for Rhode Islanders who purchase through the direct pay market is available exclusively through BCBSRI. As of February, 2007, approximately 14,300 individuals in Rhode Island purchased coverage in the direct pay market. Having the entire direct pay market covered through BCBSRI has allowed for state oversight of a carefully regulated form of medical underwriting (described below), which would be much more difficult with more than one carrier. We have been able to keep careful watch on the dynamics in this market and assure that coverage is high quality and premiums are affordable.

3. Use of Medical Underwriting. Individuals who purchase direct pay coverage by definition are not eligible for group coverage and do not receive coverage through their employment and have made a decision to spend their own money on coverage. A substantial number of the direct pay subscribers who purchase coverage through BCBSRI are high-risk, meaning either their predicted or their actual medical costs are higher than average. This makes sense, as the decision to purchase health insurance involves an assessment of the likelihood that one will need it. Those who are high-risk, due to their age or their medical conditions, are more likely to make this economic choice. However, there are some individuals in the Rhode Island direct pay market who are relatively low risk—younger, healthier people, who see a value in (and have the means to purchase) health insurance. To accommodate both types of individuals in the BCBSRI risk pool without setting prices so high that the healthier subscribers will forego coverage, BCBSRI has been allowed to use medical underwriting in this market. In the simplest terms, this allows healthier people to have lower insurance rates than less healthy people.

BCBSRI uses a health assessment to determine the risk profile of potential direct pay subscribers. Those who pass a medical underwriting test, which assesses in part whether they have pre-existing medical conditions, are assigned to the “preferred pool” and charged preferred rates. Those who do not pass this test are assigned to the “basic” pool and pay basic rates, which are substantially higher. In addition, within the preferred pool rates vary by age and gender, with younger males receiving the lowest rates. Currently, 54% of the direct pay enrollees are assigned to the basic pool. BCBSRI direct pay rates for individuals are shown below.

Rhode Island Direct Pay Monthly Premiums for Individual Coverage

Rates valid through March 30, 2008

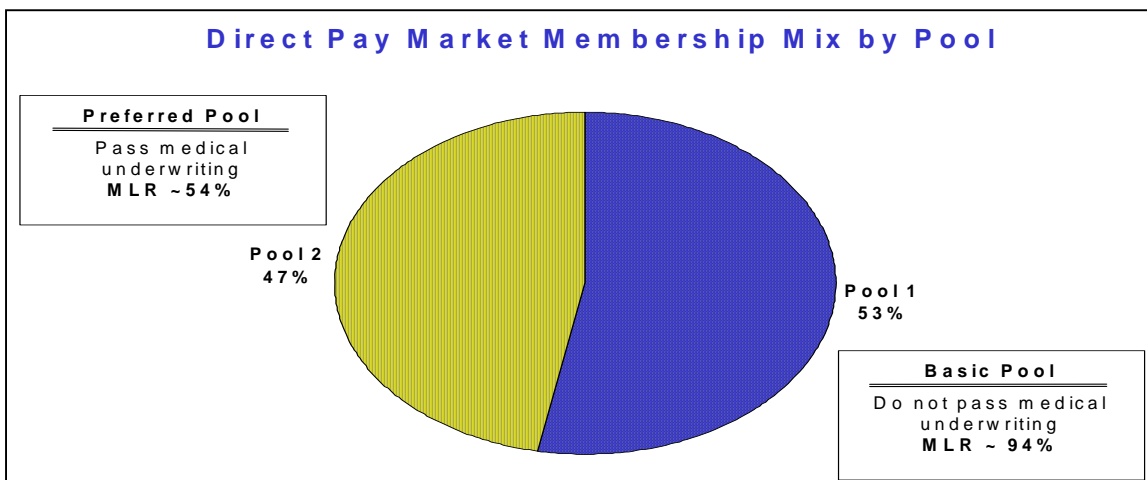
Basic Monthly Rates				
Plan type	HealthMate Coast-to-Coast® Direct		HealthMate for HSA Direct	
Cost sharing	Plan 400/800	Plan 2000/4000	Plan 3000/6000	Plan 5000/10000
Under age 65	\$595.52	\$447.52	\$383.62	\$303.14
Over age 65	\$934.75	\$702.07	\$601.51	\$474.93
Sampling of Preferred Monthly Rates				
<i>You must pass medical underwriting to qualify for these rates</i>				
Under age 25 Male	\$179.30	\$135.18	\$116.26	\$92.32
Under age 25 Female	\$249.48	\$187.85	\$161.34	\$127.86
25-29 Male	\$197.98	\$149.21	\$128.26	\$101.78
25-29 Female	\$282.28	\$212.46	\$182.41	\$144.47
30-34 Male	\$225.07	\$169.53	\$145.66	\$115.50
30-34 Female	\$334.91	\$251.96	\$216.21	\$171.12
40-44 Male	\$274.65	\$206.74	\$177.51	\$140.60
40-44 Female	\$363.15	\$273.14	\$234.34	\$185.42
60-64 Male	\$573.30	\$430.83	\$369.32	\$291.85
60-64 Female	\$573.30	\$430.83	\$369.32	\$291.85

4. Negotiated Cross-Subsidies across the Two Pools of Direct Pay Subscribers. The use of medical underwriting and age and gender rating allows BCBSRI to set rates lower for low-risk subscribers. To also assure affordable rates for high-risk subscribers, we require some cross-subsidization between lower-risk and higher-risk individuals in the BCBSRI pools. This occurs in two ways. First, there is some cross-subsidization between the preferred and basic pools. BCBSRI determines an actuarially justified rate for each pool, they propose rates that allow for some cross-subsidization from the preferred pool to the basic, and we negotiate a final rate. Second, there is some cross-subsidization within the preferred pool (from moderately high risk people to the highest-risk people) through the age and gender factors. In other words, the low risk 20-year-old male who is paying \$92.32 in premium per month would be paying *even less* if not for the fact his premium helps cover the cost of higher-risk people in the basic and preferred pools. Conversely, higher-risk individuals would pay even higher rates if not for the cross-subsidization. OHIC, through the rate approval process, regularly negotiates the extent of this cross-subsidization, and the overall spread that is allowed in direct pay rates.

5. Consumer Choice of Products. Premiums within the BCBSRI direct pay pools also vary according to plan design and benefit coverage. BCBSRI offers two types of products to individuals and their families, a preferred provider (PPO) product and a health savings account (HSA) product, with two choices of cost-sharing levels for each product. The premiums for the PPO product are higher than those for the HSA product. A high deductible plan (\$5000 deductible) was introduced in the direct pay market in 2006. In combination, the array of plans provides a choice of coverage types and premium levels that is not available to high-risk individuals in some markets.

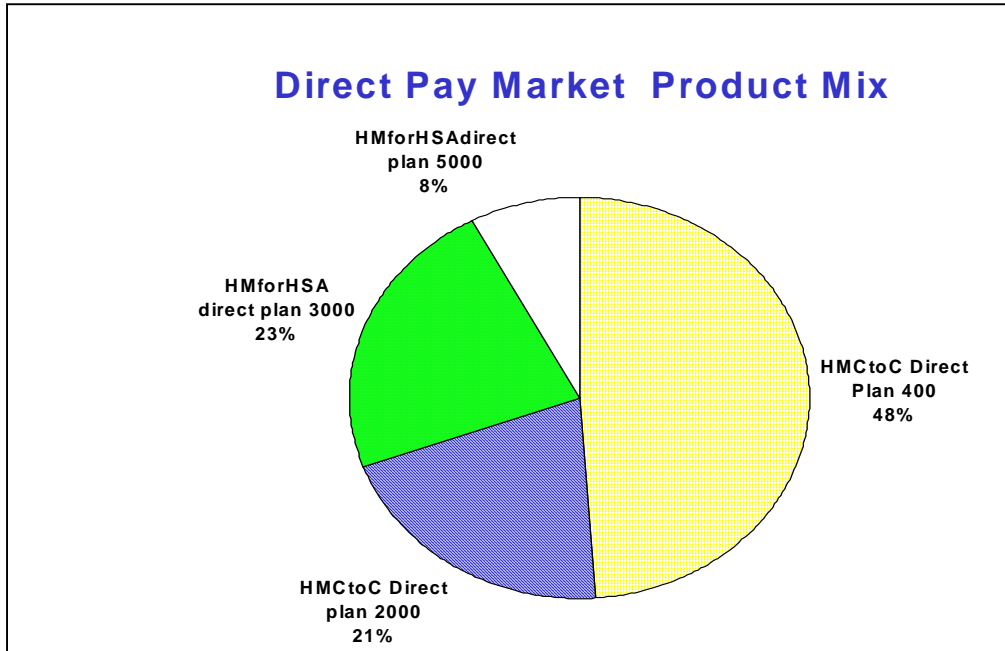
B. Direct Pay Membership and Product Mix

The membership mix and product mix of the direct pay market is described in greater detail below.



There is significant cross-subsidization between Pool 1 (Basic) and Pool 2 (Preferred). Pool 1 has slightly more enrollees than Pool 2. When you compare the share of premium dollar that is captured by medical costs for each pool, the result is particularly striking. For Pool 1, which, again, consists of enrollees who do not pass medical underwriting, almost all of the premium dollar (94%) goes to paying for medical costs incurred by enrollees in the pool. This in contrast to just 54% of the premium dollar for Pool 2 (Preferred) that is captured by medical costs. Premiums could not remain affordable for Pool 1 without this cross-subsidization from Pool 2.

Another feature of the direct pay market is that the product mix is heavily weighted toward products with significant cost sharing such as deductibles. As shown below, more than half of the products offered have at least a deductible of \$2,000 or above for an individual. In fact, no plans are available that do not have a deductible. Even the most popular plan with the least up-front cost sharing has a \$400 deductible for individuals.



C. Recent Trends, Future of the Direct Pay Market

As a result of the five key characteristics mentioned above -- guaranteed issue, a single carrier, the use of medical underwriting, negotiated cross-subsidies, and a choice of products—the Rhode Island direct pay insurance market has worked fairly well. Historically we have achieved a balance with cross-subsidization between the two pools that results in rates in the preferred pool that are comparable to or below those in the small group market. Rates in the basic pool, meanwhile, are somewhat higher than small group rates, on average.

However, the balance in the Rhode Island direct pay market has been somewhat more precarious for the past five years. In 2004 BCBSRI’s medical loss ratio increased to 99.1 percent for the direct pay market, resulting in sizable health plan losses. BCBSRI requested a rate increase in 2004, but that request was denied by state regulators due to concerns about the affordability of coverage in the direct pay market. After three years without an increase in rates, BCBSRI was granted a substantial increase in 2006 and another in 2007. The 2007 increase averaged four percent across the basic and preferred pools, even though costs in the basic pool rose at a substantially higher rate. Maintaining affordability in both pools has become more of a challenge.

This is because we have not controlled the rate of increase in health care costs for high-risk individuals. The underlying factors that are driving up costs in the direct pay market have not been addressed. High-risk individuals who purchase coverage in the direct pay market receive very little medical management or care coordination, in spite of the fact that their medical costs are skyrocketing. The overall medical loss ratio (MLR) for the BCBSRI direct pay pools (which included 13,411 subscribers) was 97 percent in 2003-2004, but the MLR for the 3,694 subscribers in the basic pool who chose the most comprehensive benefit design was considerably higher than the MLR for the remaining 3,772 subscribers in the basic pool. The table below

illustrates the extent to which the costs of the highest-risk subscribers, who have much higher rates of use of both inpatient and outpatient services than other subscribers, drive the overall costs of the pools. If we do not address the underlying costs of care for these individuals, they will continue to be a heavy burden on all other subscribers.

**Comparison of Medical Loss Ratios and Enrollment (Members) across
BCBSRI Direct Pay Pools and Products**

		Product			
		HealthMate Coast-to- Coast Direct Plan 400/800	HealthMate Coast-to- Coast Direct Plan 2000/4000	HealthMate for HSA Direct Plan 3000/6000	HealthMate for HSA Direct Plan 5000/10000
Pool	Basic				
	MLR	112%	79%	92%	23%
	Enrollment	3694	1560	1702	510
	Preferred				
	MLR	74%	48%	32%	11%
	Enrollment	3182	1327	1527	578

Data Source: BCBSRI, based on experience from April, 2006 through March, 2007

IV. Summary, Implications for this Study

This primer provides important background information describing the direct pay and small group markets in Rhode Island. This information is useful to the Insurance Market Merger Task Force as they begin to address the tasks before them, that is:

- assessing whether a merger of the direct pay and small group markets (with or without reinsurance) is a viable option for addressing some of the problems highlighted in this primer; and
- assessing whether changes to the small group rating rules are recommended.

It is clear from the data presented on the two markets that RI's insurance markets have experienced shifts over the past several years that may make the current situation untenable in the future. The small group market has been losing market share as employers drop coverage for their employees. In addition, the cross-subsidization mechanism in the direct pay market that has kept premiums affordable for the sickest individuals depends on a steady or growing share of preferred pool members in the direct pay market to work. However, the base of low-risk subscribers in the direct pay market has not grown in recent years and, in fact, in recent years there has been a decline in enrollment in the preferred pool of subscribers.

These market shifts are occurring as costs are increasing at rates higher than those seen in the rest of the country. In 2004, Rhode Island ranked second highest among states for average annual premiums (at \$4,368) for individual coverage. As overall rates increase, and the cost of cross-subsidization increases, and the base of low risk subscribers shrinks, cross-subsidization of higher-risk individuals exclusively through the direct pay pools becomes unsustainable. This could cause what is known as a death spiral in RI's direct pay market. Health individuals will thus not have affordable options in the direct pay market and sicker individuals will also face premiums that are unaffordable.

Budget pressures at the state and federal-level make it unlikely that Medicaid can serve as a safety net for current direct pay subscribers. The pressures on Rhode Island's Medicaid program are intense and the governor and legislature are considering some significant cutbacks in Medicaid eligibility. In addition, federal Medicaid and SCHIP funding are uncertain.

The work of this taskforce is timely. Our goal is evaluate one option for stabilizing these markets through the possibility of a market merger, reinsurance mechanism, and rating rule changes. We hope to do this work with good data and analysis. Our challenges are many but the ones key to this task include:

- how best to integrate the sickest members in the direct pay market into a merged market so that the effects of the merger are spread equitably across carriers;
- how to minimize disruption in the markets, particularly for small group purchasers; and
- how to develop strategies that address adverse selection.