Regulatory Changes Necessary in a Reformed Health Insurance Market

Presentation to the Finance Committee

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Tasks of the Exchange Work Group

- Evaluate options and develop recommendations regarding how to organize and regulate a reformed individual market
- Make recommendations for the implementation of a health insurance exchange
  - who could participate
  - what services an exchange should provide

Oregon's Current Individual Market

Size	233,000, including OMIP & portability (6% of total OR population)
Guaranteed issue and renewability?	**Guaranteed Issue? No** Guaranteed Renewability? Yes
Rating regulation	Rates can not be based on individual's health experience or other factors; may use age factor Portability products: for individuals rated on all groups
Coverage regulation	May exclude pre-existing conditions up to 6 mos.
Benefit regulation	Certain benefits mandated
Other	Oregon Medical Insurance Pool (OMIP) for individuals denied coverage

Oregon's Current Small Group Market (2 to 50 employees)

Size	268,000, including portability (8% of Oregon population)
Guaranteed issue and renewability?	Guaranteed Issue? Yes Guaranteed Renewability? Yes
Rating regulation	Rates pooled for all small groups. Allowed factors: benefit design, geography, age, family coverage, participation rate. Max band for age factor: 3:1
Coverage regulation	May exclude coverage of pre-existing conditions up to 6 mos. (excl. pregnancy)
Benefit regulation	Must include mandated benefits

Working Assumptions (from SB 329)

- Individual mandate → 571K uninsured will gain coverage
- State premium contribution for low-income
- Guaranteed issue, or a modified individual market
- Availability of a range of affordable plans with attractive benefits and a choice of carriers
- Risk adjustment or reinsurance

Who will enter the individual market?

- With an individual insurance requirement and guaranteed issue, enrollment in the individual market will grow.
- Over 100,000 currently uninsured people will enter the individual market and access state contributions, both
  - Directly through state premium contribution
  - Indirectly through affordability tax credit
- 50,000 new individual market enrollees not eligible for state contribution

Goals of Market Reforms

- Provide access to affordable coverage for individuals
- Make it easy for people to quickly become insured
- Create a stable and sustainable market: stable rates, participation by numerous insurers
- Mitigate effect of adverse risk events on insurers
- Provide sustainable financing for high risk segment
- Minimize impact on people who currently have coverage

Two Possible Routes for Achieving These Goals

1. Maintain medical underwriting with some changes in the individual market and OMIP

2. Establish guaranteed issue, using a robust risk adjustment mechanism and state premium contributions to ensure all Oregonians access to coverage

Work Group Recommendation

- In an environment with an individual insurance requirement, implement guaranteed issue and no medical underwriting in the individual market

- Want to see modeling results – rate impact of merging all individuals in one pool

Overview: Recommendations for Implementing Guaranteed Issue

- Single risk pool for individual insurance market
- Establish robust risk adjustment
- Limit market disruption by maintaining OMIP for enrollees for a period of time; close entry to program
- Self-employed sole workers stay in individual market

Overview: Recommendations for Implementing Guaranteed Issue, cont.

- Use a plan enrollment period to facilitate universal coverage and avoid system gaming
- Limit transition period disruption for current individual market enrollees
- Establish consistent rating rules for all carriers in this segment
- “Essential Services Benefit” definition will establish product baseline and tiers

Make the Individual Insurance Market a Single Risk Pool

- Establish a single risk pool for individual insurance market (Include: existing, new, portability, OMIP)
- Implement guaranteed issue & guaranteed renewability
- Do not use medical risk to determine insurability or risk
- Close enrollment in the high risk pool (Oregon Medical Insurance Pool – OMIP)
- To maintain carrier participation in individual market:
  - Strong enforcement rules for individual health insurance requirement
  - Strong risk adjustment mechanism

Establish Strong Risk Adjustment

- Establish a risk adjustment mechanism that adjusts revenue based on carriers' enrolled risk
- Establish an oversight methodology to review the value and efficacy of the risk adjustment mechanism, adjust the mechanism as needed

Limit Market Disruption

- Initially keep current OMIP enrollees in their current coverage and set OMIP rates to mirror those in the reformed individual market
- Close OMIP to new enrollment
- Initially maintain OMIP assessment; determine if assessment is necessary long-term with adoption of risk adjustment mechanism
- Assess impact of enrolling high risk uninsured and portability market enrollees into main individual insurance market
- Assess impact of newly eligible population on risk pool

Maintain Current Treatment of Self-Employed Sole Employees

- Continue to allow self-employed persons with no other employees to access insurance in the individual market, but not in the group market
- Once an essential services benefit is established, revisit discussion of differences between the group and individual markets

Rating Rules Should Be Consistent and Support Enrollment

- Base the medical component of rates on a carrier's experience with all enrollees, whether they are enrolled through the Exchange or not.
- Use statute or regulation to increase transparency of medical cost and administrative cost components of rates.
- Utilize natural rate band based on the actual experience of the overall individual market.
- Allow age, but not gender or health to influence rates in individual market.

Rating Rules Should Be Consistent and Support Enrollment

- Allow, but do not require carriers to implement premium discounts for healthy behaviors.
- Continue to allow geography-based rating.
- Do not change small group rating rules to match the rules in the individual market. Evaluate over time to see if changes are needed.
- Continue DCBS review of carrier rates.

Use Essential Services Benefit Definition to Establish Product Baseline and Tiers

- All carriers must offer a plan at least equal to the essential services benefit defined by the Benefits Committee and at least one buy up option
- DCBS will continue to review carrier products. Review will include check that plan benefits meet or exceed essential services benefit.
- Establish several benefit tiers, with greater benefits/cost for higher benefit tiers.
- Do not establish a low cost/reduced benefit plan for young adults.

Use a Plan Enrollment Period to Facilitate Universal Coverage and Avoid System Gaming

- Assumes all can access easy enrollment into affordable coverage; effective marketing plan
- Establish open enrollment period for individual insurance
- Identify exceptions to open enrollment limitation; establish appeals and exceptions process.

Limit Transition Period Disruption for Current Individual Market Enrollees

- Keep insurance affordable for current enrollees—need modeling
- Pair easy access to affordable, consumer valued coverage with penalty for non-coverage to encourage new and current enrollees to get and keep coverage.
- Determine which low income enrollees will be eligible for state premium contributions.
- Phase in reforms to protect individual market participants. Delay merging current OMIP enrollees with overall individual market.

The Individual Insurance Requirement: Ensuring Participation

OHFB Design Principle: The responsibility and accountability for the financing and delivery of health care is shared by all Oregonians.

Compliance Design & Enforcement Principles

- **KIS** – make it easy to administer, comply, verify coverage.
- **Fairness** – people who can afford coverage should buy it, while lower-income people may need assistance to make coverage affordable.
- **Flat of the curve** –Recognize that getting 100% compliance is probably impossible and very expensive; 99% may be sufficient to meet the goals of reducing the cost shift and minimizing adverse selection.
- **Others?**

Administering Compliance with Individual Insurance Requirement

- Make enrollment simple, provide incentives for enrollment
- Annual open enrollment period
- Significant financial penalty for non-coverage (50% or more of benchmark plan annual premium)
- Consider other incentives (e.g., require proof of insurance to get driver's license)
- Enforcement is key

- Additional issues:
  - Who, how and how often to assess compliance & impose penalties
  - What period counts for having insurance
  - Exceptions and appeal process
  - Who is responsible for coverage of minors, other dependents

Next Steps

- Review modeling results of this plan—especially impact on currently enrolled
- Based on that input and input from Finance committee, finalize Market Reform Recommendations report
- Finalize draft Exchange recommendations, including:
  - What groups will utilize an exchange?
  - What functions will an exchange perform?
  - What will be the Exchange's governing structure?
  - How will the exchange be funded?

Health Insurance Exchanges and Market Design: An Introduction

Presentation to Oregon Health Fund Board – Finance Committee

November 19, 2007

Important Questions

- *Can an exchange solve the problems of cost, quality and/or access?* No, not by itself.
- *What else do we need to consider?* Other market design elements, e.g., individual mandate, guaranteed issue, rating regulations, etc.
- *Can we simply use the Massachusetts Connector as a model for Oregon?* No, because their individual and small group markets differ from ours.

The Market Context

The current individual market in Oregon is relatively healthy compared to other states, *but . . .*

- We do not have guaranteed issue
  - In the absence of an individual mandate, we chose to
    1. allow medical screening, and
    2. create a high risk pool
  - This creates higher administrative costs, and the high risk pool is not affordable for some people.

A “new” individual market?

If we assume that we should have an individual mandate, then the individual market will have to change:

- Coverage would have to be available to all, i.e., guaranteed issue
- Coverage would have to be affordable, i.e., subsidies for low-income individuals

What would be the role of an insurance exchange in this “new” individual market?

What is a Health Insurance Exchange?

A market mechanism that:

- Brings together consumers, and
- Facilitates the purchase of health insurance from a choice of health plans
  - “one-stop shopping”
  - mirrors the functionality of large employer pools

Why do we need an Exchange?

- Individuals buying health insurance often face obstacles:
  - Administrative complexity
  - Lack of tools to shop effectively
  - Individuals don’t have the tax advantages of employer-based coverage
- And, if we have subsidies to assist low-income individuals, an exchange would provide a mechanism to administer subsidies.

The Goals of an Exchange

- Efficiency and affordability
- Convenience
- Tax advantages

What's been the experience with exchanges?

- Mixed at best
  - Some have been successful (e.g., CBIA)
  - Most have not attracted many participants
  - Most did not achieve goals of constraining health insurance premiums via efficiency or purchasing power
  - Some have collapsed financially due to adverse selection spiral

- Design and implementation are critical to success

Massachusetts Connector Design

- Two programs
  - **Commonwealth Care**: free/subsidized coverage for uninsured with income to 300% FPL, without access to coverage
  - **Commonwealth Choice**: unsubsidized commercial products for individuals above 300% FPL, small business
- Use of Connector is voluntary but is sole entry point for subsidies
- All plans offered through Connector meet Minimum Creditable Coverage requirement
- Three plan levels with differing benefits, cost sharing

The Massachusetts Connector – Initial Results

- Enrollment: higher than projected
  - CommCare: 127,000 enrollees on 10/1/0
  - CommChoice: 8,300 enrollees on 10/1/07 (covg. began 7/1)
- Financial outlook: expect to be self-sustaining by year 3 (2009)
  - Barriers: high enrollment by 55+, most younger enrollees are in fully subsidized program
- Benefit design: lots of public interest in “minimum creditable coverage” requirement

The Massachusetts Connector – Initial Results (Cont.)

- Health Plan participation has been good
- Implementation Issue: Not everyone has insurance yet
  - mandate purposely implemented slowly
  - Individuals with unaffordable employer coverage
- Implementation Issue: Consumers responded to clear information about differences between plan levels
- Connector Board now looking at cost control issues

MA vs. OR: Individual Market (prior to reform)

	Massachusetts	Oregon
Size	42,500 (1%)	218,000 (6%) [including OMIP]
Guaranteed issue and renewability?	GI: yes GR: yes	GI: no GR: yes
Rating regulation	Rates cannot be based on individual's health experience or other factors; may use age factor	Rates cannot be based on individual's health experience or other factors; may use age factor
Coverage regulation	May exclude coverage of pre-existing conditions up to 6 mos.	May exclude coverage of pre-existing conditions up to 6 mos.
Benefit regulation	No current mandate. On 1/1/09, minimum creditable coverage must meet certain benefit standards, incl. coverage of preventative & primary care, emergency services, hospital, prescription drugs and mental health care. Annual deductible maximum of $2,000 (individual)/ $4,000 (family).	Certain benefits mandated, but not mental health parity
Other	No high risk pool Ind & small group markets merged 7/1/07	OMIP for individuals denied coverage

MA vs. OR: Small Group Market
(prior to reform)

	Massachusetts	Oregon
Size	700,000 (11%); includes groups of 1-50 FTEs (self-employed = group of one)	283,000 (8%) [incl. portability]
Guaranteed issue and renewability?	GI: Yes GR: Yes	GI: Yes GR: Yes
Rating regulation	Rates cannot be based on individual's health experience or other factors; may use age factor; 2:1 rating band (age, geography, industry, size -- includes four rate basis types)	Rates pooled for all small groups. Allowed factors: benefit design, geography, age, family coverage, participation rate. Max band for age factor: 2.5
Coverage regulation	May exclude coverage of pre-existing conditions up to 6 months. Group plans cannot apply exclusion period for pregnancy, newborns or newly adopted children, children placed for adoption, or genetic information.	May exclude coverage of pre-existing conditions up to 6 mos. (excl pregnancy)
Benefit regulation	No restrictions on employer coverage: employers can design the health benefit offered to employees. By 1/1/09, all individuals must get minimum creditable coverage: preventative & primary care, emergency services, hospital, prescriptions, mental health benefits	Must include mandated benefits

Critical Success Factors – External Market Context

- Requirement for individuals to have coverage (with subsidies for low-income individuals)
- Guaranteed issue and renewability inside and outside of exchange
- Rules (including rating regulations) are the same inside and outside of exchange
  - to ensure affordability and minimize risk skimming

Critical Success Factors – Internal Design of Exchange

- Meaningful choice of health plans
- Reasonable standardization of benefit offerings
- Transparent information and decision support tools for consumers
- Mechanisms to protect insurers that enroll high-risk members
  - e.g., risk adjusters, reinsurance or high-risk pool

Summary and Implications

- An exchange is a tool, not a solution in itself.
  - An exchange won't work in a vacuum; it must be done in conjunction with other market changes, i.e., individual mandate, guaranteed issue, subsidies
  - An exchange can be a very important element of a comprehensive reform plan
- Oregon's individual and small group markets differ from Massachusetts's, so we can't simply import the Mass. Connector.
- Due to differences in Oregon's individual and small group markets, it may make sense to focus initially on the individual market.

Design Issues
(from Finance Committee Charter)

- Should insurance products for the “new” individual market be offered on the basis of guaranteed issue and renewability?
- To what degree should benefits offered by insurers in this “new” market be standardized to minimize unnecessary variation, facilitate comparison shopping and minimize risk skimming?
- What role could an Exchange fill in this “new” individual market?
- How might the Exchange be used to administer subsidies to eligible Oregonians?
- Should all individual products be sold through an Exchange, or should use of an Exchange be required only for individuals accessing subsidies?
- If a separate individual market operates in parallel with an Exchange, what is needed to avoid adverse selection between the two pools?

(cont.)

Design Issues (cont.)

- How should insurers be selected to participate in the Exchange? How are a range of product offerings managed to avoid adverse selection?
- What mechanisms should be used to protect insurers who enroll high-risk members? Should we continue to have a high-risk pool, or are other mechanisms preferable?
- What kinds of decision support tools and transparent information on cost, quality and service should there be to support informed consumer choice?
- How should an Exchange be organized and governed?
- How should the costs of an Exchange be financed?
- What should be the role of brokers/agents in the “new” individual market?
- Based on proposed reforms of the individual market, are there implications for the small group market?

Next Steps

- Nov 19 – Exchange/Market Design presentation to Finance Committee
- Week of Nov 26 - Exchange Work Group launch
- Feb ‘08 - Preliminary Exchange report due to Legislature
- March/April ‘08 – Finance Committee refines recommendations to Board