Health Insurance Exchange Options

Presentation to the Finance Committee

Denise Honzel

May 1, 2008

Health Insurance Exchange

- An exchange is a market organizer that facilitates the purchase of health insurance

- The work group discussed:

1. What could an Exchange do for Oregonians?

2. Who would use the Exchange?

1. What Could an Exchange Do for Oregonians?

- Tier 1: Information, Enrollment and Administration
- Tier 2: Benchmarking and Standards
- Tier 3: Rate Negotiation and Selective Contracting

Tier 1 Functions

- Create a central clearinghouse for information about health plan and insurance product choices
- Design decision support tools and provide cost, quality and service transparent information
- Manage open enrollment process with efficient, user-friendly health plan enrollment
- Establish an eligibility confirmation and state premium contribution administration process
- Help employers and others to set up and administer Section 125 accounts

Tier 1 Functions (continued)

- Provide a mechanism to collect and aggregate premium contributions from multiple sources
- Ensure provision of customer services, (provide and coordinate with brokers and carriers)
- Administer risk adjustment mechanism to protect insurers who enroll high-risk members
- Train agents and brokers on exchange functions; connect people with educated agents, brokers

Tier 2 Functions

- All Tier 1 functions, plus…
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes

Tier 2 Functions (continued)

- Allow contracting for full packages of products and services from the carriers, or contracting separately for benefits or services that might better achieve benchmark performance

- Establish agent and broker role in distribution and marketing of plans offered in the exchange.

Tier 3 Functions

- All Tier 1 and Tier 2 functions, plus…
- Solicit bids or price proposals
- Negotiate prices and/or discounts with carriers
- Select which carriers would participate in the exchange

Implications of an Exchange with a Broad Range of Functions

- Likely to have greatest impact on lowering costs and improving quality
- Maximize the value of government contribution for low and moderate income people
- Rate negotiation may affect carrier participation
  - If fewer carriers participate, consumers will have less choice

Recommendation: Role of the Exchange

- The work group recommends an Exchange that functions at a “strong” Tier 2
  - Strong benchmarking and standards
  - Some price negotiation
  - Plans that meet standards can participate
- Hold open option for Tier 3 if needed

Recommendation: Section 125 Plans

- Work Group recommendation: all employers must set up Section 125 plans for employees
  - Exception: employers funding 100% of ESI
  - Voluntary participation by employees
  - Reduces cost of insurance for employee, reduces payroll burden for employer
  - Requires changes in tax law

- Finance Committee concurred with recommendation at March 19 meeting

2. Who Uses the Exchange?

- Categories of participants that could benefit from an Exchange
  - A. Individuals getting state premium contributions (income between 150-299% FPL)
  - B. Individuals getting tax credit for premium purchase (income between 300-399% FPL)
  - C. Individuals not eligible for employer's ESI, but who use Sect. 125 plan (income above 400% FPL)
  - D. Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)
  - E. Self-employed or non-employed individuals with income above 400% FPL
  - F. Employees of small employer groups
  - G. Employees of medium and large employer groups

Core Exchange Populations

- Individuals receiving a state contribution would be required to use the Exchange for insurance purchase
  - People getting direct state premium contributions (income between 150-299% FPL)
  - Individuals using tax credits for premium purchase (income between 300-399% FPL)
- Rationale:
  - Most of these people are currently uninsured
  - Helps maximize the value of government contributions
  - Streamlines administration of premium assistance, tax credit

Group C: Voluntary on Employer-by-Employer Basis

- Group C: Individuals not eligible for employer's ESI, who use Section 125 plan (income above 400% FPL)
- Rationale:
  - Helps part-time employees
  - Using Section 125; get pre-tax benefit
  - Voluntary on an employer-by-employer basis
    - Whole "class" of employees must go into Exchange or to direct market
    - For seamlessness, such employees would ideally have the option of buying an individual plan offered by the same carrier in the direct market, or into the employer's group plan

Group D – Required Participation in the Exchange

- Group D: People working for non-offering employer, who use Section 125 plan (income above 400% FPL)
- Rationale:
  - Most are employed by “micro-employers”
  - Tend to move in and out of premium assistance/tax credit eligibility as income fluctuates
    - Close to 70% are subsidy-eligible (Group A)
    - Nearly 30% will receive a tax credit (Group B)
    - The remainder will be in Group D
  - When not eligible for direct state contribution get pre-tax benefit of Section 125
  - Improves continuity of care
  - Limits risk selection

Group E – Voluntary Participation in the Exchange

- Group E: Self-employed or non-employed individuals with income above 400% FPL
- Rationale:
  - Pros
    - Allows the exchange to prove its value as consumers “vote with their feet”
    - Less disruptive - allows individuals to stay with current carrier
    - Access to exchange services
  - Cons
    - Danger of adverse risk selection unless regulatory and administrative steps are taken
    - Increased complexity
    - Exchange pool may not be as large

Employer Group Participation: Options Explored

1. Do not allow groups into the Exchange
2. Let small groups in Exchange; merge with individual pool and offer individual plans
3. Let small groups in; set up separate risk pool for small groups
4. Merge micro-groups (2-9 empl.) into the individual market; let them use the Exchange with individual market rules

Allowing groups to participate has major obstacles

- Merging group and individual markets will cause disruption for many consumers
- Dual group markets adds administrative complexity and increases adverse selection
- Letting groups enroll using individual market rules causes risk selection between Exchange & outside market
- Unclear how to risk adjust for groups with voluntary Exchange

Group F – Do Not Enroll Initially

- Group F: Employees of small employer groups (2-50 employees)

- Rationale
  - Some employed individuals are already in Exchange
  - Merging markets could cause disruption
  - If rules are the same inside and out of Exchange for groups, not clear what value Exchange brings
  - Voluntary enrollment creates adverse selection

Group G – Do Not Allow to Enroll Initially

- Group G: Employees of medium and large employer groups
- Rationale:
  - Entry must be voluntary due to ERISA preemption of state regulation of health benefits for self-insured employers
  - Many large employers already offer choice of plans, have HR department
  - Selection concern: if voluntary option for employers, the exchange may face adverse selection

Next Steps: Finalize Exchange Report

- Market reform recommendations
- Exchange recommendations
  - Exchange functions
  - Populations using an exchange
  - Exchange governance/administration
  - Funding for the exchange
  - Enforcing an individual coverage requirement
- Incorporate actuarial analysis on impact of merged individual market
- Evaluate work of the benefits committee

Modeling Results for Straw Plans A, A1, and A2

For Discussion Only

OHFB Finance Committee

May 1, 2008

Payroll Tax Modeling Changes from Straw Plan A

- Straw Plan A^T
  - Only modification to scenario was payroll tax amount
- Straw Plan A1
  - Change in individual contribution level
  - Change in FPL range of subsidy
  - Change in tax credit
- Straw Plan A2
  - Change in individual contribution level
  - Change in tax credit

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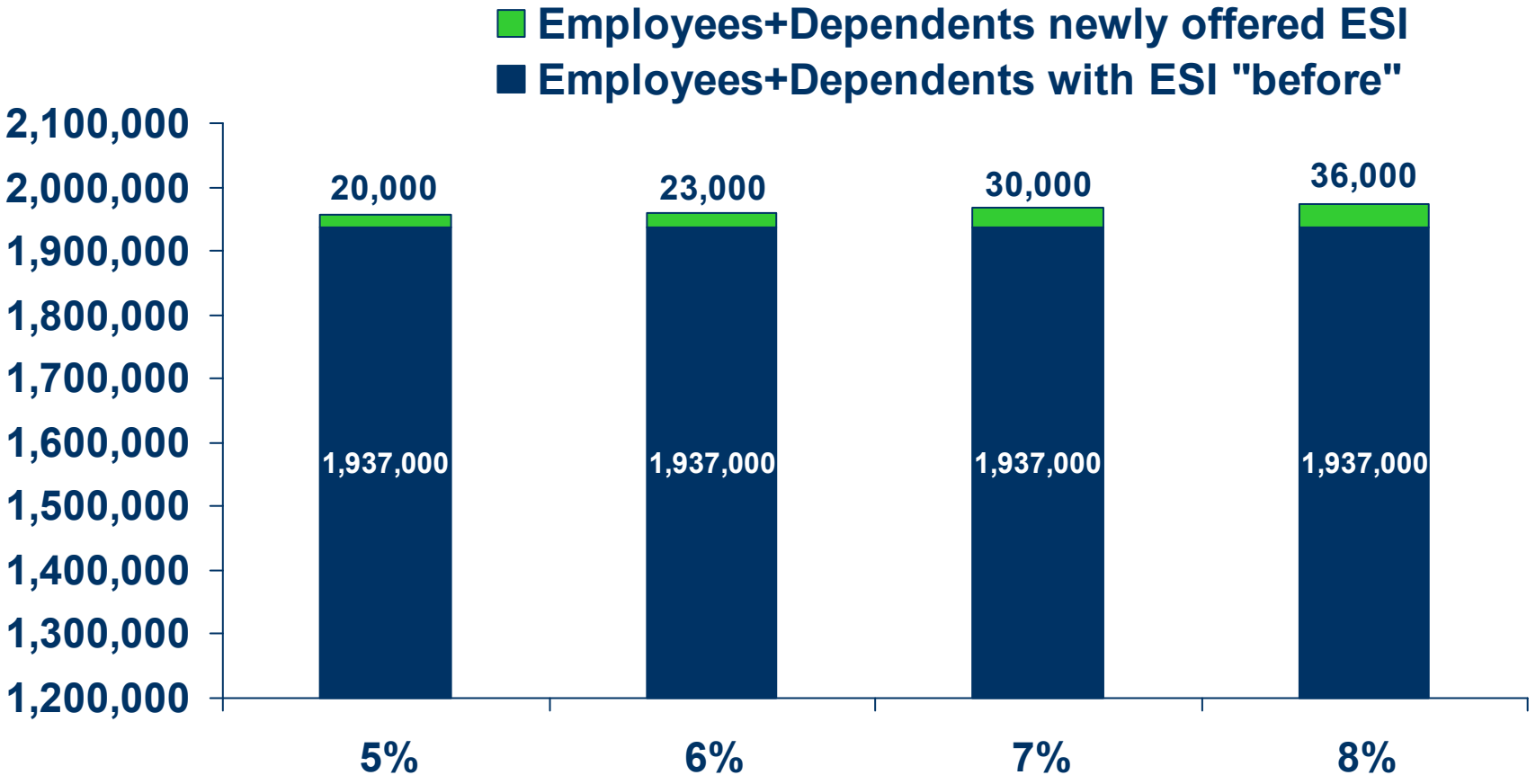
Straw Plan A^T: Employee (& Dependent) Coverage by Payroll Tax Level



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Straw Plan A^T: Summary of State Costs at Different Payroll Tax Levels

($ Millions)	5%	6%	7%	8%
Cost of Public Coverage	$1,050	$1,050	$1,040	$1,030
Cost of New Exchange Population	$1,040	$1,000	$970	$940
State Income Tax Revenue Loss	$70	$70	$80	$90
Payroll Tax Revenue	($620)	($700)	($780)	($850)
Federal Match	($920)	($900)	($890)	($880)
Total State Costs	**$610**	**$520**	**$430**	**$350**

Policy Parameters (1 of 2): All Apply to Scenarios A, A1, and A2

- Individual mandate
  - Guaranteed issue
  - "Affordability waiver" at 5% income for people <400% FPL with access to ESI
    - “Access to ESI” → employer pays 50% of premium for single coverage
    - “Access to ESI” → employer pays 25% of premium for family coverage
  - Mandate effectiveness: 85% for employees and dependents; 70% for all other
- Payroll fee (5% on total SS payroll)
  - Offering (“play”) employers: receive credit up to 4.75% against tax
  - Non-offering (“pay”) employers: no credit, pay full 5%
- Public (OHP) includes
  - Adults: 0-100% FPL
  - Children: 0-200% FPL
- Affordability tax credit eligibility based on estimated premium of a $2,500 deductible plan
  - Calculated after the 30.3% assumed 125-plan savings

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Policy Parameters (2 of 2): Differences in Scenarios*

	Straw Plan A		Straw Plan A1	Straw Plan A2
Sliding-Scale Contributions (100-150/150-200/200-250/ 250-300% FPL)	Childless Adults 0/2/3/5%	Parents 0/0/3/5%	**All Adults 0/3/6/NA%**	**All Adults 0/3/6/7%**
Exchange Populations	100-300% FPL		**100-250% FPL**	100-300% FPL
Tax Credit Level	300-400% FPL		**250-400% FPL**	300-400% FPL
Phase-Out	None		**300-400% FPL**	**300-400% FPL**
Based on Plan at x% Income	5%		**6%**	**6%**
Exchange PMPM	$355		**$300**	**$300**

*__Bold Underline__ Indicates Change from Plan A

Table 1: Coverage Status Before and After Reform*

Coverage Status (Thousands)	Before	Change under A	Change under A1	Change under A2
Public (OHP)	290	↑241 – 264	↑237 – 242	↑239 – 245
New Exchange	0	↑372 – 532	↑354 – 437	↑360 – 496
Non-group	160	↓64	↓64	↓62
Group (Employer)	1,940	↑10 - ↓174	↑30 - ↓57	↑20 - ↓123
Uninsured	680	↓559	↓558	↓556
Total	3,060			

NOTE: Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the "additional crowd-out" number was the same as Gruber's.
*Population totals based on 2010 Census projections, less ~500,000 65+ and ~230,000 0-64 on Medicare or CHAMPUS. Coverage estimates based on 2006 CPS, not actual program enrollment where applicable. Totals may not add due to rounding.

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Table 2: Cost of Public (OHP) Coverage*

Cost of OHP ($ Millions)	A	A1	A2
Total Cost	$1,052-1,152	$1,044-1,064	$1,049-1,080
Federal Match	$667-731	$662-675	$665-685
Net State Cost	**$385 – 422**	**$382 – 389**	**$384 – 396**

NOTE: Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the "additional crowd-out" number was the same as Gruber's.
*Assumes current Medicaid match rates at current waivers. Assumes SCHIP match rate from current OHP limit to 200% FPL for children.

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Table 3: Cost of Exchange Populations

Cost of Exchange ($ Millions)	A	A1	A2
Total Costs	$1,518 - 2,172	$1,218 - 1,504	$1,271 – 1752
Individual Contrib's	$483 – 691	$565 – 698	$543 – 749
Total Federal Costs	$253 – 362	$203 – 251	$206 – 284
Total State Costs	**$782 - 1,119**	**$450 – 556**	**$522 – 720**

NOTE: Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the "additional crowd-out" number was the same as Gruber's.

Table 4: Payroll Tax Revenue

Payroll Tax Revenue ($ Millions)	A	A1	A2
"Play" Employers (0.25%)	$134 - 132	$135 - 134	$134 - 132
"Pay" Employers (5.0%)	$490 - 529	$469 - 490	$483 - 516
Total	**$624 – 661**	**$604 – 624**	**$617 – 648**

NOTE: Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the "additional crowd-out" number was the same as Gruber's.

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Table 5: Employer Spending

Employer Spending	% Change under A	% Change under A1	% Change under A2
For Group Coverage	↓0.8% - ↓9.0%	0% - ↓3.9%	↓0.5% - ↓6.9%
Total (including payroll tax)	**↑7.0% - ↓0.7%**	**↑7.5% - ↑3.9%**	**↑7.3% - ↑1.2%**

NOTE: Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the "additional crowd-out" number was the same as Gruber's.

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Table 6: Summary of State and Federal Costs

($ Millions)	A	A1	A2
Cost of Public Coverage	$1,050-1,150	$1,040-1,060	$1,050-1,080
(Subsidy) Cost of New Exchange Population	$1,030-1,480	$650 – 810	$730-1,000
State Income Tax Revenue Loss	$70	$70	$70
Total State and Federal Costs	**$2,150-$2,700**	**$1,770-1,940**	**$1,850-2,150**

Note: State costs are dependent on additional federal funds that would require waivers. **Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out"**. Where there is only one number, the "additional crowd-out" number was the same as Gruber's.

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Table 7: Summary of State Costs and Needed Revenue

($ Millions)	A	A1	A2
Total State Costs	**$1,230-1,610**	**$900-1,020**	**$980-1,190**
Payroll Fee Revenue	$620 - 660	$600 - 620	$620 – 650
Projected Additional Revenue Needed	**$610 - 950**	**$300 - 400**	**$360 - 540**

NOTE: Ranges indicate "Gruber's estimate – IHPS estimate with additional crowd-out". Where there is only one number, the "additional crowd-out" number was the same as Gruber's.

Modeling Results for "Straw Plan A": Payroll Fee with Credit Allowed

For Discussion Only

OHFB Finance Committee

April 16, 2008

Keep these things in mind…

CPS data used in modeling

- More accurate income data for estimating # eligible for OHP and premium contributions
- May not fully reflect current enrollment in public and private health insurance due to self reporting
- Net effect – likely overestimating the change in enrollment due to reform

Keep these things in mind…

ERISA constraints on payroll tax & credit design

- States can regulate insurance but not private employer-offered benefits
- Rules of thumb to reduce likelihood of ERISA challenge – state policies should not:
  - Require employers to offer health coverage
  - Dictate terms of an employer's health plan such as covered services, premium levels, contribution levels, etc.
  - Tax employer-sponsored health plans *per se*
  - Set standards to qualify for tax credit that are dependent on employer providing health insurance

Keep these things in mind…

Federal matching funds:

- Pricing includes assumptions regarding federal match rate
- No way to know right now what federal government will approve
  - Based on administrative policy priorities – usually not legislation or regulation
  - Can change when there is a new Administration
- Contingency planning could be part of recommendations

Policy Parameters and Assumptions (1 of 5)

- Individual mandate
  - Guaranteed issue
  - "Affordability waiver" at 5% income for people <400% FPL with access to ESI
    - “Access to ESI” → employer pays
      - 50% of premium for workers only (single coverage)
      - 25% of premium for workers AND dependents (family coverage)
  - Mandate effectiveness: 85% for employees and dependents; 70% for all other
- Payroll fee (5% on total SS payroll)
  - Offering (“play”) employers: receive credit up to 4.75% against tax
  - Non-offering (“pay”) employers: no credit, pay full 5%

Policy Parameters and Assumptions (2 of 5)

- Affordability tax credit 300%-400% FPL
  - Tax credit eligibility based on estimated premium of a $2,500 deductible plan
  - Limits family spending to 5% of gross family income
    - Calculated after the 30.3% assumed 125-plan savings
- PMPMs based on DMAP data and preliminary actuarial estimates
- Cost is for full implementation in 2010 dollars

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Policy Parameters and Assumptions (3 of 5)

- **Public (OHP)** includes
  - Adults: 0-99% FPL
  - Children: 0-199% FPL
- **Exchange** includes
  - No individual premium contribution
    - Childless adults, couples: 100-149% FPL
    - Parents: 100-199% FPL
  - Sliding-scale coverage (shared contribution between state and individual)
    - Childless adults: 150-299%
    - Families: 200-299% FPL
  - Affordability tax credit eligibles: 300-399% FPL
  - Employees from "pay" employers 400%+ FPL **(not receiving any state contribution)**
- **Non-group**
  - Anyone purchasing coverage directly from broker or insurance carrier
- **Group**
  - Anyone getting coverage through an employer

Policy Parameters and Assumptions (4 of 5)

- Basic Gruber model:
  - Assumes firms with 100+ workers are *very* unlikely to drop coverage
  - Does not allow employers to drop coverage for some workers and not for others
- Under Straw Plan A:
  - Employers with a number of workers <300% FPL would benefit from by changing their plan-eligibility rules to make those workers ineligible for their plan
    - Employers could save money
    - Workers could get wage increases and would be eligible for the Exchange
  - Most offering employers spend considerably more than 5% of SS payroll on health benefits.
    - Could reduce coverage and still meet the test
  - About 1/3 of all Oregonians with employer coverage are <300% FPL

Policy Parameters and Assumptions (5 of 5)

- **Thus, two different estimates are presented:**
  - Gruber's estimate
  - An additional (non-Gruber) estimate that illustrates the possible extent of additional state costs
    - This additional estimate is labeled *"if more shift" and is always shown in red italics*

HIGHLY PRELIMINARY ESTIMATES-
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Eligibility and Enrollment Affordability Recommendations

- No personal contribution toward premium
  - 0-149% FPL for individuals and couples
  - 0-199% for families
- Sliding-scale structure of shared personal and state premium contribution from 2-5% gross family income towards premiums
  - 150-299% FPL for individuals, couples
  - 200-299% families
- State affordability tax relief
  - Tax deductions, pre-tax premium payments, or tax credits
  - Households 300-399% FPL

HIGHLY PRELIMINARY ESTIMATES-
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Table 1a: Coverage Status Before and After Reform*

Coverage Status (Thousands)	Before	(Gruber) After	(Gruber) Change	Percent Change
Public (OHP)	290	530	+240	+84%
New Exchange	0	370	+370	n/a
Non-group	160	100	-60	-39%
Group (Employer)	1,940	1,950	+10	+0.5%
Uninsured	680	120	-560	-83%
Total	3,060	3,060		

*Pop'n totals based on 2010 Census projections, less ~500,000 65+ and ~230,000 0-64 on Medicare or CHAMPUS. Coverage estimates based on 2006 CPS, not actual program enrollment where applicable. Totals may not add due to rounding.

HIGHLY PRELIMINARY ESTIMATES-
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Table 1b: Coverage Status Before and After Reform*

Coverage Status (Thousands)	(Gruber) **After**	***(If more shift) After***	**Difference**	**Percent Difference**
Public (OHP)	530	*550*	+20	+4%
New Exchange	370	*530*	+160	+43%
Non-group	100	*100*	-	-
Group (Employer)	1,950	*1,770*	-180	-9%
Uninsured	120	*120*	-	-
Total	3,060	*3,060*	-	-

*Pop'n totals based on 2010 Census projections, less ~500,000 65+ and ~230,000 0-64 on Medicare or CHAMPUS. Coverage estimates based on 2006 CPS, not actual program enrollment where applicable. Totals may not add due to rounding.

HIGHLY PRELIMINARY ESTIMATES-
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Table 2: Cost of Public (OHP) Coverage

Cost of OHP ($ Millions)	**Gruber Estimate**	***"If More Shift" Estimate***	***Difference***
Total Cost	$1,050	*$1,150*	*+$100*
Federal Match*	$670	*$730*	*+$60*
Net State Cost	**$380**	***$420***	***+$40***

*Assumes current Medicaid match rates at current waivers. Assumes SCHIP match rate from current OHP limit to 200% FPL for children.

Exchange Population (Gruber)

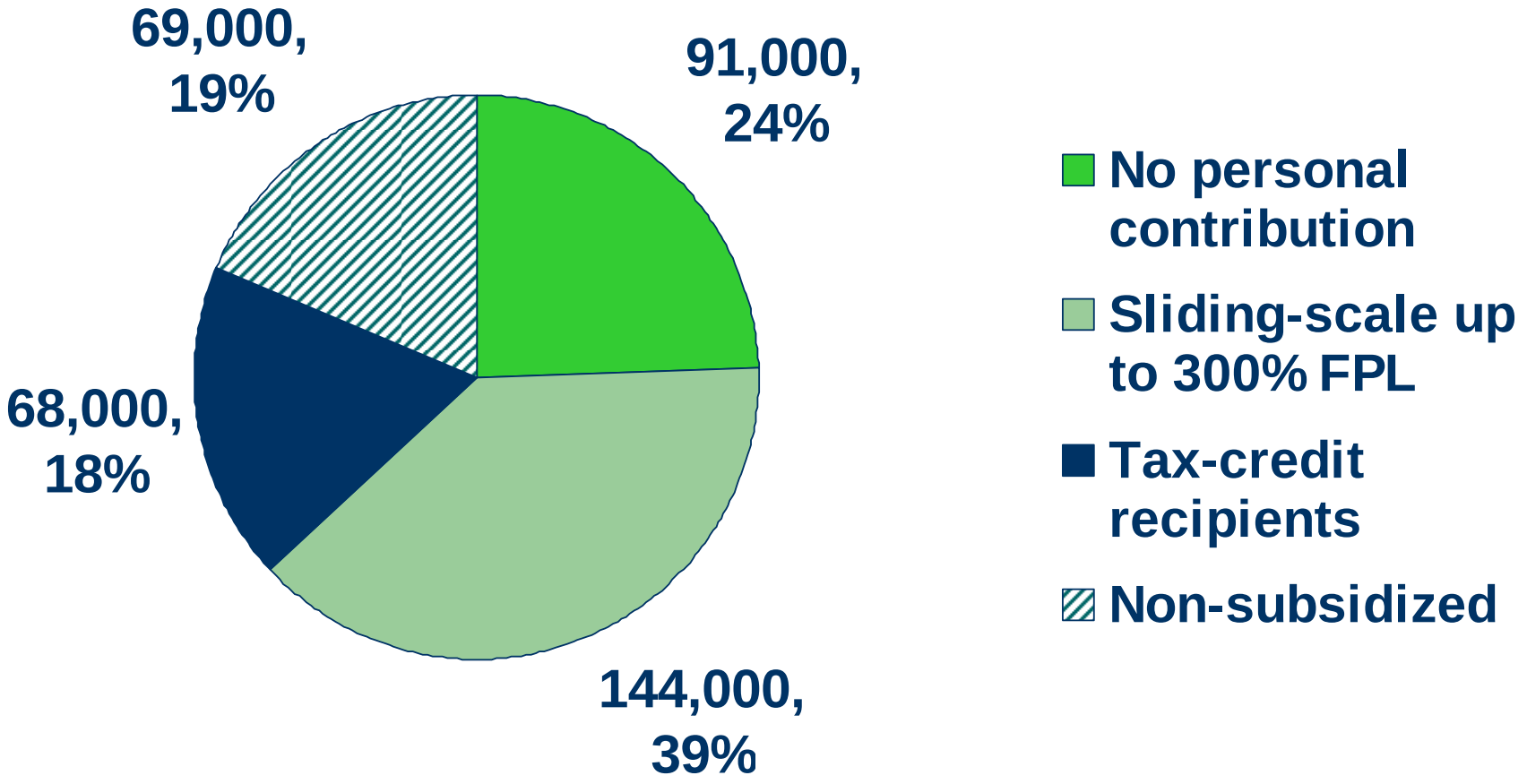

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Table 3: Cost of Exchange Populations

Cost of Exchange ($ Millions)	Total	No Personal Contrib.	Sliding -Scale	Tax Credit	No Subsidy
Total Cost (Gruber) ***If more shift***	**$1,510** ***$2,170***	**$400** ***$580***	**$650** ***$940***	**$240** ***$340***	**$220** ***$310***
Individual Contributions	$480 *$690*	- -	$100 *$150*	$160 *$230*	$220 *$310*
Total Subsidy Needed	**$1,030** ***$1,480***	**$400** ***$580***	**$550** ***$790***	**$80** ***$110***	**-** **-**
Federal Matching Payments	$250 *$360*	$250 *$360*	- -	- -	- -
Net State Cost	**$780** ***$1,120***	**$150** ***$220***	**$550** ***$790***	**$80** ***$110***	**-** **-**

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Table 4: Payroll Tax Revenue

Payroll Tax Revenue ($ Millions)	**All Employers (0.25%)**	**"Pay" Employers (4.75%) (Gruber)**	***"Pay" Employers (4.75%) (if more shift)***
No Personal Contribution	$20	$140	*$140*
Sliding-scale	$30	$80	*$100*
Tax Credit	$20	$50	*$60*
No Subsidy	$90	$200	*$200*
Total = $630	**$160**	**$470**	***$500***

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Table 5: Employer Spending

Employer Spending ($ Millions)	Before	After	Change	Percent Change
For Group Coverage	$8,000	$7,940	-$60	-0.8%
Payroll Fees	-	$630	$630	-
Total	**$8,000**	**$8,570**	**+$570**	**+7%**

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Table 6: Summary of State and Federal Costs

($ Millions)	Total	Federal	State
Cost of Public Coverage *If more shift*	$1,050 *$1,150*	$670 *$730*	$380 *$420*
Cost of New Exchange Population	$1,030 *$1,480*	$250 *$360*	$780 *$1,120*
State Income Tax Revenue Loss	$70 *$70*	- -	$70 ***$70***
Total Costs	**$2,150** ***$2,700***	**$920** ***$1,090***	**$1,230** ***$1,610***

Note: State costs are highly dependent on additional federal funds that would require waivers.

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Table 7: Summary of State Payroll Fee Revenue

($ Millions)	Total	Federal	State
Payroll Fee Revenue *If more shift*	$630 *$660*	n/a *n/a*	$630 *$660*
Summary of costs	$2,150 *$2,700*	$920 *$1,090*	$1,230 *$1,610*
Projected Additional Revenue Needed	**$1,520** ***$2,040***	**-** **-**	**$600** ***$950***

Decision Points for Adjustments to Modeling

- Federal match assumptions
- Affordability standard
- FPL bands for contributions
- Payroll fee level
- Per worker per hour requirement in addition to percent of payroll requirement
- Additional funding mechanisms necessary to meet reform goals

ERISA Implications for State Health Care Access Initiatives

Patricia A. Butler, JD, Dr.P.H.
Oregon Health Fund Board
Federal Laws Committee
March 25, 2008

ERISA

- Federal Employee Retirement Income Security Act of 1974
- Regulates private sector pension programs and (to a limited extent) employee welfare benefit programs, including health coverage
- Applies to all plans offered by private sector employers or unions (except churches) *whether offered through insurance or self-insured*
  - *Both types of plans are "ERISA plans"*

2

ERISA Preemption

- Preempts state laws that "relate to" employee benefit plans (including health plans) (even if they don't conflict with federal law)
- Exception to preemption:
  - State regulation of the business of insurance ("savings clause")
- But states cannot deem private employer or union plans to be insurers, therefore:
  - States cannot regulate ERISA plans directly, but by regulating health insurers, states can affect insured ERISA plans

3

ERISA Preemption

- Preemption applies despite limited federal regulation of ERISA health plans (in comparison with state health insurance standards)
- Object of preemption was to encourage employers to sponsor plans and not be subject to multiple, varying state laws
- Courts interpret meaning of preemption clause

4

Court Interpretations of ERISA's Preemption Clause

- Does state law "relate to" private union- or employer-sponsored health plan?
  - Does it refer to such plans?
  - Does it have a connection with such plans by:
    - Regulating areas ERISA addresses?
    - Regulating plan benefits, structure, or administration?
    - Imposing substantial costs on plans?

5

ERISA Preemption

- Increasingly broad court interpretation of preemption from 1974 to 1994
  - Narrowed in 1995 *Travelers* case (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance* (S. Ct. 1995))
    - Upheld NY hospital rate-setting law that could raise ERISA plan costs to some extent
- Basic tests for preemption remain:
  - State law cannot refer to or have a connection with ERISA plans

6

ERISA Preemption

- Courts have held that states cannot:
  - Require employers to offer health coverage (*Standard Oil v. Agsalud,* invalidating Hawaii employer mandate (9th Cir.1980))
    - NB: Hawaii's 1983 congressional exemption to its employer mandate
  - Dictate the terms of an ERISA health plan's coverage, employer's premium share, etc. (*Hewlett-Packard v. Barnes, holding* California HMO law inapplicable to self-insured employer plans (9th Cir. 1978)
  - Tax employer-sponsored health plans (*Bricklayers Local No. 1 v. Louisiana Health Ins. Assoc*., holding that state cannot assess self-insured employer plans to fund high risk pool (E.D. La. 1991)

7

ERISA "Savings Clause"

- Important exception to ERISA preemption:
  - State laws regulating *insurance* (as well as banking and securities) [can have access implications]
  - U.S. Supreme Court has recently simplified the test for what state laws constitute insurance regulation (*Kentucky Health Plan Assoc. v. Miller (S. Ct. 2003))*
    - Laws must be aimed at insurers and insurance practices (not just any insurer activities)
    - Laws must "substantially affect risk pooling arrangements" between insurer and insured

8

ERISA Implications for State Employer-Based Access Initiatives

- Mandates that would be preempted:
  - Requiring employers to cover workers or directly regulating contents or financial arrangements of employer- or union-sponsored plans (Standard Oil and Hewlett-Packard)
  - Standards applying only if an employer voluntarily offers coverage (*District of Columbia v. Greater Washington Bd. of Trade (*S. Ct. 1992))
  - Requiring health insurance to cover auto accident medical claims
  - Coordination of health insurance, disability coverage, and workers' compensation

9

ERISA Implications for State Employer-Based Access Initiatives

- Health coverage tax credits
  - As a voluntary incentive, should not be preempted
  - Arguably general tax powers are traditional exercise of state authority sanctioned by Supreme Court in 1995 *Travelers* case
- Requiring health coverage as a condition of participating in public works contracts
  - Some courts have held ERISA does not preempt public works contract employee benefits mandates under certain circumstances
- Prevailing wage laws
  - Some courts have held ERISA does not preempt state and local "total package" prevailing wage laws

10

ERISA Implications for State Employer-Based Access Initiatives

- Broad-based “Pay or Play” Initiatives
  - State creates a public program, financed partially with taxes on employers (not plans)
  - Employers offering employee health coverage receive a credit for coverage costs
  - Likely to withstand an ERISA challenge if:
    - Broad-based tax-financed program
    - State is neutral regarding whether employers offer coverage or pay tax [not a disguised mandate]
    - State does not set standards to qualify for tax credit or otherwise refer to ERISA plans

11

Maryland “Fair Share Law” & RILA case

- 2006 law required for-profit employers >10,000 workers to pay into state Medicaid fund difference between what they spend on employee health care & 8% of payroll
- In *RILA v. Fielder*, 4th Circuit Court of Appeals held ERISA preempts this law because it is ‘connected with’ ERISA plans

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RILA v. Fielder 4th Circuit Decision

- Law is a mandate not a tax
  - Targeted at plan of a particular employer and Wal-Mart indicated it would expand coverage rather than pay fee
  - Bill sponsors said it was intended as a mandate
- Court not persuaded that affected firm could satisfy law by health spending other than through establishing or expanding an ERISA plan
- Law interferes with multi-stat plans' uniform national administration
  - Conflicts with other state laws and proposals
  - Requires employer to segregate its expenditures in each state

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Suffolk County (NY) Court Decision
(RILA v. Suffolk County)

- County required large grocery retailers to make health care expenditures for workers in an amount that equals the per person cost of the county to treat an uninsured worker
  - Employer spending defined similar to MD law
  - Employer spending less than required amount would pay the shortfall to the county
  - Although not directed only at Wal-Mart, it would be affected by law and was one target
- Federal court held ERISA preempts this law
  - Analysis similar to that of 4th Circuit in MD case

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San Francisco Program

- SF "Health Access Program" = public health (hospital and clinic) delivery system for uninsured city residents
  - Enrollees pay sliding scale premiums
  - Employers pay a per-hour-worked assessment:
    - $1.17/hr: private employers with 20-99 workers or nonprofits with 50 or more workers
    - $1.76/hr: private employers with 100 or more workers
    - Spending defined broadly (reimbursement for employee health spending, HSA contributions, insurance, direct care costs)

15

San Francisco Program

- In late 2007 federal district court held ERISA preempts the law
  - Held ordinance refers to and is connected with ERISA plans
  - Applied 4th Circuit reasoning to hold that the ordinance requires a "mandatory level of coverage" and therefore regulates employer plan benefits
- Order stayed by 9th Circuit Court of Appeals pending appeal decision (January 2008)
  - Held city is likely to succeed on appeal because law is not benefits mandate but only a payment requirement
    - allows employer to choose to pay fee or create/amend an ERISA plan
  - Appeal to be heard in spring 2008 – decision later this year

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Massachusetts 2006 Health Care Access Law

- Requires all residents to obtain coverage (if affordable) or face income tax penalty
- Requires employers of >10 workers to:
  - offer section 125 plans (for employees to buy coverage w/ pre-tax $)
    - Or be liable for up to 100% of uncompensated care costs of employees & dependents with high uncompensated care costs
  - Pay up to $295/worker/yr (to fund uncompensated care) if at least ¼ of employees are not enrolled in plan or firm does not pay at least 1/3 of premium

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Massachusetts 2006 Health Care Access Law: ERISA Issues

- Even individual mandate could raise ERISA problems
  - Arguably, requiring individuals to have minimum coverage is an attempt to influence employer-sponsored plan design
- DOL policy: Section 125 plans are not ERISA plans
  - so arguably neither 125 plan mandate nor "Free Rider" penalty has 'connection with' ERISA plans
- "Fair Share" contribution arguably has an impermissible 'connection with' ERISA plans because exemption from fee depends on employer contribution levels
  - Low cost may not encourage employers to litigate
  - Business community broadly supported the law

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ERISA Implications for Raising Revenues for Access Initiatives

- Taxes directly imposed on employer- or union-sponsored plans
  - Would be preempted if applied directly to self-insured ERISA plans
  - Taxing insurers or health care providers should not be preempted, even if this imposes some costs on ERISA plans (3 post-Travelers Ct of Appeals decisions)
- Payroll taxes to support public programs (e.g., single payer) ought to be O.K. though they may be challenged as requiring employers that want to provide uniform multi-state plans to pay tax in violation of ERISA
- Employer pay or play requirements (not conditioned on coverage meeting standards)

19

Health Insurance Exchange Options

Presentation to the Finance Committee

Denise Honzel

March 19, 2008

What is an Exchange?

- A market organizer that facilitates the purchase of health insurance.
- Can offer a range of services:
  - Give individuals with purchasing advantages similar to a large group
  - Offer consumers an easy way to shop for and enroll in coverage
  - Give tax advantages to people not enrolled in employer-based coverage
  - Offer access to continuous, portable coverage
  - Simplify administrative functions for users
  - Administer public subsidies to low & moderate wage individuals, families
  - Give small employer groups access to a larger range of plan options than are usually available to small groups
  - Utilize value-based purchasing strategies that align with similar initiatives by state health care purchasers to improve the quality and efficiency of Oregon's delivery system

Health Insurance Exchange Issues

1. Who uses the Exchange?

2. What could an Exchange do for Oregonians?

1. Who Uses the Exchange?

- Categories of participants that could benefit from an Exchange
  - A. Individuals getting state premium contributions (income between 150-299% FPL)
  - B. Individuals getting tax credit for premium purchase (income between 300-399% FPL)
  - C. Individuals not eligible for employer's ESI, but who use Sect. 125 plan (income above 400% FPL)
  - D. Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)
  - E. Self-employed or non-employed individuals with income above 400% FPL
  - F. Employees of small employer groups
  - G. Employees of medium and large employer groups

Groups A and B – The Core of the Exchange

- Group A: Individuals getting state premium contributions (income between 150-299% FPL)
- Group B: Individuals using tax credits for premium purchase (income between 300-399% FPL)
- Rationale:
  - Most of these people are currently uninsured
  - Helps maximize the value of government contributions
  - Streamlines process for administering premium assistance and tax credit

Group C – Voluntary on an Employer-by-Employer Basis

- Group C: Individuals not eligible for employer's ESI, who use Section 125 plan (income above 400% FPL)

- Rationale:
  - Include part-time employees
  - Voluntary on an employer-by-employer basis
    - For seamlessness, these employees would ideally have the option of buying an individual plan offered by the same carrier in the direct market, or into the employer's group plan in the Exchange

Group D – Required Use of the Exchange

- Group D: Individuals working for non-offering employer, who use Section 125 plan (income above 400% FPL)
- Rationale:
  - Most are employed by “micro-employers”
  - Tend to move between subsidized and unsubsidized coverage as income fluctuates
    - Close to 70% are subsidy-eligible (Group A)
    - Nearly 30% will receive a tax credit (Group B)
    - The remainder will be in Group D
  - Improves continuity of care
  - Limits risk selection

Group E – Voluntary Participation in the Exchange

- Group E: Self-employed or non-employed individuals with income above 400% FPL
- Rationale:
  - Pros
    - Allows the exchange to prove its value as consumers “vote with their feet”
    - Less disruptive - allows individuals to stay with current carrier
    - Access to exchange services
    - Increases population to spread exchange’s fixed administrative costs
  - Cons
    - Danger of adverse risk selection unless regulatory and administrative steps are taken (such steps could restrict market offerings inside exchange)

Group F – To Be Determined

- Group F: Employees of small employer groups
- Pros and Cons
  - Offer choice to consumers, most of whom do not have a choice of carrier in their current small group coverage.
    - Could have a secondary effect on lowering costs and improving quality in the delivery system and insurance administration.
  - Reduce employers' administrative costs by delegating the benefits administration and enrollment functions to the exchange.
  - Danger of adverse risk selection and possible "rate shock"
    - Might need to combine individual and small group markets
    - Need more information on market disruption

Group G – Not Required to Use the Exchange

- Group G: Employees of medium and large employer groups
- Pros and Cons
  - Entry must be voluntary due to ERISA preemption of state regulation of health benefits for self-insured employers
  - Many large employers already offer choice of plans, have HR department
  - Selection concern: if voluntary option for employers, the exchange may face adverse selection

2. What Could an Exchange Do for Oregonians?

- Tier 1: Information, Enrollment and Administration
- Tier 2: Benchmarking and Standards
- Tier 3: Rate Negotiation and Selective Contracting

Tier 1 Functions

- Create a central clearinghouse for information about health plan and insurance product choices
- Design decision support tools and provide cost, quality and service transparent information
- Manage open enrollment process with efficient, user-friendly health plan enrollment
- Establish an eligibility confirmation and state premium contribution administration process
- Help employers and others to set up and administer Section 125

Tier 1 Functions (continued)

- Provide a mechanism to collect and aggregate premium contributions from multiple sources
- Ensure provision of customer services, (provide and coordinating with brokers and carriers)
- Administer risk adjustment mechanism to protect insurers who enroll high-risk members
- Train agents and brokers on exchange functions; connect people with educated agents, brokers

Tier 2 Functions

- All Tier 1 functions, plus…
- Establish standardized or comparable benefits offered by carriers to clarify and simplify the consumer choice process and minimize risk selection
- Establish performance benchmarks for carriers, including network adequacy, benefit design, price and quality outcomes

Tier 2 Functions (continued)

- Allow contracting for full packages of products and services from the carriers, or contracting separately for benefits or services that might better achieve benchmark performance
- Establish agent and broker role in distribution and marketing of plans offered in the exchange.

Tier 3 Functions

- All Tier 1 and Tier 2 functions, plus…
- Solicit bids or price proposals
- Negotiate prices and/or discounts with carriers
- Select which carriers would participate in the exchange

Implications of an Exchange with a Broad Range of Functions

- Likely to have greatest impact on lowering costs and improving quality
- Maximize the value of government contribution for low and moderate income people
- Rate negotiation may affect carrier participation
  - If fewer carriers participate, consumers will have less choice

Recommendation: Role of the Exchange

- The Work Group's discussions have led to a preliminary preference that the Exchange play a role that falls between Tiers 2 and 3
  - Strong benchmarking and standards
  - Some price negotiation and possible bidding process

Next Steps

- Finalize draft Exchange recommendations
  - Groups using an exchange
  - Functions an exchange will perform
- Build recommendations on additional issues
  - What will be the Exchange's governing structure?
  - How will the exchange be funded?
- Work Group will meet in April to finish its work

Modeling Health Care Reform

An Overview of Jonathan Gruber's Microsimulation Model

Alyssa Holmgren

Presentation to the Finance Committee

November 19, 2007

Goals of Modeling Health Care Reform

- To analyze comprehensive models for increasing access to health insurance
- Elements to consider in designing reform
  - Costs
    - State and Federal
    - Other
  - Movement (including crowd-out)
  - Participation rates
  - Revenue estimates

Source: A. Lischko, "Modeling Health Care Reform: What States Need to Know," Presentation at SCI Modeling Workshop, November 10, 2004.

Questions to Answer before Modeling Can Begin

- What policy options do you want to evaluate?
- What output do you require? Who is your audience?
- What data are available?
  - State, Federal, other
- Does the work require outside expertise?

Source: A. Lischko, "Modeling Health Care Reform: What States Need to Know," Presentation at SCI Modeling Workshop, November 10, 2004.

The Gruber Microsimulation Model

- Shows how policy changes affect the economy
- Inputs
  - Policy parameters
- Outputs
  - Impact on public sector costs
  - Distribution of insurance coverage
  - Effect on public sector revenues
- Similar to approach used by Treasury Department, CBO, and other government entities

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

The Gruber Microsimulation Model

- Demonstrates the effect of government interventions in health insurance markets
  - Impact of tax subsidies on employer insurance
  - Impact of public coverage on private insurance take-up (crowd-out)
  - Impact of lower health insurance costs for employers on employee wages

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Strengths of the Model

- Holistic approach
  - Considers the effect of interventions on all firms and individuals in the state
- Focuses on price
  - Can address multiple integrated policy approaches by converting their effects into price changes
  - Determines how firms and individuals will react to those price changes based on behavioral evidence from health economics
- Assesses firm reactions by looking at a set of workers within the firm and aggregating impacts to the firm level

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Potential Weaknesses of the Model

- Most reliable when comparing similar proposals that only differ along a small number of dimensions
- Relative impacts are more reliable than absolute impacts
- Estimates become more uncertain as we depart farther from existing experience in the insurance market

Source: J. Gruber, "Modeling Health Care Reform in California," Presentation, May 16, 2007. Available at http://calhealthreform.org/pdf/GruberStudy062807Addendum.pdf

Data Needed for Modeling Reform

- State
  - Individual Data
  - Employer Data
  - Insurance Market
  - Medicaid and other public program cost data
- Federal
  - Current Population Survey (CPS)
  - Medical Expenditure Panel Survey (MEPS)
- Other
  - Behavioral responses from literature
  - State-specific behavioral responses

Source: A. Lischko, "Modeling Health Care Reform: What States Need to Know," Presentation at SCI Modeling Workshop, November 10, 2004.

California-Specific Model

- California sample of the Feb/Mar 2001 CPS
- Updated with 2005 CA Health Insurance Survey data
- Premiums, cost-sharing, and offer rates by firm size updated with 2004 California-specific MEPS data, updated to 2007
- Cost of non-group policies difficult to determine

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

CA Specific Model – Policy Decisions

- Public insurance expansion
  - To what level?
  - Adults and kids?
  - Documented and undocumented?
- Central purchasing mechanism
  - Who is eligible?
  - Cost of policies available?
  - Cost sharing required?
- Individual mandate?
  - What qualifies as the minimum coverage required?
  - Effective for both documented and undocumented populations?
- Non-offering assessment
  - Which employers pay?
  - How much?

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Population Flows Pre- and Post-Reform

Table 1: Population Flows for Children & Documented Adults					
	FROM: Old Source of Insurance				
TO: New Source of Insurance	Public Insurance	Employer-Provided Insurance	Non-Group Insurance	Uninsured	New Totals
Public Insurance	5.9	0.3	0.1	1.2	7.6
Employer-Provided Insurance	*	17.5	*	0.8	18.3
Non-Group Insurance	0	0	1.6	0.8	2.4
New Pool	0.2	0.6	0.1	1	1.9
Uninsured	0	0	0	*	*
Old Totals	6.1	18.3	1.9	3.8	30.1

Note: Population counts shown in millions. Totals may not sum due to rounding

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Net Changes in Insurance Status Due to Reform

Table 2: Net Changes in Population for Entire Population (Under Age 65)			
Insurance Source	Before	After	Change
Public Insurance	6.6	8.1	1.5
Employer-Provided Insurance	18.8	18.8	0
Non-Group Insurance	2	2.7	0.7
New Pool	0	1.9	1.9
Uninsured	4.9	0.8 *	-4.1
Total	32.2	32.2	0

Note: Population counts shown in millions. Totals may not sum due to rounding.

* These individuals will be covered by the counties.

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

Effects of Reform on Public Spending

Table 3: Effects on Public Insurance Spending			
Eligibility Category	Net Change in Public Enrollment (millions)	PMPM ($/month)	Total Cost ($ millions /year)
Children Under 100% FPL	0.25	103	310
Children 100-250% FPL	0.55	103	655
Children 250-300% FPL	0.1	103	125
Adults, Previously Eligible	0.25	177	530
Adults, Newly Eligible	0.4	177	830
Total	1.5		2450

Source: J. Gruber, *Modeling Health Care Reform in California*, prepared for The California Endowment and the California HealthCare Foundation, February 2, 2007. Available at http://gov.ca.gov/pdf/press/Gruber_Modeling_Health_Care_Reform_In_California_final_study_020207.pdf

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

Financing coverage for Oregon's uninsured

John McConnell, PhD
Oregon Health & Science University

Objectives of this talk

- Review of health care costs
  - Why is health care in the U.S. so expensive?
  - Why do health care costs go up?
  - Uncompensated care in Oregon
  - Variations in care
  - Chronic illness
  - Evidence on markets
- The cost of covering the uninsured
  - Review of Health Policy Commission model and estimates

Why is health care in the U.S. so expensive?

Why is health care in the U.S. so expensive?

- U.S. per capita spending 2.5 times greater than median Organization for Economic Cooperation and Development (OECD) country
- 50% higher than the second highest (Switzerland)
- Why so much higher than other countries?

“It’s the prices, stupid.”

Anderson et al, Health Affairs 2003

- Expenses = Price * Quantity
- Utilization measures are lower
  - Fewer physicians, nurses, and hospital beds per capita than OECD median
  - Fewer office visits, acute care bed days, shorter inpatient bed stays than OECD median
  - MRI/CT scans equal to OECD median
- Prices are higher
  - Oregon insurance CEOs focus on “unit price increases”
  - Payments to providers
  - “Quality” of services
    - Some of this is good, some of it is questionable

Why do health care costs go up?

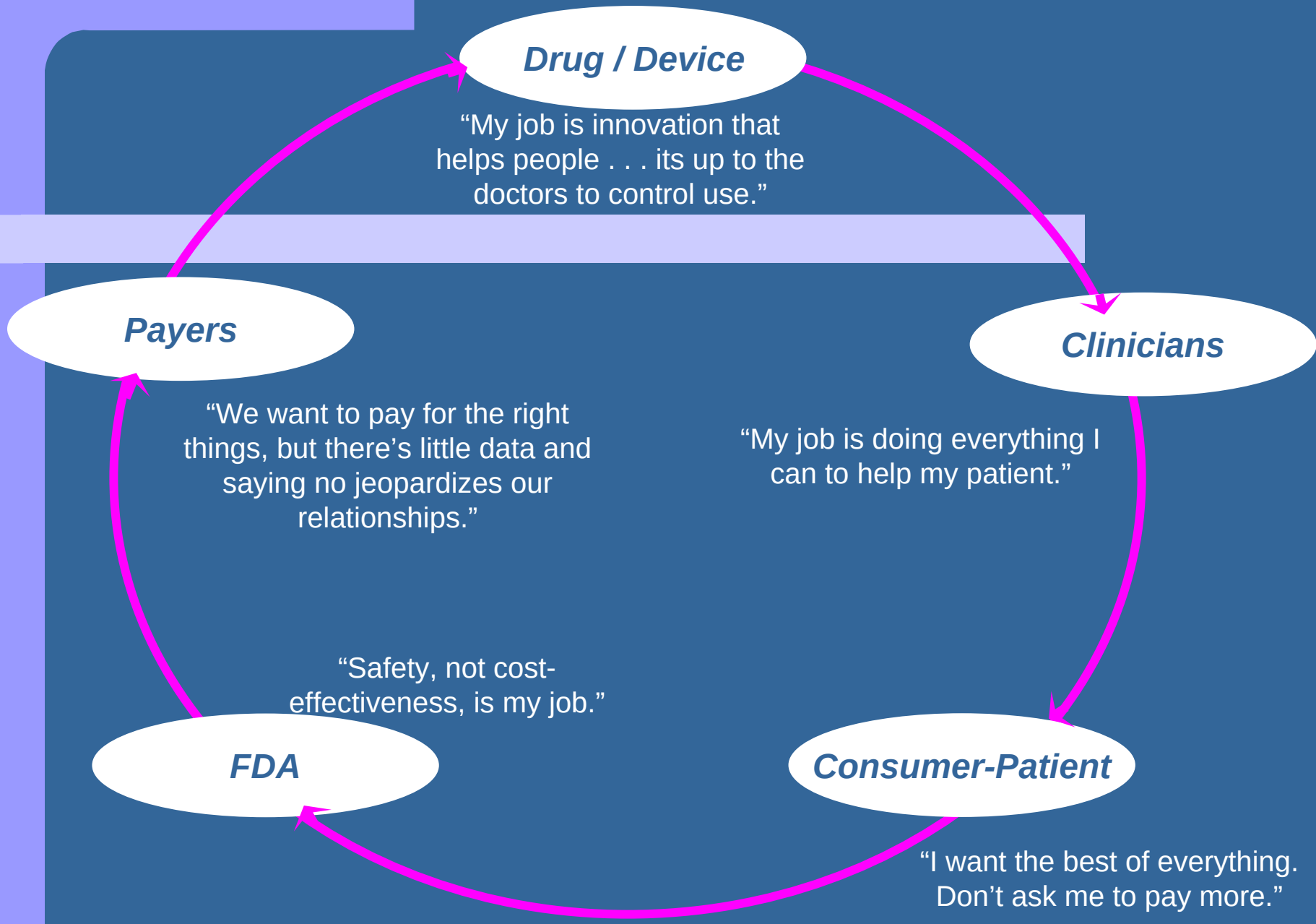
Why do health care costs go up?

- Costs are high, but *will get higher*
  - In the US and in the OECD
  - The rate of cost increases is similar across countries
  - Just hurts us more because our baseline levels are so high to begin with
- What drives health care costs up?
  - Lots of little reasons
  - One big one….

Technological change

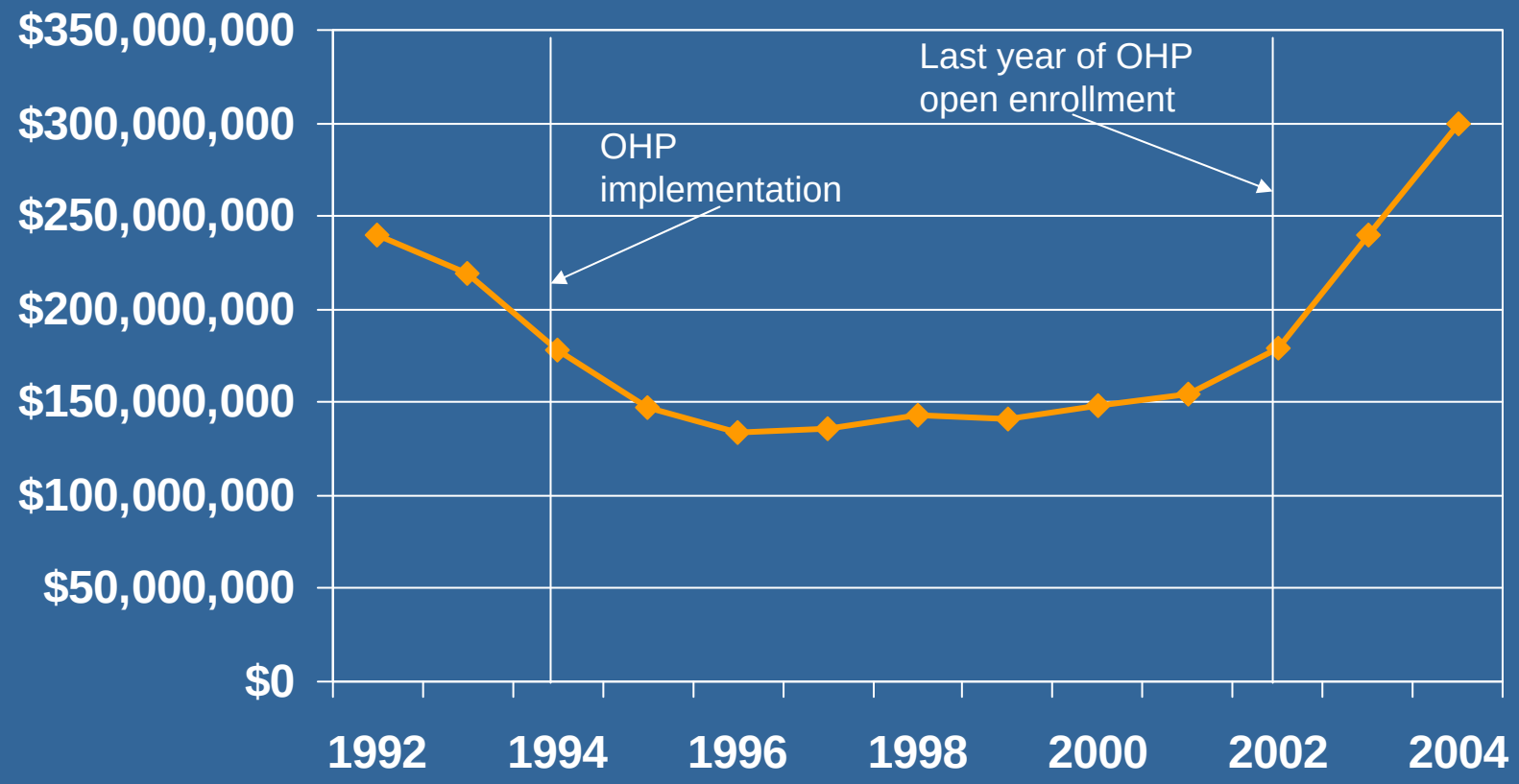
- New procedures, drugs, equipment
  - Many of which lead to longer, healthier lives
  - All of which increase total health care costs
- Example:
  - 1956: heart disease = death
  - 2006: heart disease + $40,000 = life
- Spending related to new technology (procedures/drugs/devices) accounts for 50% to 75% of increases in spending

The Cycle of Unaccountability



Uncompensated care and cost shifting in Oregon

Uncompensated care in hospitals in Oregon



Uncompensated care in Oregon (preliminary estimates)

- 2004 hospital uncompensated care: $299M
  - Total uncompensated care for 2004 estimated to be $425M
- What is the burden on those with commercial insurance?
  - Approximately 6% - 9% of 2004 Oregon family premium of $9,906

Health reform & the cost-shift

- Cost shifting not a viable long-term strategy
  - An “inefficient” hidden tax
  - Implicit agreement to support catastrophic care over preventive care
  - Adds to the increasing cost of commercial premiums and erosion of employer-sponsored health insurance
- The magnitude of uncompensated care in Oregon is large
- Substantial savings for employers/employees from policies that cover the uninsured
  - But need to consider polices to insure savings actually get to employers/employees

Variations in care

Variations

- The Wennberg variations
  - Pick your procedure (Back surgery, MRIs, CABG, Vioxx) and your region (states, counties with states)
  - E.g., Medicare's costs per enrollee by region varied from $4,500 to nearly $12,000 in 2003
  - Better outcomes not associated with higher spending
  - Estimates of 20% - 30% of spending could be eliminated
- Big savings – how to capture it?
  - More rigorous use of evidence-based medicine
  - Investment in Information Technology
  - Better coordination of care

Chronic Illnesses

Spending on chronic disease

- 5% of the population accounts for 56% of health care expenditures
- Fastest area of health care cost growth
- Bodenheimer: “Can we decrease costs for our sickest patients by 50%?”
  - Large theoretical savings from disease management/EMR/HIT
  - “Care Management Plus” model at OHSU – nurse-based care management + IT for patients with multiple chronic illnesses

Markets and competition

A lot of interest in what markets and competition can do for health care

- This is a natural response
- Markets are the “American way”
- Concern about moral hazard
  - Consumers aren’t consumers
  - More shopping would lead to better utilization and/or lower prices
  - Focus on consumer-driven health plans (CDHP), high deductibles, health savings accounts (HSAs)

Markets – supply side and demand side

- Supply side
  - Focus on the provider/health plan
  - *Ex ante* price setting
- Demand side
  - Focus on the patient/consumer
  - *Ex post* price setting

Supply side – the evidence

- Focus on provider
- Real (inflation-adjusted) health care spending was flat for much of the 1990s
- Complaints from providers & patients
  - But no observed quality/outcome problems
- How did managed care do it?
  - Most savings came from rate reductions & provider discounts
  - Not from gatekeeping, better utilization review or other ways of managing care
- Were there “process improvements” from providers?
  - Some – but a lot of focus on achieving counterbalancing market power
  - Some lessons from prepaid group model
    - Freedom from FFS & chances to innovate (group visits)
    - Some evidence of process improvements, costs savings

Demand side – the evidence

- Yes, in fact, moral hazard exists
- BUT – savings smaller than you would think
- Co-payments/deductibles have the biggest impact on access, not on price
  - Whether or not you go
  - Not how much you pay once you are there.
- Estimated savings if *everyone* moved into Health Savings Account:
  - Range of 2.5%-7.5%
  - One-time only savings – does not do much for the technology problem
- Evidence on HSA take-up
- Co-payments for poor/Medicaid populations?

Can markets tackle long-term growth?

- In 2007, TramGenix releases a cure for Alzheimer's. Cost: $20,000/year
  - This is great! (and "cost-effective" by conventional standards)
  - 50K Oregonians with Alzheimer's, another 26K with related disease
  - Implies an additional $3000 in health premiums or taxes for an Oregon family of four
  - Best estimate: adds another 100K to 200K to uninsured through increased premiums
  - This is bad!

- It is very difficult to manage a drug that costs $20,000 (or $100,000) with no substitute
- Is there a market solution for this problem?

Summarizing markets

- If markets have been successful at cost control, it has been primarily by extracting discounts from providers (supply side)
  - i.e., impact on “price” not “quantity”
  - Public programs can do this, too
- Evidence on savings from “consumerism” is real but so far relatively small
- Markets don’t have a great answer for the technology-cost relationship
- Markets don’t do subsidies

Covering the Uninsured – the Cost to Oregon

OHPC modeling based on 3 building blocks to expand coverage

- Individual health insurance requirement/mandate
- Extending publicly financed coverage and insurance premium subsidies to more Oregonians
- Health Insurance Exchange

Assumptions

- Reform occurs in 2008.
- 100% coverage (0% uninsurance)
- OHP eligible to any individual with income <200% FPL
- Uncompensated care is estimated to be $540 million per year in Oregon
- Crowd-out is estimated to be 25%
- No subsidies for those currently covered with ESI (“firewall”)
- Subsidies for commercial premiums are such that the individuals spending on premiums is capped according to the following schedule:
  1. Individual with incomes between 100% and 200% FPL have spending for premiums capped at $720 for adults and $360 for children
  2. Individual with incomes between 200% and 300% FPL have spending for premiums capped at $1,440 for adults, $720 for children
  3. Individual with incomes above 300% FPL do not have spending caps on their premium spending

Basic structure

- Model has three components
  - Enrollment
    - Medicare
    - Medicaid (by PERC)
    - Commercial (ESI/Individual)
    - Uninsured (by FPL)
  - Spending on health services
    - Medicare (ok data)
    - Medicaid by PERC (good data)
    - Commercial (weak data)
    - Uninsured (decent estimate based on hospital uncompensated care)
  - Cost of coverage
    - Medicaid
      - Based on spending + administrative overhead + federal match
    - Commercial
      - Based on spending + admin. overhead + allows for savings from reduced uncompensated care

Outputs of interest defined as

- Total state spending (OHP/Medicaid *plus* premium subsidies)
- Federal match (non-Medicare spending)
- Employer spending
- Individual spending on premiums

- Results are annual figures (not biennium)
- Results are for adults & children

Current snapshot of the uninsured

	Adults	Children
<100% FPL	89K	18K
100%-200% FPL	144K	34K
200%-300% FPL	78K	26K
>300% FPL	173K	31K
Total	484K	109K

The next step: implementing policy

- UNINSURED – assume universal coverage (i.e., no uninsured)
- Individuals under 100% FPL:
  - Assume 100% moved into OHP/Medicaid
- Individuals at 100%-200% FPL:
  - Assume 80% moved into Medicaid
  - Assume 20% purchase ESI with 80% premium subsidy
- Individuals at 200%-300% FPL:
  - Assume 50% purchase individual insurance with 50% premium subsidy
  - Assume 50% purchase ESI with 50% premium subsidy
- Individuals at >300% FPL:
  - Assume 34% purchase individual insurance (no subsidy).
  - Assume 66% purchase ESI (no subsidy).

Integration with Employer Sponsored Insurance (ESI) *[J.Gruber]*

- Low income pool – how to treat those with ESI? Three alternatives

1) Firewall – MA approach – but 30,000 are excluded from affordable coverage

2) Premium assistance
  - sounds attractive, since many uninsured are offered ESI – leverage employer dollars
  - But it is actually incredibly expensive

Premium Assistance: Facts *[J.Gruber]*

- *Fact #1:* Among those who are offered ESI below 300% of poverty, vast majority take it
  - Below 100% of poverty: of all offered, only 25% uninsured
  - 100-200% of poverty: 13% uninsured
  - 200-300% of poverty: 6% uninsured
- Implication: if you offer premium assistance to low income populations, most of those eligible already have coverage!
- Great for horizontal equity – not for coverage

Premium Assistance: Facts *[J.Gruber]*

- *Fact #2*: Among those offered ESI who are uninsured, price sensitivity is very low
  - After all, these individuals were already offered a very large subsidy and declined!
  - These are folks who don't want insurance
- *Fact #3*: If you subsidize employee contributions for a sizeable share of employees, employers will raise those contributions!

Premium Assistance: Implications *[J.Gruber]*

- Simple example: 1000 persons below 300% of poverty offered insurance at $2000/year – 100 of them are uninsured
- Offer premium assistance of $1000/person
  - 750 of 900 already taking ESI take assistance
  - 25 of 100 not offered ESI take assistance
- Cost: $775,000
- Newly covered: 25 persons
- Costs/Newly covered: $31,000!
- Not unreasonable: Gruber's study of impact of Section 125 for Federal employees found cost per newly insured of $31,000 to $84,000

Alternative #3: Vouchers *[J.Gruber]*

- Allow employees to come to the pool with employer dollars
- In theory, same as premium assistance
- In practice, perhaps less expensive because employees who are covered are reticent to drop that coverage and move to the pool
- But still expensive per newly insured
- Bottom line: Hard choices on low income ESI eligible
- Our estimates assume a firewall

Individual market coverage and income

	Adults	Children
<100% FPL	**15K**	**6K**
100%-200% FPL	**21K**	**11K**
200%-300% FPL	33K	11K
>300% FPL	68K	42K

ESI market and income

	Adults	Children
<100% FPL	**38K**	**26K**
100%-200% FPL	**129K**	**89K**
200%-300% FPL	213K	100K
>300% FPL	1000K	300K

When does crowd-out from ESI happen?

- Some happens with job turn-over
- But biggest threat is likely to be firms with large % of low-wage employees
- Approximately 150K to 200K receiving ESI from firms where the majority of employees are low wage (<$10 hr)
  - About average for the country

Results

Outputs of interest defined as

- Total state spending (OHP/Medicaid *plus* premium subsidies)
- Federal match (non-Medicare spending)
- Employer spending
- Individual spending on premiums

- Results are annual figures (not biennium)
- Results are for adults & children

Where do the uninsured go?

	Uninsured adults & children pre-policy		OHP	ESI	Indiv. Mkt.
<100% FPL	107K	→	107K	-	-
100%-200% FPL	178K	→	142K	36K	-
200%-300% FPL	104K	→	-	52K	52K
>300% FPL	204K	→	-	134K	70K
Total	603K	→	249K	222K	112K

Population	Baseline (status quo)	100% coverage	Difference
Uninsured children	109	0	-484
Uninsured adults	484	0	-109
Children covered through OHP/Medicaid	211	278	+67
Adults covered through OHP/Medicaid	220	483	+263
Children covered through ESI	515	550	+35
Adults covered through ESI	1,380	1,540	+159
Children covered through ind. market	70	76	+6
Adults covered through ind. market	137	199	+62

Results: spending

	Baseline (status quo)	HPC Policy (100% coverage)	Δ
State	$831M	$1,379M	+ $548M (66%)
Federal match (non-Medicare)	$1,287M	$2,134M	+ $847M (66%)
Employer	$5,472M	$5,506M	+$34M (1%)
Individuals (spending on premiums)	$2,318M	$2,247M	-$71M (-3%)

Rationale

- State spending up $548
  - $496 from OHP/Medicaid enrollment
  - $52M for subsidies going to previously uninsured
- Employer spending relatively flat
  - Greater number of employees covered, but some savings from reduced uncompensated care
- Individual spending slight decline
  - More people covered, but large number 100%-300% FPL with ESI who become eligible for new subsidies

Thank you…

…and questions?

503.494.1989
mcconnjo@ohsu.edu