Rethinking State Health Insurance Market Structure and Regulation

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System Problems

- Growing uninsured population.
- Coverage instability.
- Increased cost of coverage.
- Coverage issues impede making delivery system:
  - More effective (continuity, coordination and appropriateness of care).
  - More efficient (reduced overhead).

Economic Factors

- Employment that varies from ESI premise of stable jobs at large firms.
  - Independent/contingent workers.
  - Self-employed.
  - Workers with multiple jobs.
  - Part-time and/or seasonal workers.
- Disproportionate administrative burden of ESI for small firms.
- Group insurance actuarially unsound below a certain firm size.

Medical Science Factors

- Wider variations from the mean in individual costs.
  - Cause: New medical therapies.
  - Effect: 'Community-rating' of ESI undermined.
- Greater predictability of individual costs.
  - Cause: Conversion of acute conditions into chronic conditions.
  - Effect: Increased selection behavior.
- More frequent asymmetries of information.
  - Cause: Sophisticated diagnostic technologies.
  - Effect: Insurance principle undermined.

Implications

- Transformation in the purpose of health 'insurance.'
  - Compensation for loss => pre-payment of medical care.
  - Cross-subsidization based on risk => cross-subsidization based on health status.
- Employment-based system impeding economic dynamism/growth?

Key Needs

- True portability of coverage.
- Regular opportunities to change coverage without new underwriting.
- Wider choices of coverage to suit the preferences of individual consumers rather than the interests of employers.
- A fairer spreading of risks and costs.

Reform Principles

- Consumer-Centric
  - Competition for consumers drives plan and benefit designs.
- Individual Choice
  - Both among plans and plan types.
  - Fair rules for changing coverage.
- Portability
  - Keep, or seamlessly switch, coverage when personal situation changes.
- Universality
  - Erase or transcend current market segmentation.
  - Improve infrastructure for subsidizing coverage.

Elements of Solution

- Insurance Exchange - 'One-stop shopping' for coverage.
- Payment Aggregator - Combine contributions from multiple sources.
- Uniform Rules - Enrollment, rating, underwriting.
- Pooling/Cross-subsidization - Market-wide mechanisms.
- Risk Adjustment - Keep plan competition focused on value.

#1 Insurance Exchange

- Central place to offer/obtain coverage. Like a stock exchange.
- Multiple access avenues - Individuals directly, employers, brokers, government, private social service entities.
- HR Function - Administer enrollment, open season.
- Limited to major medical plans.
- No regulatory functions - clearinghouse only.
- Self-funded, independent - GSE model.

#2 Payment Aggregator

- Added functionality to market exchange.
- Operate payroll withholding system.
- Individual billing, account management.
- Private social service entities could subcontract.
- Could integrate public program premium support and even administer eligibility.
- Assumes payment risk now held by plans.
- Acts like a giant TPA offering a single menu of diverse plan choices.

#3 Uniform Rules

- Blend best features of current group and non-group markets.
- Rating factors - Age, geography, rating bands?
- Standardize coverage duration and election.
- Seamless transitions across remaining regulatory divisions (e.g., state/federal).
- Reward continuous coverage, penalize delayed enrollment.
- Incentives (mandates?) for healthy to buy coverage.

#4 Pooling/Cross-subsidization

- Risk pool requirements:
  1) Large, 2) Stable , 3) Random
- Selection in/out of pool (first order) much more important than selection within the pool (second order).
- Ways to get a good pool.
  - Combine market segments.
  - Enroll employment groups (include state/local government workers).
  - Default enrollment mechanisms.
  - Residency/employment screens.

#5 Risk Adjustment

- Principally to address second order selection (within the pool/market).
- Insurer funded and operated (no external funding or interference).
- Similar in design to high risk pools.
  - Market-wide application.
  - Required carrier participation/funding.
- But 'back-end' mechanism.
  - High risk have same coverage options as everyone else.

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Overall Effects

- Inverse of previous small-group reforms.
  - Old approach: Standard coverage offered by diverse array of employer plans.
  - New approach: Diverse coverage choices offered as a standard menu by all employers.
- Auto market analogy:
  - Henry Ford: 1kind of car - many dealerships.
  - CarMax: 1 dealership - many kinds of cars.
- Personal, portable coverage that qualifies as 'employer group' coverage eligible for existing tax subsidies.

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Advantages of Approach

- Focused roles:
  - Exchange/Aggregator - Handles HR functions.
  - Plans - Compete on care management.
  - Employers and Public Programs - Handle bookkeeping and financial optimization (tax benefits/subsidies).
  - Consumers - Needs/preferences drive market responses.
- Better foundation:
  - Single system organizes coverage for a diverse population with differing needs and preferences.
- Flexible - can scale size/scope.

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Implications for Individuals

- One place/system to get/change coverage with simple, predictable rules.
- Can chose the plan they prefer - not stuck with someone else's choice.
- Coverage is portable.
- Premiums increase with age, but can still switch coverage at standard rates even if health status deteriorates.
- Consumer needs and preferences drive plan designs.

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Implications for Employers

- No need to pick plan - employees do.
- Exchange/Aggregator handles 90%+ of administrative burden.
- Can focus on core business.
- Compensation issues reduced to setting total amounts and then allocating in most attractive/tax favored way for workers.
- New hires come with coverage.
- Better control over the impact of 'trend' in health costs on business profitability.

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Implications for Insurers

- Exchange assumes payment risk - ensures premiums are paid.
- Exchange becomes continuation coverage.
- Competition based on delivering value to consumers - not on risk segmentation.
- Increased focus on care management and optimizing efficiency/outcomes.
- Encourages innovation in plan offerings.
- Rules control selection in/out of market.
- Market-wide risk adjustor tool.

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Implications for Brokers

- Get standard commission for sending individuals/groups to Exchange.
- Can offer benefits counseling to individuals and groups.
- Could sell supplemental/cafeteria plans to more small businesses.
- Sales of supplemental/limited benefit plans to individuals unaffected.

Implications for Providers

- More insured patients = less uncompensated care.
- Helps shift focus of provider competition from cost to quality of care and outcomes.
- A central place to refer patients without coverage.
- Government able to convert provider subsidies into coverage subsidies.

Implications for State Government

- More insured = less uncompensated care.
- Easier to convert funding for provider subsidies into coverage subsidies.
- Easier to mainstream Medicaid/SCHIP enrollees and shift from all or nothing coverage to sliding-scale subsidies.
- DOH free to focus on eligibility and enrollment instead of on managing plans.
- Creates new opportunities to partner with private social-service entities to reach hard to insure sub-populations.

Implications for Health System

- Ensures continuity of coverage.
  - Eliminates coverage gaps.
  - Greater continuity of care
  - Long-term provider-patient relationships = better outcomes.
- FEHBP experience with plan choice - once consumers find a plan they like, they stay with the plan for years.
  - Plans can capture more back-end savings from front-end focus on prevention/early intervention.

Implementation Options

- State
  - Pro - Can change most market rules/structure.
  - Con - Must 'work-around' federal law (tax code, ERISA/HIPPA, Medicaid/SCHIP).
- Federal
  - Pro - Can change federal laws/programs.
  - Con - Must incent state reforms, or preempt state law.

Current State Initiatives

- District of Columbia - Draft legislation
- Massachusetts - Bill in conference
- Maryland - Legislation introduced

DC vs. MA vs. MD Proposals

	DC	MA	MD
Exchange	Yes	Yes	Yes
Aggregator	Yes	No	Yes
Limited number of plans	Yes	No	No
Group market	Yes (any size firms)	Yes (small firms)	Yes (small firms)
Sec. 125 assistance	No	Yes	No
State employees	Yes	No	Yes
Separate non-group market	Yes	No (?)	No
Individual mandate	No	Yes	No
Rating	Age, with bands	Community	Modified community.
Insurance mandates	Included	Can be waived	Repealed
Premium support	No	Some	Not yet
Reinsurance	Yes, all market, private	Yes, limited, public	Yes, all market, private

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Assessment of DC vs. MA

- DC takes more of the burden off employers.
- DC casts a wider net.
- DC has better rating rules.
- DC has broader risk-adjustment.
- MA has stronger selection controls.
- MA converts uncompensated care subsidies.
- MA has individual mandate.

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