Market Stability Workgroup

Date of Meeting: November 20, 2019
Meeting Time: 9:30 am
Meeting Location: United Way of Rhode Island
50 Valley St., Providence RI 02909

Workgroup Members Present: Co-Chair Marie Ganim, Co-Chair Lindsay Lang, Monica Auciello, Mike Ayotte, Marc Backon, Steve Boyle, Sarah Bratko, Al Charbonneau, Dave Chenevert, Ralph Coppola, Shamus Durac, Dr. Peter Hollman, Dr. John Luo, Joyce Therrien, Scott Mathieu, Elizabeth McClaine, Jamie Moran, Susan Storti, Melissa Travis, Larry Warner, John Marcantonio

Workgroup Members Absent: Marcela Betancur, Erin Donovan-Boyle

Minutes

I. **Meeting was called to order** at 9:33 am by Commissioner Ganim. Commissioner Ganim asked for any comments on the minutes, there was one edit to the attendance.

a. Commissioner Ganim introduced Sabrina Corlette, with Georgetown University's Health Policy Institute. Sabrina what other states have done to improve their small group market, and what options make the most sense for Rhode Island.

b. Commissioner Ganim reviewed the agenda for the meeting, followed by the guiding principles.

c. Signed contract with Rhode Island Foundation to do the employer survey.

d. Lindsay Lang introduce Sabrina Corlette, a research professor, founder, and co-director of the Center on Health Insurance Reforms (CHIR) at Georgetown University's McCourt School of Public Policy. At CHIR she directs research on health reform issues, with a focus on state and federal regulation of private health insurance. She provides expertise and strategic advice to individuals and organizations on health insurance laws and programs and provides technical support through the publication of resource guides, white papers, issue briefs, blog posts and fact sheets. She has testified numerous times before the U.S. Congress and is frequently quoted in the news media on emerging health care issues. She has published dozens of papers relating to the regulation of private health insurance and health insurance marketplaces. Prior to joining the Georgetown faculty, Ms. Corlette was Director of Health Policy Programs at the National Partnership for Women & Families, where she provided policy expertise and direction for the organization's advocacy on health care reform.

II. Insurer Presentations on the Small Group Market

a. Sabrina provided a brief overview of Georgetown's Center on Health Insurance Reform (CHIR):
   - A team of experts on private health insurance and health reform
   - Conduct research and policy analysis, provide technical assistance to federal and state officials and consumer advocates
   - Based at Georgetown University's McCourt School of Public Policy

b. Sabrina began her presentation by describing two competing visions in regards to insurance regulation; the first is a scenario where everyone is put into the same risk pool and the second is everyone gets their own pool. In the first scenario all businesses must play by the same rules, in the small group market this includes the same risk pool, rating requirement, essential health benefits, and risk adjustment. The alternative to have an escape valve in the market, healthier younger groups can get out from under the rules and get lower more affordable rate, but that leaves out the older group and women of child bearing ages.

   The goal today is to look at different policy options of how to address declining offer rates in the small group market in RI. Potential policy options have been bucketed into four categories: (1) Products, (2) Rates and incentives, (3) Employer/consumer protections, and (4) Market structure

c. **Products**

   Alternative Plan Designs: Narrow Networks, Reduced Benefits
   Plan options can be more affordable if provider networks are narrowed
   - Pros: (1) Reducing benefits through increasing cost sharing or changing benefit design (2) Narrow network doesn't necessarily mean lower quality (3) Price concessions from providers.
   - Cons: (1) Rhode Islanders like broad networks and rich benefits, one the questions are if narrow network products are built will employers choose them? (2) cost shift to employees (3) less choice of providers, difficult to narrow networks with employees living/working in different states

   i. Ralph Coppola asked if Rhode Islanders like certain products or are they just used to them?
   ii. Sabrina responded that RI is heavily broker dominated, and the products brokers are promoting and presenting to employers can have an influence on choice. There is not a lot of incentive for them to promote different products

   Microgroup Targeted Products, Administration
   Micro groups are defined as fewer than ten employees, micro groups have the lowest offer rates in the small group market. This tends to be an underserved community and one of the questions to ask is are there ways to incentivize brokers and carriers to service this community? Also does the promotion of health reimbursement arrangements (HRAs) make

sense? Health reimbursement arrangements are a tax deferred account that the employer puts a set amount of money into from which the employee can buy coverage through exchange or the market off the Exchange. An employer cannot offer a group plan and an HRA, they have to choose one or the other. Another option to push enrollment through SHOP and encourage full choice option.

- Pros: (1) Better customer service, (2) products may be a better fit, (3) improve the risk pool in the larger small group market, (4) employee choice through SHOP
- Cons: (1) greater administrative costs, (2) cost-shift to employees (HRAs), (3) uncertainty in the individual market, (4) potential for adverse selection

Alternative Provider Payment Methods

Alternative provider payment methods (APM) addresses the cost side of the healthcare equation. Terms such as accountable care organizations, bundle payments, patient centered medical homes are all examples of different types of APMs. APMS essentially ask providers and provider groups/healthcare systems to live within a budget and if the cost of care exceeds that budget, the provider/group takes on that additional risk. This can do a lot address underlying cost drivers utilizing additional strategies such as building in quality metrics into the APMs. Challenges with APMs are providers have to work with commercial payers and agree to contracts that include these APMs, concerns about access issues, and in the Medicare programs there have been some modest savings, there is no evidence that there is a huge return on investment. There are also places in the country with consolidated provider groups who have the ability to not work with carriers around APMs

- Pros: (1) Addresses underlying cost drivers, (2) Pay for quality, not volume, (3) Alignment with other payers
- Cons: (1) Will providers agree to participate in APMs, (2) Access issues for patients, (3) Lack of evidence on ROI

Encourage SHOP enrollment with full choice.

Employers who purchase coverage through SHOP can offer full choice in which employees can have choice of insurance companies and plans. The ability for employees to choose lower cost plans means potential of lower costs for the employers. Experience nationally has been mixed. The cost of running SHOP in some cases exceeds the amount of revenue brought in. There is recent data out from Massachusetts demonstrating employers were saving on average 20% on premiums by purchasing through SHOP. Specifically, employees choosing a plan through SHOP are choosing narrow network plans and driving down costs for employers.

- Pros: (1) Employers able to offer choice of insurers, plans, (2) Ability to choose lower-cost plans can mean lower costs for employers
- Cons: (1) Investment needed (marketing, maybe additional tax credits), (2) Is there insurer interest, (3) is there broker interest?

i. Al Charbonneau asked if for all these options, if the cost of running SHOP is factored into premiums?
ii. Sabrina responded that this is already done generally through an assessment on carriers and reflected as part of the premium.

iii. Scott Mathieu asked do employees choosing a narrow network plan understand what they are purchasing?
iv. Ralph Coppola commented that as a broker he is seeing that employers are putting considerable thought into the plan they are selecting as a benchmark plan, and employees with full choice are doing the same. This indicates that employees are at least somewhat knowledgeable of what they are purchasing.
v. Jamie Moran commented when you start offering more than one or two options, it forces the customer to stop and think about the plans they are choosing and not just consider premium price.
vi. Monica Auciello added that BCBS's experience on SHOP is that choice is price driven unless a customer needs a rich plan. The premium is not sufficient to offset the high utilizers of the richer plans if everyone else is choosing a plan with a lower premium. This is something that would have to be monitored closely if the market was to expand.
vii. Sabrina responded that in theory risk adjustment should account for that but you do run into selection issues. SHOP has not taken off nationally, one of the reasons is carriers concerns about selection issues. And with brokers, incentive is with direct purchase through the carrier and working one on one with employees takes more time.
i. Lindsay Lang commented that we have in some ways bucked the national trend with just over 11% of the market on the Exchange. Of the employers who purchase through HSRI, about 97% are exercising the full choice option.
ii. Sabrina asked Ralph if going through SHOP was more work than it would be to go directly through the carrier?
iii. Ralph Coppola responded that RI is unique because there is a lot of support from the HSRI staff who are extremely knowledgeable about all of the options available. The extra support makes the entire process smoother.
iv. Jamie Moran added that in RI, the support for SHOP makes the job easier for smaller groups purchase healthcare. A lot of the responsibility gets transferred over to the HSRI team to enroll.
v. Sabrina commented that New York has recently discontinued their SHOP program and transitioned to direct enrollment through the carriers.
vi. Jamie Moran suggested giving customers the tools to make good decisions.
vii. Commissioner Ganim – time constraints.

d. **Rates and Incentives**

Reinsurance for the small group market
RI is already reaping the benefits of reinsurance in the individual market which has been demonstrated by the decreased rates for 2020. However, there is question if the effort is worth the outcome. Reinsurance requires an injection of resources and where those resources come from are something to consider. There are also administration and oversight costs associated with it.

- Pros: (1) lowers premiums (2) Likely to increase offer rates
- Cons: (1) requires investment up front (2) can require significant administration

Target Employer Incentives for Coverage
Can incentives be created for employers to participate in the small group market either in the form of tax relief or tax credits.

- Pros: (1) likely to increase offer rates (2) make coverage more affordable for lower-income individuals
- Cons: (1) Requires state investment, (2) doesn't address underlying cost drivers

i. Al Charbonneau asked if the reinsurance program, is it a one time hit and a short-term solution?
ii. Sabrina responded that it will lower premiums right away, but the reinsurance pool has to be maintained over time. Generally, reinsurance programs result in a onetime reduction in premiums
iii. Ralph Coppola added even though it is a onetime reduction in premium it creates stability for employers and the carriers.
iv. Steve Boyle asked if there is any data around HRAs and employers shifting to this model and individuals moving to the individual market?
v. Sabrina responded that the Trump administration's individual market HRAs are going into effect 1/1/2020. Prior to 2020, HRAs were an option but they have had to be offered in conjunction with a small group plan. These new HRAs and for SHOP and brokers is not a great option because it does siphon off employees from the small group market. However, as an employer this can be an attractive option.

e. **Employer/Consumer Protections**

Stop Loss / Self Insurance
A policy option on the table is to limit or make it more difficult for a business to become self-insured. Many states prohibit the sale of the stop loss policies to business (New York), other states limit by the size (Delaware business under 20). Stop loss polices are underwritten and allow healthier groups to escape the small group market and get a lower rate. There are some significant financial risks in some of the contracts in regard to the exposure to medical claims. Reasons to regulate these plans include to protect the small group risk pool, lower premiums, and protect small businesses form unanticipated liability. However, this is taking away an option for healthy groups.

- Pros: (1) Improve small group market risk pool, lower premiums, (2) Protect small businesses from unanticipated liability, (3) require comprehensive benefits
- Cons: (1) Fewer options for healthy groups, (2) pushback from insurers marketing these products

Regulatory protections in regards to association health plans (AHPs) and professional employer organization (PEOs).
The US department of labor regulates multiple employer welfare arrangements (MEWA), MEWAs are regulated by both the state and federally. In Rhode Island if AHPs are marketing to small group employers they have to follow the same rules. PEOs do not have to follow these rules.

- Pros: (1)) Improve small group market risk pool, lower premiums, (2) Comprehensive benefits, (3) protect small employers from experience rating
- Cons: (1) Fewer options for healthy groups, (2) pushback from entities marketing these arrangements

i. Ralph Coppola asked if it is possible for Rhode Island to disallow medical underwriting for stop loss plans, would this level the playing field?
ii. Commissioner Ganim replied that there is no underwriting for each medical product, but there is a medical underwriting for the entire plan. It would have to be a legislative decision and much more pronounced such as no sales to groups under a certain size.
iii. Sabrina added that New York limits the sale of stop loss but now has a large issue with PEOs because that is where all the healthy employers are going. The risk for the small group market is that there are groups who leave AHPs or PEOs and are then dumped back into the risk pool.
iv. Jamie Moran stated that the challenge is an individual business can save significant money in one of these products and makes them more competitive with their peers. The issue is that they are now taking people away from the pool.

f. **Market Structure**

Merge Markets Individual and Small Group
Merging individual and small groups markets would create a bigger and more stable risk pool. Conversely there would be some winners and losers on premiums and some market disruption. Three states have currently merged their SHOP and individual markets (VT, DC, MA). VT fully merged, DC/MA merged for rating purposes. There are different carriers in different markets, what decisions do those carriers make and does it impact options. RI is now a reinsurance state, what happens to the reinsurance program if merged?

- Pros: (1) Bigger risk pool, (2) more stable premiums
- Cons: (1) Winners & losers on premiums, (2) depending on approach, disruption for firms

i. Monica Auciello commented that BCBSRI would expect small group rates to increase because the small group pool is healthier. Merged markets do not achieve the affordability issues the group is trying to solve for.
ii. Ralph Coppola asked if you increased the small group size to 100 would it have an impact?
iii. Monica Auciello responded that there would be a shift from the large group market to stop loss plans. The cost burden would just be shifting between markets.
iv. Sabrina added that four states go up to 100. NY for example has seen the 50-100 employer groups shift to PEOs. Rhode Island would have to think about leakage of the larger small groups to other products. There is also an issue with the employer mandate for greater than 50 employers and you would be subjecting them to additional requirements.
i. Monica Auciello commented that for the 51 -100 size employers, one of the big changes is switching to list billing verse composite billing. Prior to ACA the same rate was

applied across your group, now employers have a different rate for every employee in their group based on their age which has a significant impact on rating variation. This is very disruptive. One of the things to think about is would this shift the issue to the large group market?

ii. Jamie Moran commented that the ACA rating is one of the biggest challenges for the small group market.

iii. Al Charbonneau added that there are so many large companies in the large group market and this kind of shift would move them to other products.

Health Reimbursement Account (ICHRA).

Employers have a choice to offer a group health plan or an HRA. With an HRA an employer they can cap what their monthly contribution, its predictable but some cost risk shifts to the employee. For the employee they have more choice.

- Pros: (1) Predictable (capped) employer contributions, (2) employee choice of individual market plan
- Cons: (1) Cost-shift to employee, (2) less generous coverage, (3) complex to administer, (4) adverse selection by employees, (5) employee confusion

i. Ralph Coppola commented that there are not a lot of brokers that will push an HRA, there is not a lot of incentive for employers to move towards the HRA plan when they can still offer a defined contribution through the SHOP plan.

ii. Sabrina asked if anyone has seen marketing for HRA plans?

iii. Jamie Moran responded that yes there is a company in MA with about 300 employees that has opted to move towards the HRA.

iv. Commissioner Ganim asked if there are any states looking at not implementing the HRA option?

v. Sabrina responded that there are some states but there are concerns about tax policy and authority to regulate.

vi. Commissioner Ganim asked if Sabrina has heard anything about allowing states to opt out of offering HRAs?

vii. Sabrina responded that she does not think States can opt out.

viii. Jamie Moran commented that the biggest issue in any of these plans is that older people are going to end up paying more and younger people are purchasing really rich plans because they have extra dollars to spend. Whereas a fifty-year-old with a family and health concerns is struggling to find the capital to purchase enough coverage. Older populations are penalized.

III. Discussion

i. Sabrina opened the discussion by speaking about the public option that Colorado has recently proposed. Colorado has just released its report for a public option plan, the first phase is just for the individual market, but the plan is to expand to the small employer market. The public option plan caps the rate that it pays to providers as a percentage of Medicare plans. Provider prices would be capped at 160-200% of the Medicare rate. It

was not on the list but mentioning because it is another potential option that could be explored.

ii. Al Charbonneau commented that Colorado used the RAND Healthcare Hospital Pricing study 2.0 to provide guidance for their public option plan and Rhode Island is currently considering participating in the 3.0 version of the study hospital pricing.

iii. Scott Mathieu asked are the benefits of the public option benefiting one population at the cost of another?

i. Sabrina responded that the idea is the rate of the of the public option is to put pressure on other groups. Making the public option available to self-funded plans is a way to head off cost sharing.

ii. Monica Auciello commented that Washington state is further along in the public option, Colorado has a lot more push back than Washington.

iii. Sabrina added that Colorado formed a group to review, the legislature will likely way in.

iv. Monica Auciello responded that a 200% of Medicare rate would be huge rate increase in Rhode Island and not feasible for carriers.

v. Scott Mathieu said this is an example of one group subsidizing another group.

vi. Sabrina responded that in Rhode Island there are not the same provider price issue as in other states.

vii. Al Charbonneau commented that hospital costs are 50 cents on the premium, if Rhode Island does not do something in regards to controlling this cost then we are not addressing affordability.

viii. Commissioner Ganim suggested that the group decided what solutions will not get us to the issue of the offer rate.

ix. Monica Auciello stated that the lack of data to support any of the policy options makes it difficult to determine which ones should be taken off the table.

x. Lindsay Lang responded that the goal is to determine which options the group wants to learn more about and to decide what should be explored further.

xi. Monica Auciello commented that its important that a deeper dive is done into some of the policy options to ensure that something that looks good at surface level actually makes sense.

xii. Lindsay Lang responded that the next couple of meetings will be focused on the deeper dive of policy options, but the group needs to narrow down which ones are explored further.

xiii. Al Charbonneau added that we need to make sure that the group looks at expenses in premium, hospital costs, specialty costs, and ask questions about what we can do about them and address what is driving premiums up.

xiv. Monica Auciello stated that a deeper dive should be done on policy options numbers 1, 5, 9, 10 (*see table below)*.

xv. Lindsay Lang added that the group should look options 1,4 with an emphasis on the education piece, also policy option 5 for reinsurance and policy options 9,10.

xvi. Ralph Coppola commented that the issue with policy option one is that it reduces benefits but is not addressing reducing cost. Reducing cost should be added to policy option 1. Option five to look at reinsurance is not going to accomplish a lot. We have to address losing healthier people in the small group market place.

xvii. Monica Auciello commented that all of this does not address the underlying driver to address cost. APMs are trying to do this however it has not trickled into the small group market.

xviii. Al Charbonneau said the argument could be made that there has not been a big impact on fee for services and there is a lot going on and perhaps in the small group market in regards to provider impact there is opportunity to do something in that area.

xix. Liz McClain stated that policy options 1,3,4,5,9,10 should be further reviewed and added that the reinsurance does not seem like something worth looking further into.

xx. Monica Auciello responded that a reinsurance program would help address the unique cases of significant costs but how a reinsurance program for small group would be funded is still a question, this something the group should learn more about.

xxi. Deb Faulkner added that it is known that a large share of the low offer rate is in specific industries, is there a way to encourage those industries to offer through incentive, for example hospitality and service. What that would look like needs some flushing out but it is something that should be considered.

xxii. Scott Mathieu responded that this is intriguing, but the issue is where the money is coming from. How does the business community get more involved in the conversation?

xxiii. Monica Auciello commented that the solution could be individual HRAs for these industries.

xxiv. Scott Mathieu said policy options seven and eight could address this.

xxv. Deb Faulkner commented that option seven is focused on cost sharing which really isn't the issue we are trying to address, policy option eight may be more appropriate.

xxvi. Steve Boyle stated that policy number four is crucial to helping employers manage their bottom-line cost. Employers need predictability.

xxvii. Commissioner Ganim recapped the discussion stating that the group has identified a focus on products, rates, and regulation and policy options 6,7,11 can be eliminated.

xxviii. Lindsay Lang summarized that policy options 1,3,4,5,6,9,10 should be considered for a deeper dive.

xxix. Ralph Coppola asked if any states mandate that groups of a certain size go automatically into the SHOP program?

xxx. Sabrina responded that some states have put the requirement in place for carriers that they can only offer small group plans through the exchange. Washington DC has merged individual and small group markets and requires anyone purchasing healthcare has to do so through the exchange, there are no direct sales.

Category	Policy Option	Guiding Principles		
		Market Options	*Costs & Risk Pool*	*Value of Coverage*
Products	1. Alternative plan design (e.g., limited networks, reduced benefits)	√		√
	2. Micro-group (<5) targeted products, administration	√		√
	3. Alternative provider payment methods			
	4. Encourage SHOP enrollment with full choice	√		√
Rates and Incentives	5. Reinsurance for small group market	√	√	
	6. Enhanced Small Group rate regulation	√	√	
	7. Cost sharing subsidies	√	√	
	8. Targeted employer incentives for coverage	√	√	
Employer/ consumer protections	9. Regulatory protections re: stop loss/self insurance		√	
	10. Regulatory protections re: PEOs		√	
	11. Regulate allowable employee eligibility restrictions		√	
Market Structure	12. Merge markets (Ind/Small Group) potentially with HRA	√		√
	13. Merge markets (Small Group up to 100)	√		
	14. Alternative structures using AHPs, HRAs			

IV. Public Comment

Commissioner Ganim asked for any public comment, there was none.

V. Adjourn

Commissioner Ganim adjourned the meeting at 11:09am.