Market Stability Workgroup

Date of Meeting: December 11, 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, Steve Boyle, Sarah Bratko, Al Charbonneau, Ralph Coppola, Jim Delisle, Dr. Peter Hollmann, Marybeth Liang, Dr. John Luo, Joyce Therrien, Scott Mathieu, Elizabeth McClaine, Jamie Moran, Larry Warner

Minutes

I. Meeting was called to order at 9:33 am by Commissioner Ganim. Commissioner Ganim asked for any comments on the minutes, Sarah Bratko and Peter Hollmann were not at the previous meeting.

a. Commissioner Ganim reviewed the work group syllabus, guiding principles, and the agenda for the meeting.

II. Deep Dive on Target Policy Options

a. Deb Faulkner reviewed the policy options the group decided to include and exclude in the prior meeting. Policy options highlighted in green below were identified for a deeper dive.

Category	Policy Option
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*

The group identified offer rate as the biggest issue facing the small group market, policy options were taken off the table that did not focus on improving this. The group also discussed merging markets, however decided that because the risk pools currently are not eroding, exploring this option was not a priority. Enhanced rate regulation was also taken off the table because currently Rhode Island does a good job at this.

i. Ralph Coppola asked if the group has looked at the numbers if we were to merge the small group market with the 51-100 group? What would happen to the market size?
ii. Deb responded that it would almost double in size, and what we heard from BCBS is that they set their rates looking at risk over their entire book of business.
iii. Ralph asked what do the other carriers think? Would it be a plus to merge the groups, why or why not?
iv. Jim Delisle responded there is a certain amount of volatility and in determining risk we look across the Rhode Island base, there is a certain aspect of predictability with a merged market. However, Tufts would not support this because currently there is more flexibility to manage the trends through different rating methodologies for each market.
v. Scott Mathieu added that from a UHC perspective putting the 51-100 into the small group market would not be beneficial. UHC agrees that it does bring some predictably but not necessarily better cost. UHC for example uses other states to compare to for rating because they do not have a big enough block of customers in Rhode Island. Additional regulation is also something UHC would not want to see.
vi. Monica Auciello added that HSRI engaged with Wakely back in 2012 about merging markets (51-100) and at the that time it was shown as not being a positive outcome. It may be worth sharing any already existing studies done on merging the markets.
vii. Deb responded that the market was so different at the time and a comparison from back then may not be useful because the pool and products were very different.
viii. Liz McClain added that NHPs small group is very hard to rate and suggested that the group look at other states that expanded to 100 and see what the data says.
ix. Sabrina Collette added that there is not great data on the states that expanded the small group size. The good news is the concerns about massive disruption and jump in rates did not happen, but what regulators did see is that there was a shift to self-funded or PEOs as a way for healthier groups to exit the market.
x. Commissioner Ganim commented that Maine is considering merging their markets and Massachusetts is looking at opportunities within their merged market. There may be opportunity for us to learn from the other states.
xi. Deb recapped that the group would like to get more information on merged markets, both the 51-100 and small group/individual.
xii. Al Charbonneau asked if the group needed to make decisions today without any additional data.
xiii. Commissioner Ganim clarified that there may be some decisions that can be made without extensive data and others we may need more data to understand impact before we make a decision.
xiv. Al Charbonneau added that the group should make sure decisions aren't being made that will result in shifting problems to a different market. The workgroup additionally

needs to look at things such as fees, taxes, etc that are driving people to explore other options.

xv. Deb responded that the small employer survey should be able to help understand these concerns, but also reminded the group that survey results will not be available until after the workgroup has wrapped up.

xvi. Monica Auciello asked if the small employer survey has been designed yet and asked that survey be shared with the committee members.

xvii. Deb responded that the national survey is currently being reviewed and shortened to better fit Rhode Island. If there are specific things that anyone wants incorporated into the survey to please let her know

xviii. Dr. Peter Hollmann added that it may be helpful to eliminate questions for which there is no policy option.

xix. Deb added there are a lot of questions about the specifics of the benefit options which is not the focus of the workgroup, so those questions are being whittled down.

xx. Scott Mathieu commented that we still have the challenge of cost and asked what policy options on the list are going to address cost? With each of the policy options cost has to be addressed otherwise the solutions will just shift the problems to a different market.

xxi. Deb responded that as we go into each policy option, we tried to address the goal and purpose of that option.

xxii. Steve Boyle asked if the survey includes questions about the top reasons why employers have opted out of offering coverage.

xxiii. Deb responded that this is embedded in the survey and in general coverage cost always comes up as a primary reason for not offering.

b. **POLICY OPTION I. PRODUCTS – ALTERNATIVE PLAN DESIGNS & APMS**
Goal: Low cost plans to entice new/retain existing employers.

There are several potential pathways to low cost plan designs. Looking first at medical expenses, these range from 89%-93% of premium for 2016 through 2018. These can be addressed through benefits and cost sharing and/or provider network partnerships. On average the plan administration margins range form 7%-11% for 2016 through 2018 and RI Health Plan margin range: -1% to 3% for 2016 through 2018. These margins are relatively low and there is not a real opportunity to decrease these margins. This leads us to hospital cost, and how can we can lower hospital costs. Hospital costs can be addressed with either benefits or how providers are paid.

Under policy option 1, there are three avenues to consider: (1) Benefits and cost sharing; (2) limited and tiered network plans; and (3) employer contribution strategies (HRAs)

Benefits and Cost Sharing

Employers in Rhode Island are not picking low cost plans, the vast majority of plans sold are gold and platinum plans. This is not unique to Rhode Island, and follows similar trends nationally, however RI small group actuarial value for plan selection is about 6% higher than the national average. In Rhode Island employers are choosing to offer

extremely rich plans or no plan at all. What can be done to encourage employers to pick a lower cost plan design versus not offering at all?

i. Jamie Moran stated that one of the challenges is that many of the employers have moved to an average $2,000 deductible plans, the premium differential to offer a lower premium plan is so little that its not worth the increase in the out of pocket plan. Why would an employer move from a gold level plan to a bronze level plan and expose their employees to a lot of out of pocket expenses if the difference in premium is not that significant.
ii. Scott Mathieu added that UHC would rather have richer plans and collect more premium so that when a large group takes a high deductible health plan, that groups experience gets much more volatile because of the large claims. When UHC sold HRAs when they first came out there was an MLR problem because they lowered rates but still had large claims to pay. Some of it is good for risk but not for what employers are paying.
iii. Jim Delisle said in regards to HRAs when employers fund them at a high rate utilization rates remain high, when they are funded at 50% or less then the data shows the plans being used more like high deductible plans.
iv. Peter Hollmann added that when talking about how to offer lower cost plans there needs to be better value-based benefit design which would provide high value at a lower cost.
v. Ralph Coppola commented that a few years ago HMOs and PPOs were supposed to solve the problem of cost and spend, it feels like we are going in a circle here of just shifting costs to different areas. We aren't getting anywhere, what do we need to do to make significant change happen?
vi. Deb responded that member cost sharing is not sufficient to tackle this problem because employers are not buying lower cost plans, yet carriers continue to struggle with pricing. HMOs were pathway around network through a narrow or engaged network that would manage the population better. Either through the network or plan structure, it would manage the population through controlling utilization or encouraging the population to use a specific network. It is less about employer cost share but more about can we do something with our providers to do something different to address unit cost or unit utilization. What is the provider readiness for alternative payment methodologies? More providers are shifting into different product designs. The market structure makes it difficult in Rhode Island. In Massachusetts there has been a significant push to narrow or tiered networks. If you could convince providers to participate in alternate payment methods there could be some movement but the challenge continues to be interest and willingness to participate.
vii. Jim Delisle commented that provider uptake in alternative payment models has not been what was expected in Massachusetts but certainly more than in Rhode Island.
viii. Scott Matthieu asked if there is consideration to tiering the physicians versus tiering the hospitals. Putting more resources into primary care, specifically modes such as patient centered medical homes in which all care is coordinated through the primary care physician. That way you are not tiering the network but you have access to primary care and subsequent specialist as needed but coordinated through one entity.
ix. Al Charbonneau commented that on the outside looking in at Massachusetts it doesn't look like it is working, there is a lot going on but they put $75 million into community hospitals and it doesn't seem to have had an impact. Underlying all the suggestions is fee-for-service and unless we address that we are not going to make any progress.

Keeping people out of the system is not driving down the cost of the system becoming more expensive. The benefit piece is important but we also need to go to employers and ask if they would consider offering anything other than a PPO.

x. Scott Mathieu suggested that this should be added to the survey.

xi. Larry Warner asked if there is anything in the pipeline from the cost trend work that the workgroup should know about?

xii. Commissioner Ganim responded that at this point in time there are no long-term strategies immediately on the horizon.

xiii. Steve Boyle commented from the health services counsel side that many primary care focused interventions are not making it to the hospitals and many patients are coming into the hospitals for duplicate services. There has been a major expansion of emergency service rooms and yet a significant amount of time is spent trying to keep people out of emergency rooms.

xiv. Deb commented that Medicare ACOs have really started to take root here and with that taking on more risk and responsibility amongst the hospital based ACOs. This is a big driver in their profits and when they start to take risk in that environment it drives changes in behavior. This movement can open the door for that pathway in the commercial world.

xv. Al Charbonneau responded that if there is not a fundamental change in payment then the cost is not being addressed. The hospital must work to make themselves financially viable and yet more affordable for the community.

xvi. Deb responded that the first step to that is to move away from fee-for-service and move towards providers taking on more risk. The product design based on alternatives to fee-for-services and/or risk-based provider payment would in theory strategize to get you there.

xvii. Cory King commented that OHIC recently posted for public comment the Affordability Standards with focus on downside risk in provider contracts.

xviii. Ralph Coppola asked if there is no capitation in primary care in Rhode Island?

xix. Peter Hollmann stated that in Rhode Island it is not reasonable to look at tiering the networks, the bigger issue is Boston or not Boston.

xx. Jamie Moran commented that the challenge is the risk reward dynamic, it has to be at the provider, employer and patient level. If risk is pushed on all three of those levels there has to be a reward to encourage good behavior. There has not been a program that does this successfully. Wellness rewards programs see some lower claims for those that participate. A program that separates the pool for risk may work better versus tiering networks or moving people in other directions. Without something to reward providers only incremental changes will be made.

xxi. Monica Auciello cautioned that Boston can be more expensive but there are some services that cost less, in BCBS experience it is not as big of a rate impact that people think. All of it is incremental, where BCBS offers wellness programs that you can earn 80% back on premium for employee participation, there has has been some change in employee behavior based on reward yet it tends to be the healthier people who participate. There is also a utilization issue and there is a need to educate consumers on how to push back on their providers. Regarding HMOs and other models, BCBS has introduced a lot of them and doctors do not like them because of the additional

administrative work required of them. Provider impact should be considered in any decision the workgroup makes.

xxii. Ralph Coppola commented that Rhode Island needs to start developing centers of excellence so that consumers want to stay in Rhode Island for Care.

Limited and Tiered Network Plans

Limited or narrow network plans offer limited choice of in-network providers based on price, quality, or other factors. Generally, these plans do not cover costs of out-of-network care (i.e. HMO model) and they may or may not be integrated. Tiered network plans offer greater choice of in-network providers and often out-of-network benefits, they require enrollee cost sharing based on providers' costs and/or performance on quality metrics, and there is lower cost-sharing for providers on "high value" tier.

Narrow/tiered network plans can reduce costs in two ways: (1)Providers offer discounts to be in-network or on more favorable tier; (2) Reduced utilization. Tiered networks could save 5-12 percent according to a study done by Health Affairs of BCBSMA plans. Narrow network plans can save more, depending on market, estimate include: (1) 12-30 percent hospital price reductions *(CalPERS study); (2)*40 percent reduction in spending per enrollee *(NBER/Mass GIC study)*; 26 percent reduction in cost of individual market plans *(McKinsey study)*.

There are a handful of ways to move towards limited or tiered network plans: (1) Encourage Culture Shift: Business Community communication plan to encourage alternative plan designs, less rich benefits; (2) Require Options: Require carriers to offer at least one limited or preferred network product on SHOP (3) Specify Product: Design a specific product, provider partnership model that must be offered by all carriers.

Deb handed the presentation over to Sabrina Corlette who continued with Policy Option 1 Products: Alternative Plan Designs and APMs: employer contribution strategies.

Employer Contribution Strategies: HRAs

Health reimbursement arrangements are not new, they are tax-preferred, account-based health benefit funded by employers to pay for health care expenses. HRAs do not meet ACA group plan standards because they violate annual limit and preventive services coverage requirements. Obama-era IRS allowed HRAs that are "integrated" with the group health plan and in 2016, Congress created "Qualified Small Employer" HRAs, but there was limited take up. The new rule under the Trump administration allows employers to fund HRAs to help employees buy individual market coverage (or Medicare). The rule was finalized June 2019, effective Jan. 2020. The "Individual Coverage HRA" (ICHRA) requires the employee to attest to purchasing ACA-compliant individual insurance, there is no cap on amount of contribution, and there are rules to prevent employers to shift sicker workers to the individual market, special enrollment period (SEP) for new HRA recipients. There are new excepted Benefit HRAs which can be used to buy short-term plans or excepted benefit products (i.e.,

accident-only, disability income, fixed indemnity). These are capped at $1,800 per employee per year.

There are implementation issues with HRAs: (1) employees may be offered traditional group plan *or* ICHRA, not both (2) employers must make the same offer to all employees within a defined class (i.e., full-time vs. part-time, salaried vs. non-salaried, minimum class size is 10 employees for employers with fewer than 100 employees); (3) employer contribution can vary only by age or # of dependents; (4) employers must provide notice about HRA & interaction with ACA premium tax credits (PTCs), if HRA deemed "unaffordable" under ACA, employee can decline HRA and qualify for premium tax credits via exchange and the employee must be given annual opportunity to opt out (5) employers may allow employees to cover their premium through a cafeteria plan, but employees must then buy the plan *off-exchange* (6) employers may not select or endorse any particular plan for employees, there are questions about if you can bring in a brokers; (7) employees must substantiate ACA-compliant individual market coverage

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, (5) employee confusion

There is not a huge State role in HRAs, there is not necessarily Sate policy needed for growth or expansion

i. Ralph Coppola asked if ultimately the employer would have to have someone administer an HRA plan?
ii. Sabrina responded yes, the employer would likely have to work with some type of vendor to help with administration of the plan and a vendor who would be able to package all of it together
iii. Ralph Coppola asked if would you get the same affect if you went through the SHOP program, in general this would be more enticing to states that do not have a strong SHOP program?
iv. Correct, the value proposition is different. Brokers get paid for one and not the other.
v. Jamie Moran asked: applicable to large employers under the ACA, how do you determine affordability of the HRA?
vi. Sabrina responded that affordability is determined by the price of the cost of the lowest cost silver individual plan, and if you are paying more than 9.78% of your income.
vii. Jamie Moran stated that an employer would have to look at their lowest compensated employee and determine what their contribution should be and make their contribution greater than 9.78% for it to be deemed affordable for all employees.

c. **POLICY OPTION III: REGULATORY PROTECTIONS**
Goals: (1) To protect small businesses from unanticipated liability; and (2) to foster a level playing field, limit adverse selection

Stop Loss/Self Insurance: State Options

State regulation of self-funded employer plans generally preempted under ERISA but since enactment of the ACA there has been more marketing of some combinations of self-funding and stop-loss are fully insured products "in disguise". The risk to the employer is set low enough the issuer is bearing most of the risk. There are usually contractual issues with things such as lasering where there is a stop loss policy that applies to the healthy people but if the employer is exposed to higher risk for someone with a preexisting condition.

State options for employer protections include: (1) allow stop-loss for small employers only over a certain size (i.e., NY, NV, NC, DE), (2)contracts have minimum policy standards e.g. prohibiting lasers, (3) required disclosures specific to risks, (4) increase attachment point to protect the employer from a high cost claim or high utilization (i.e., CA, DC, MD), in Rhode island the attachment point is $20,000, aggregate 120%. Milliman study said attachment should be $ 60,000 and aggregate at 130% to make the product more truly like a self-funded product and carriers would only offer to employers that can take that risk; (5) rate/form review & approval; (6) assessment to support small group market (e.g., reinsurance, incentives)

i. Commissioner Ganim asked what size businesses have the states allowed to offer stop loss?
ii. Sabrina responded that NY is at 50, Delaware is at 9,
iii. Monica asked if that would require statutory change?
iv. Deb responded that it would.
v. Ralph Coppola asked if changing the attachment point to $60,000
vi. Sabrina responded that an attachment point of $60,000 is where the carrier would take on 100% of the cost, the employer would be responsible for the cost until that point
vii. Ralph Coppola so just by economics this would exclude certain groups.
viii. Commissioner Ganim responded that to change the attachment point from $20,000 to $60,000, it would have to be addressed in legislation.
ix. Scott Mathieu stated that UHC offers this product at a lower price point, lower taxes and gets to the cost issue.
x. Marybeth Liang it doesn't' seem to be impacting the broader market in CT and ME.
xi. Scott Mathieu stated that it does deliver what we are trying to do
xii. Ralph Coppola commented: but you are not skirting some of the requirements of the rest of the small group market making it an uneven playing field
xiii. Sabrina commented that you could try to calculate how much of the healthy market is being siphoned away..
xiv. Jamie Moran commented: there have been a fair amount of clients both in and out of the products. They are marketed by carriers as fully insured. If anything is going to be controlled, it should be mandating how they are marketed to employers. Specifically what is not included in the product. There is also a lot of administration cost to these products. The admin costs sometimes outweigh the benefits yet the premium costs are 10-12% below the market. It is more about education the consumer in what they are purchasing and what their risks are. If we are going to do anything it should be more requirements about education.

xv. Lindsay Lang commented that the previous studies on merged markets would be sent out along with the previous employer survey results and the final employer survey for Rhode Island.

III. Public Comment

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

IV. Adjourn

Commissioner Ganim adjourned the meeting at 11:09am.