

Reforms Proposals Developed for Feedback

(March 19, 2008)

Connector with Reinsurance and Comparable Market Reforms

1. Establish a connector to cover uninsured Ohioans

Governance: The connector would be run by an appointed board. The connector would hire an executive director and staff to carry out operational functions.

Operations - The connector would:

- Create minimum standards for health plans offered through the connector;
- Contract with carriers selling coverage through the connector through an RFP process that would include negotiation with carriers on the terms of coverage, including premium rates;
- Determine eligibility for coverage and low-income subsidies at issuance and renewal;
- Enroll individuals in connector coverage and any expanded Medicaid coverage;
- Determine what is affordable in terms of an individual mandate that would require people to purchase coverage where affordable coverage is available;
- Collect premiums from individuals, employers and government, and remit payment to insurers,
- Conduct marketing and outreach;
- Facilitate the creation of Section 125 plans by employers at no cost to the employer; and
- Allow agents who refer clients to the connector to be paid a modest commission by carriers.

Eligibility:

- Any uninsured person could buy coverage through the connector
- Low income subsidies would be available only to individuals who have been uninsured for six months. This waiting period should be enforced to prevent “crowd out.”
- Coverage would be guaranteed issue for all eligible individuals

Coverage:

- Employed and unemployed individuals could buy coverage through the connector. Coverage would be owned by the individual and would be portable.

- Minimum benefit plans would be available through the connector. Coverage beyond minimum benefits plans could be offered through the connector with the approval of the connector board.
- A variety of standardized plans would be offered.
- First dollar coverage or low copayments would be available for prevention, primary care and chronic care management.
- Benefit plans would be value based. Low value services would be subject to higher cost sharing.
- Policy provisions or “riders” excluding or limiting coverage for specific health conditions would be prohibited.
- Pre-existing condition exclusions would be prohibited with an individual mandate.
- Insurers selling coverage through the connector would be required to offer the same plans in the regular insurance markets.

Wellness:

- Enrollees would be required to complete a health risk assessment.
- Consumers would be expected to comply with healthy behavior and care management recommendations, and such compliance would be incentivized through rewards and penalties.

Provider reimbursement:

- Carriers selling coverage through the connector may reimburse providers no more than Medicare rates.
- Primary care providers will also be compensated for care coordination on a per member per month basis.

Rates:

- Premium rates would be limited to a 5 to 1 rating variance.
- Premium rates could vary to reflect healthy behaviors such as successful participation in wellness programs (smoking cessation, weight control).

Subsidies and funding:

- Individuals who have been uninsured for six months would be eligible for subsidies.
- Enrollees below 100% FPL would get a full subsidy, and those between 100% and 300% FPL would get sliding scale subsidy.

- Workers and non-workers could access subsidized coverage.
- Employers could contribute to the cost of coverage and treat the contribution as an employee benefit for tax purposes.

2. Market reforms

Individual market:

- Coverage would be guaranteed issue -- all plans offered by a carrier must be offered to all individuals that apply.
- Policy provisions or “riders” excluding or limiting coverage for specific health conditions would be prohibited.
- Rates would be limited to a 5 to 1 rating variance.
- Dependent eligibility in family policies would be expanded to include older children and some other household members.

Small group market:

- Same underwriting and rating rules, except rates would be limited to a 5 to 1 rating variance.

3. An Individual Mandate

Individuals are required to purchase coverage if affordable coverage is available. Penalties adequate to enforce compliance should be adopted. Ohioans would report insurance status on tax returns.

4. Employer Requirements

Employers would be required to establish Section 125 premium only plans to allow employees to purchase health insurance coverage with pretax dollars. The connector would provide the legal documents necessary to establish Section 125 plans to employers at no cost to the employer.

5. Establish a reinsurance program to stabilize the small group market

A reinsurance program would be created to help stabilize rates in the regular small group market. Adverse impacts on the small group market caused by market reforms (merging the markets and establishing more restrictive rating bands) could be offset in whole or in part through a reinsurance program.

6. Projected Costs and Impact

- Establishing a connector, with guaranteed issuance of coverage, 5 to 1 rating limits inside and outside the connector, subsidies to low income individuals up to 300% FPL, and comparable market reforms, would reduce the number of uninsured Ohioans by 610,000 in the first year at an estimated cost of \$1.67 billion. By the fifth year, 873,000 more Ohioans would have coverage, at a cost of \$2.9 billion. Individual rates in the connector would be 13% less on average than regular market rates. Older and less healthy individuals would get greater reductions, some exceeding 50%. Average rates outside of the connector would be reduced 7% for individuals and rise 13% for small businesses. Small businesses with older and less healthy workers would see rates go down. (Scenario 4.)

The following reforms will have the following estimated impacts when coupled with Scenario 4.¹

- Limiting provider reimbursement rates for connector coverage to no more than Medicare rates (instead of Medicare plus 15%) would reduce premium rates within the connector by 7% and reduce the cost to the state for low income subsidies by \$120 million.
- Prohibiting pre-existing condition exclusions for connector coverage would raise premium rates by 5% and increase the cost to the state for low income subsidies by \$90 million.
- Introducing a reinsurance program for the regular small group market (with a 5 to 1 maximum rating limits) would maintain average small group rates at current levels (as opposed to an average increase of 13%), at a cost to the state \$800 million for the reinsurance program. This reform would reduce the number of uninsured Ohioans by an additional 130,000 in the first year (over and above the 610,000 reduction estimated for Scenario 4.)

¹ These reform scenarios have not been modeled as a package. The cost and impact estimates were developed from information generated from modeling other scenarios. These estimates are rough, ballpark estimates. There has been no confidence level analysis associated with them.

Reforms that could compliment a Connector

1. Medicaid expansion/reforms

- a. Expand Medicaid for parents of Medicaid eligible children up to 150% FPL.

Benefits

- Benefits to be offered through this Medicaid expansion would be scaled back as permitted by the Deficit Reduction Act, which allows cost sharing of up to 10% of the cost of service and up to 5% of family income.

Impact and cost

- FY 2010, 86,539 people would be covered at a total cost of \$282 million. The cost to the State would be \$113 million, which equals \$1,303 per member per year.
- In FY 2011, 132,755 people would be covered at a total cost of \$451 million. The cost to the state would be \$180 million, which equals \$1,359 per member per year.

- b. Increase enrollment of uninsured Medicaid eligible individuals into expanded Medicaid plans through a connector.

2. Medical home models

- Incorporate medical home model principles into connector coverage.
- Encourage providers to build networks locally that focus on care delivery and coordination of care.
- Pay for care management.
- Establish clear expectations for consumers, with rewards/penalties for compliance.
- Establish a system to track success.

3. Community health centers

- Increase the number of primary care providers in medically underserved areas by increasing funding for expansion of community health centers.

Alternative Reforms vs. a Connector

1. Tax credits

- Instead of a connector with low income subsidies, provide tax credits directly to low income individuals to purchase coverage on the open market. There would be no connector and no other market reforms.

Impact and cost

This reform would need to be modeled.

2. Establish a reinsurance program similar to Healthy NY, with low income subsidies

- Establish a state sponsored reinsurance program to help cover high cost uninsured individuals. The program would be offered on a guaranteed basis to eligible uninsured individuals. The program would lower the cost of coverage for uninsured individuals by approximately 28% in comparison to current market rates. The reinsurance program would be coupled with sliding scale subsidies for lower income individuals up to 300% FPL. There would be no connector and no other market reforms. (Scenario 11.)

Impact and cost

Approximately 530,000 uninsured Ohioans would obtain coverage in the first year of the program, at a first year cost to the state of approximately \$1.6 billion.

3. Guaranteed issuance of a basic benefit plan

- Require that all insurers offer a basic benefit plan to all individuals who apply for coverage. The level of benefits would be approximately 50% less than the average level of benefits in the current market. Sliding scale subsidies would be provided to low income individuals. There would be no connector and no other market reforms. This reform would be implemented with an individual mandate on workers. (Scenario 9.)

Impact and cost

Approximately 296,000 uninsured Ohioans would obtain coverage in the first year, growing to 298,000 uninsured Ohioans with coverage

by the fifth year. The cost to the state would be \$535 million in the first year growing to \$776 million in the fifth year.

Funding options utilized in other states to explore

- Medicaid Waiver for coverage expansion;
- Utilize federal matching funds for a Medicaid expansion for parents of Medicaid eligible children up to 150% of FPL;
- Redirect Safety Net Funds (HCAP);
- Hospital/provider/physician revenue assessments;
- Mandates on Employers/Assessments on Employers Not Providing Coverage;
- Sin Taxes (Tobacco, Alcohol, Other);
- Assessments on Health Insurance Carriers;
- Redirect Reduced Spending In Other Areas to Coverage -- Capturing Savings From Less Uncompensated Care and Improved Health Status;
- Mandates on Individuals; and
- Three Share Programs (Employer, Employee, State all contribute)

Sustainability

- Support adoption of health information technology;
- Make information on price and quality data available to Ohioans.
- Standardization of benefit plans
- Increase focus on prevention and wellness
- Improve quality outcomes
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