

# Agenda

## Experts' Intensive

### Health Insurance Partnership

January 4, 2008 – 9:00 AM to 4:00 PM

Red Lion Hotel – Olympia, Washington

Hosted by the National Governors Association

- 9:00 - 9:05 Welcome – Steve Hill, Administrator, Health Care Authority
- 9:05 - 9:15 Introductions – Beth Walter, Program Manager, HIP
- 9:15 - 9:25 Overview of the Day – Lance Heineccius, Session Facilitator

### Topics for Expert Discussion

- 9:25 - 11:25 Choice Among Plans (Phasing-in Individual Choice)
- Adverse Selection Issues
- Rating Issues
- 11:25 - 11:30 Brief Break
- 11:30 - 12:45 Employer Minimum Contribution
- 12:45 - 1:00 Break to Get Lunch
- 1:00 - 2:00 Plan Sponsorship and Administration
- ERISA Issues
- COBRA Issues
- 2:00 – 2:55 Designated Health Plans
- 2:55 - 3:00 Brief Break

For each of the above topics, the discussion will be structured as follows:

- Brief statement of the issue (see attached)
- Opening statement by each expert – 3 minutes each
- Discussion among experts – 10 -15 minutes
- Impact on small group insurance market
- Questions to experts (as time allows)
- Next steps and wrap up

- 3:00 - 3:45 Next Steps for the Health Insurance Partnership
- Essential immediate steps – through December 2008
  - Short-term implementation steps – 2009 and 2010
  - Longer-term steps – phasing-in additional components
- 3:45 - 4:00 Closing Remarks (as time allows)



## **Topic Statements for Expert Discussion**

### **Choice Among Plans (Phasing-In Individual Choice)**

Proposed legislation will allow the Board to consider limiting individual choice during the initial two years of program implementation. While choice is a very important feature of health insurance, the administrative complexity of requiring employers to offer all plans initially would increase administrative costs of the offerings and increase the administrative burden on employers and plans. How should the Board limit individual choice initially, and in what manner? How can individual choice be phased-in during the two years to minimize the administrative complexity and adverse selection?

### **Adverse Selection Issues**

In addition to the individual choice issues discussed previously, are there other potential adverse selection issues the Board should be aware of in implementing HIP, and what are your recommendations for avoiding these problems?

### **Rating Issues**

The law requires that the medical experience of all persons covered through HIP must be included in the same adjusted community rate pool as the medical experience of those in the same plan who obtain their coverage outside the HIP program. A recent opinion by the Insurance Commissioner further clarifies that the law “would appear to give the HIP Board some limited leeway in determining rating methodologies as long as the Board exercises its authority under this provision in a manner consistent with the provisions of [existing insurance statutes for the small group market].” What rating changes, if any, should the Board take into consideration in structuring HIP rates?

### **Employer Minimum Contribution**

The Board is required to set a minimum employer contribution level for financial participation for employers that decide to participate in HIP. What are the key issues the Board should take into consideration in setting this employer minimum contribution level, and where do you recommend it be set?

### **Plan Sponsorship and Administration**

What are the best options for the Board and the HCA to consider in structuring the legal arrangements for plan sponsorship (including fiduciary responsibility), and in awarding a contract for third party administration of the program? Are there other models in use or under consideration in other states for similar programs, and what are the lessons that have been learned in these settings?

### ERISA Issues

What issues have arisen relative to ERISA (the federal Employee Retirement Income Security Act of 1974) in other states implementing similar programs, and what are the lessons that have been learned in these settings? What recommendations do you have on dealing with ERISA issues?

### COBRA Issues

What issues have arisen relative to the health benefits continuation requirements of COBRA (the federal Consolidated Omnibus Budget Reconciliation Act of 1986) in other states implementing similar programs, and what are the lessons that have been learned in these settings? What recommendations do you have on dealing with COBRA issues?

### Designated Health Plans

The Board will be evaluating all small group market health plans to determine which should be eligible for a subsidy. What are the most important criteria for the Board to consider in evaluating health plan offerings to determine which should be eligible for the subsidy?

### Washington Small Group Market Impact

For each of the major topics discussed above, how is the implementation of HIP likely to impact the fragile small group insurance market in Washington State? What have been the small group market impacts (actual or potential) in other states implementing similar programs, and what lessons have been learned in these settings? For each topic, what recommendations do you have on minimizing negative impacts of implementing HIP through the small group insurance market?

# Facilitator's Meeting Notes

## Washington State Health Insurance Partnership

### Experts' Intensive Session

January 4, 2008

Facilitator: Lance Heineccius

Panelists: Amy Lischko, Tufts University  
John Grgurina, Independent Consultant  
Ed Haislmaier, The Heritage Foundation

#### **Choice Among Plans:**

All three panelists identified individual subscriber choice as the single most important aspect of having an “exchange” or “connector” such as the HIP. It was also noted that this did not mean unlimited choice among all possible products in the small group market – but rather, a reasonable choice among several different plan designs and carriers. All noted that even this limited choice was much greater than current small group market participants get.

#### **Adverse Selection:**

Individual choice brings choice but the associated adverse selection makes it unsustainable. Health carriers do not want to participate in any program where they believe they will be exposed to unacceptable levels of risk due to adverse selection. The panelists suggested that a separate committee sit with carriers to work out the issues of risk adjustment and phasing in choice.

#### **Rating Issues:**

All panelists emphasized – emphatically – that the HIP needed to use exactly the same rules that employers face in the small group market or perverse incentives would result that could fatally damage HIP (or, potentially, the small group market). If the current rules are perceived to be unfair, the advice was to work with the Office of the Insurance Commissioner to change those rules for the entire small group market rather than attempt to “fix” the problem by having different rules for the HIP.

#### **Employer Minimum Contribution:**

All three panelists agreed that this was somewhat of a “red herring” in that the real issue is how to get high employee participation rates among the eligible employees - in order to calm health carrier anxieties about potential adverse selection. Minimum contribution is only a means to ensure high participation, and a focus on the contribution level is misguided. Setting too high a required employer contribution level may have the negative impact of giving nervous

employers a disincentive for participation at all. The strong recommendation was to focus efforts on getting high employee participation rates (“take up rates”) and not worry too much about the minimum employer participation. Panelists agreed with Steve Hill that this is a hot political issue, however, and agreed that having some employer participation in the premium was politically important as long as it did not make employers refuse to buy coverage at all.

### **Get Clear on Priorities**

Panelists – especially John Grgurina – emphasized that the HIP Board needed to first get clear on the primary intent of the program before making specific decisions about specific features. Three possible primary intent objectives were identified by Grgurina, as follows:

- Increase participation in health insurance for employers who have not previously offered health benefits to their employees (new entrants).
- Increase participation in health insurance for employees who now have health insurance available to them through their employer but who have not previously taken advantage of this offering (increase take-up rate).
- Keep employers and employees that currently have health insurance participating in health insurance as rates become more unaffordable in the future (preserve existing insurance).

Depending on which of these three objectives is the primary intent of the HIP, the Board will then need to adopt different policies and make decisions specific to meeting that intent. Panelists cautioned that – in a small, start-up program – trying to achieve multiple objectives was a recipe for failure.

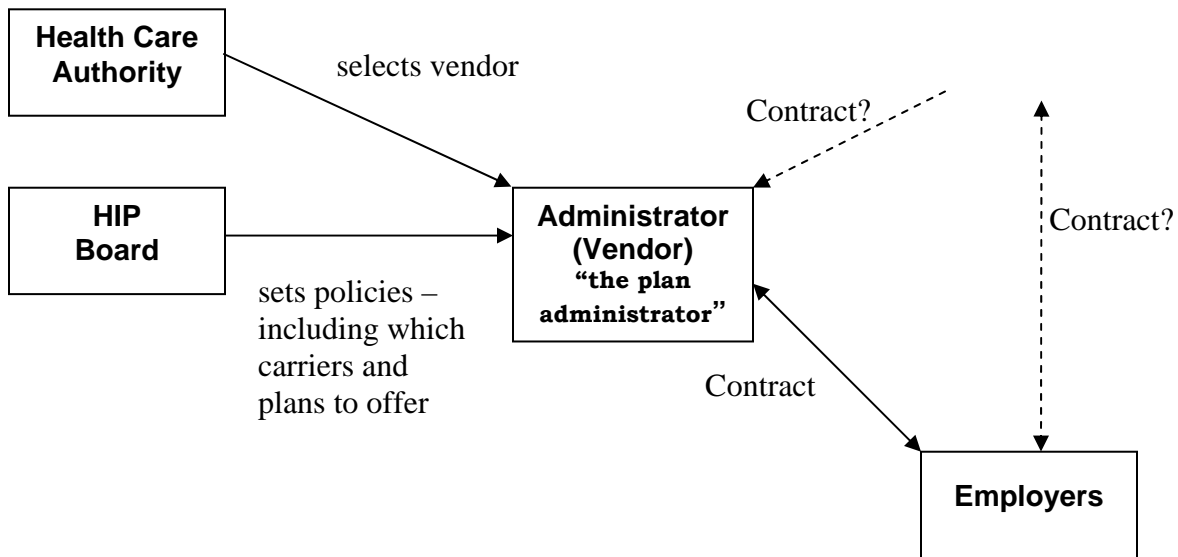
### **Plan Sponsorship**

All panelists agreed that the employer is the legal plan sponsor of the health benefits offered under HIP according to federal law.

### **Plan Administrator**

Panelists indicated that different approaches were possible, although getting an advance ruling from the federal Department of Labor on which approaches were “legal” under ERISA regulations might not be possible. Amy Lischko and Ed Haislmaier favored making the vendor hired to administer the plan the formal “plan administrator”, while John Grgurina determined (after a phone call) that in California the plan administrator role was left with the carriers. A diagram (replicated at the top of the next page) was drawn by Jane Beyer to indicate the possible relationships among the various entities, with several final decisions still to be made by the HIP Board.

<b>Insurance Carriers</b>
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**What to Do Now (for 2008)**

Select a reasonable number of carriers and product offerings for the first year, with the product offerings varying by plan design features (such as networks, deductibles, co-payment levels, comprehensiveness of services covered). Then the two options are:

- Employer picks a carrier, and the employee selects a plan offering from within that carrier’s offerings.
- Employer picks a level of benefits (comprehensive, medium, catastrophic) and the employee picks a carrier from among the offerings at that level.

Visually (as an example):

	Carrier 1	Carrier 2	Carrier 3	Carrier 4
Comprehensive				
Medium				
Catastrophic			<i>no offering</i>	

The choice sequence can either be horizontally for the employer, then vertically for the employee – or vertically for the employer, then horizontally for the employee. Or, give employees complete choice among all cells in the table. The Board should ensure that the most popular products (those with the highest enrollment) that are now offered in the small group are included in the list of designated plans. Several cost sharing levels (deductible and copays) can be offered (across carriers – or even within a cell above) to give greater choice, if desired. All panelists agreed – keep it as simple as possible.

**Risk Adjustment**

All panelists agreed that a formal risk adjustment mechanism is unneeded in the first year. Panelists recommended that risk adjustment be part of a “back-burner” study, and that in the first year (and maybe longer) all that is probably needed is some form of a retrospective risk transfer agreement that focused on protecting against the extreme high cost case (e.g., individual case stoploss protection). Again, those carrier representatives present disagreed.

### **Designated Plans**

If the above approach is adopted, panelists recommended keeping it simple and allowing all of the plans selected to be in the table to eligible receive employee subsidies. Set the benchmark plan as “what is affordable, adequate, adds value” – in other words, do not make it a comprehensive plan. Panelists expressed a preference for a no deductible plan as the benchmark, and encouraged experimentation and innovation in co-payment arrangements.

### **Specific Steps for 2008 – Panelist Suggestions**

1. Figure out the program goals – who is the target audience?
2. Establish the policies and procedures
3. Get the RFP process underway to select a vendor to administer the program
4. Define the rules and requirements for the program
5. Develop a communication strategy and get it underway
6. Finalize the contract design
7. Select the carriers
8. Contract negotiations
9. Begin enrollment

Panelists emphasized that the important focus is “just do it” and get something operational, then have the flexibility to adjust as HIP moves forward. Comments made included:

- “Don’t wait for perfection”
- “Keep it simple”
- “Hit the deadlines” (this was especially emphasized by John Grgurina)

### **What are the most important details to focus on?:**

- Select carriers and products that work in this market!
- Get assurance from Legislature about a sustainable subsidy over time.
- Manage expectations, especially around initial year enrollment.

There was also an extended discussion on the critical importance of an effective marketing campaign that specifically focused on the target audience. The essential role of the brokers and agents was emphasized, including making it as easy as possible for them to sell the product. Sales support ideas included:

- Preparing effective and focused materials for brokers/agents to use
- Hosting events/meetings that brought a number prospective employers to the brokers (to help them easily identify prospects)
- Keep the broker role as simple as possible – for example, don't expect them to help determine subsidy eligibility, because that takes too much time (especially for the smallest employers, where commission is low).
- Partner with specific brokers, give them extra help and payment

### **Association Plans**

The meeting ended with a brief discussion of Association plans and their interrelationship between the HIP and the small group market.

Meeting adjourned at 4:10 pm.