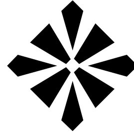


Washington State
Health Care Authority

Health Insurance Partnership Board

June 5, 2008 Meeting

AGENDA

Health Insurance Partnership Board

June 5, 2008
9:00 a.m. to 4:00 p.m.
Seattle Marriott Airport Hotel
3201 South 176th Street, Seattle, Washington

Teleconference: 1-877-597-2663, code 3716220

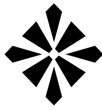
9:00 a.m.	**Welcome and Introductions**	Sue Sharpe	
9:05 a.m.	**Approval May 8, 2008, meeting minutes**	Sue Sharpe	Action
9:10 a.m.	**Overview of Fiserv Health**	Helmut Braun	Information
9:55 a.m.	**Board Studies –Rating in the HIP**	Michael Arnis Deborah Chollet James Matthison	Action
10:55 a.m.	**Break**		
11:05 a.m.	**Executive Session** Designated Health Benefits Plans		
12:30 p.m.	**Lunch Break**		
1:30 p.m.	**TAC Report**	Karen Merrikin	Information
1:45 p.m.	**Designated Plans and Benchmark Plan**	Beth Walter Ben Diederich	Action
2:30 p.m.	**Break**		
2:45 p.m.	**Subsidy Scale**	Beth Walter Ben Diederich Megan Atkinson	Information
3:45 p.m.	**Public Comment**		
4:00 p.m.	**Adjourn**		

The Health Insurance Partnership Board will meet Thursday, June 5, 2008, at the Seattle Marriott Airport Hotel, 3201 South 176th Street, Seattle, Washington. The number to join is: 1-877-597-2663, code 3716220. The board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: HIPBoard@hca.wa.gov

Materials posted at: http://www.hip.hca.wa.gov



Washington State
Health Care Authority

HIP Board 2008 Roster

Name/Title	Address	Term Expires
Steve Hill	Health Care Authority Olympia WA	Chair
Cindy Watts	University of Washington Seattle WA	7/15/09
Don Brennan	Bellevue WA	7/15/10
Susan Sharpe	Whatcom Alliance for Healthcare Access Bellingham WA	7/15/11
Jeffrey Gingold	Lane Powell PC Seattle WA	7/15/10
Theodore Blotsky	Associated Industries Spokane WA	7/15/09
Norm Inaba	Inaba Produce Farms, Inc. Wapato WA	7/15/11
Melissa Burke-Cain Assistant Attorney General	*Attorney General's Office Olympia WA*	*Counsel*

Washington State
Health Care Authority

HIP Board Vision, Goals, and Principles

HIP Board Vision Statement: Adding value in and increasing access to health insurance for low-income employees of small businesses.

HIP Board Goals:

- Develop a program that covers low-income, uninsured employees of small employers.
- Create a sustainable safety net for the target population to improve coverage.

HIP Board Guiding Principles:

- **Do no harm.** Consider all of the potential consequences, both intended and unintended, from all policy decisions related to the program.
- **Keep it simple.** Build a program that is easy to understand and access.
- **Stay consistent with the Blue Ribbon Commission recommendations.** The program is one component of a larger whole. Include the BRC innovations to advance coverage.
- **Get the most "bang for the buck."** Build on the existing infrastructure, using innovation when necessary.
- **Build in sustainability.** Create a program that will retain participation and value over time.
- **Focus on what's achievable.** The Board's efforts need to lead to covering as many eligible people as possible within the parameters of the legislation. By focusing on what the legislation requires us to do, we can positively contribute to the foundation for larger change.
- **Focus on access, and include cost and quality.** As the program develops, the value proposition must remain an incentive for small employers, their employees, and carriers.
- **Increase education.** People with health insurance are healthier. Access to care benefits individuals and is less costly in the long run. Change the way people--especially younger people--think about health insurance.
- **Emphasize incentives to self-care.** Change or encourage positive health behaviors.
- **Don't let the Perfect be the enemy of the Good.** Be mindful of the positive changes we can affect and recognize this is but one step in incremental change.

Health Insurance Partnership Board
Meeting Minutes

May 8, 2008
10:00 a.m. to 12:00 p.m.
Teleconference: 1-877-597-2663 code 3716220

Members Present:
Steve Hill
Ted Blotsky
Don Brennan
Norm Inaba
Cindy Watts
Sue Sharpe
Jeff Gingold

DRAFT

Call to Order
Steve Hill, Chair, called the meeting to order at 10:00 a.m. Sufficient members were present to allow a quorum. Board member and audience introductions followed.

Approval of Minutes
It was moved, and seconded to approve minutes from the April 3, 2008, board meeting as written.

Technical Advisory Committee Report
Karen Merrikin reported that the Carriers are working with Milliman on the plan comparison grid. They are finding some differences in philosophy around serving low-wage and subsidy-eligible individuals. There was some discussion that other plans may enter the HIP at a later date and offer the same types of plans currently being offered.

Michael Arnis reported that there is ongoing discussion with the association plans on their participation in the Board studies. Discussions with association plans will continue.

Designated Health Plans
Beth Walter gave an update on the work being completed to assist the Board in designating health benefit plans to be offered through the HIP. Staff have been coordinating with carriers, brokers and the TAC to assist the Board in choosing the health plans.

Update on TPA Selection
The HCA received four responses to the RFP. Harrington Health was selected as the apparent successful vendor. The HIP program will be administered from Harrington's Bothell location.

We will now begin contract negotiations with Harrington Health and plan to begin implementation by June 19th.

Public Comment

No public comment given.

The meeting was adjourned.

Respectfully submitted,

Steve Hill, Chair

DRAFT

Preliminary study of Expanded Health Insurance Partnership (HIP) Rating options for small employer groups: pros and cons June 5, 2008

Limited time and resources do not allow the Board to model both list and composite rating for small employer groups in the Preliminary Study of an Expanded HIP. As the Board deliberates which rating method to select, the members should consider, among many factors, which rating method would produce the most informative results in the studies. The following facts and assumptions, and pros and cons, are provided to summarize the many issues that surround the selection of list or composite rating for the studies.

Facts and assumptions on rating an Expanded HIP

1. Carriers will offer the same plans to individuals and small employer groups.
2. The same list-rated premiums will apply to enrollees purchasing as individuals and through small employer groups. (But, as will be discussed, the Board will need to decide whether to require carriers to establish small group composite rates based upon the group's list-rated premiums, such that employers and employees would contribute against the composite rate, as they do now.)
3. Small group adjusted community rating applies to HIP plans.[1]
4. Each enrollee will select from any plan offered in the Expanded HIP ("unrestricted choice").
5. A small group composite rate would not reflect each employee's choice of plan.
6. We **assume** that HIP premiums will include the administrative cost of implementing any risk adjustment or reinsurance mechanism. (To be decided by the Board on June 5.)
7. We **assume** that employers will be allowed to choose between contributing 1) at least 40 percent of an employer-selected benchmark plan ("defined contribution"), or 2) at least 40 percent of the premium for any plan that an employee selects . (To be decided by the Board on June 5.)
8. The high risk pool, Washington State Health Insurance Pool (WSHIP), will continue to apply to people purchasing individual coverage in HIP and the highest-cost applicants will be referred to WSHIP.

[1] Washington State implements adjusted community rating for small groups in the following way: a) A plan's premium must reflect the benefit design and can be adjusted for only these factors: age, geography, family type, and wellness; b) A carrier will apply the same premium increase to every HIP plan offered by a carrier (there is one exception that allows carrier's to adjust a plan's premium by four percentage points); and c) The premium increase will be based upon the claims experience of the carrier's HIP enrollees.

Considerations in selecting list or composite rating for small groups

List rating

Pro:

- Truly merges individual and small group populations into one market: plans and premiums would be the same for enrollees purchasing as individuals or through small groups. An enrollee's premium will differ by only the employer's contribution when moving from group to individual coverage.
- Risk will still be spread among enrollees in the same 5-year age intervals (20-24,…60-64), and across all ages because premiums for 60 year-olds can at most be 3.75 times the premium for 20 year-olds.
- Younger workers in groups with older workers would be more likely to take-up coverage because their premiums will decrease. The employer's premium contribution for these younger workers (if a percent of premium) would also be lower.
- Administratively simpler than composite rating and the premium is easy to understand. Insurers *might* need risk adjustment or reinsurance because of unrestricted choice of plan—although in Massachusetts insurers have not yet needed this assistance to manage list rating in the Connector.

Con:

- Older workers in groups with younger workers will experience "premium shock" because their premiums for the same or similar coverage in the current market will no longer be averaged across lower cost workers in their group.
- Premiums for older workers will increase, and the employer's premium contribution for older workers also could increase (if a percent of premium). Older workers may respond by choosing less comprehensive coverage, potentially becoming underinsured.

Composite rating

Pro:

- Cross-subsidies within groups would continue so that workers' group premiums would likely be closer their current premiums, even with unrestricted choice.
- Older workers would be more likely to retain comprehensive coverage.
- Employers can select to contribute to premiums with a defined contribution without pricing older workers out of coverage.

Con:

- As in the current market, premiums would be much higher for older workers for the same coverage, and lower for younger, healthier workers when moving from group to individual coverage. The sharp premium increase for older workers will retain the problems of dropping coverage, under-insurance, and job lock as in the current market.
- Many younger workers would continue to be priced out of small group coverage.
- Composite rating under unrestricted choice necessitates two forms of risk adjustment and/or reinsurance. Implementing them will add administrative cost. Not all carriers are confident that risk adjustment and/or reinsurance will level the playing field under an Expanded HIP.

Draft Motion

[List/composite] rating, as described in Mathematica's May 12, 2008 memo, should be used to estimate and model premiums for the Expanded HIP in the Preliminary Study.

The cost of administering any risk adjustment and/or reinsurance mechanisms for an Expanded HIP, under list or composite rating, should be included in the estimated premium modeled by Mathematica in the Preliminary Study.

Mathematica should model an Expanded HIP in the Preliminary Study that allows employers to select either a defined contribution or a percentage of premium, as described in Mathematica's May 12, 2008 memo, when contributing to employee premiums.

MATHEMATICA
Policy Research, Inc.

MEMORANDUM

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Washington, DC 20024-2512
Telephone (202) 484-9220
Fax (202) 863-1763
www.mathematica-mpr.com

TO: Michael Arnis

FROM: Deborah Chollet and James Matthisen **DATE:** 5/12/2008

SUBJECT: HIP Board Guidance on Small Group Rating in the Initial and Expanded HIP

This memorandum requests guidance from the HIP Board and/or HCA staff with respect to rating and employer contribution practices in both the initial and the expanded HIP. "List rating" is now used to calculate premiums by 5-year age intervals in the individual market, and we understand that the Board would retain list rating for individuals covered through the expanded HIP. The rest of this memo focuses on options for rating small groups in the expanded HIP.

As currently envisioned, two aspects of the HIP create particular challenges for rating small-group coverage:

- Small-group employees in the HIP would have unrestricted choice of plans within the HIP.
- The small-group and individual markets would be merged. That is, the same plans would be available to small-group employees and individuals at the same (per member per month) rates.

The implications for rating associated with each of these features of the HIP are discussed below, as informed by individual, hour-long discussions that we conducted with knowledgeable officials at Group Health, Premera, and Regence. We conclude with three specific questions for the Board. We request guidance on these questions before proceeding with the modeling.

I. Employee Choice of Plan

Unrestricted employee choice of plan creates some complexity both with respect to how the premium is calculated within groups, and how the employer contribution is calculated.

A. Small-Group Premium Calculation

All plans in the HIP would be available to small-group participants and individual participants on the same basis: employers and individuals alike could get from the HIP or a

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producer a table of rates by individual age within 5-year intervals.[1] If composite rating is used, a calculator on the HIP web site or the employer's producer could compute a "composite" rate for the small group—that is, for each plan in the HIP, the per-member-per-month rate if the employer's whole group chose to enroll in that plan (the same as in the current small group market).

An example of each alternative is developed below, illustrating the impact of applying list rating or composite rating to small groups in HIP. To simplify the examples, we assume that only employees (not also dependents) enroll in the plans. We assume that the employer contribution is calculated as a percent of a benchmark plan (as discussed later). [2]

1. List Rating

Employers would see HIP plan rates for each employee that are identical to those for individuals. Employees, then, would confront *individual variation* in their rates due to their age as well as their selection of a plan within the HIP.

In Figure 1, we assume the HIP offers 5 representative plans, with different benefits and cost sharing. ABC Hauling Company has three employees, aged 25-60. When ABC requests HIP rates for all available plans, it is given a rate quote for each worker for each plan. Employers would no longer average employees' rates to compute a single composite rate that would apply to all employees. Instead, each of ABC's three employees would pay the *list rate* for the plan he selects. Note that the rate each employee pays reflects his own age, as well as differences in plan benefits and cost sharing.

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[1] Authorizing HIP legislation specifies that current small group regulation would prevail in the HIP. At present, carriers may vary rates by type of contract, geography, and age. Rates may vary by age within a band of 3.75:1.

[2] Note that if all or most employees chose a plan more expensive than the benchmark, it is possible that the employer's contribution to coverage could prove to be less than 40 percent of actual premiums. Conversely (and as in the examples) if employees chose plans that are less expensive than the benchmark, the employer might pay more than 40 percent of coverage—for the youngest employee in Figures 1 and 2, the full premium. But it would be impossible to know in advance what percentage the employer ultimately will pay—especially as the 75-percent participation rule could force the employer to contribute more than 40 percent against the benchmark. Also, if low-income workers selected more comprehensive coverage, either their contributions or the state's subsidy outlays could be higher than anticipated.

FIGURE 1
ILLUSTRATION OF LIST SMALL-GROUP RATING IN THE HIP

ABC Hauling Co.	Employee Age
Worker 1	25
Worker 2	40
Worker 3	60

	List rate pmpm	Employee choice	Employer contribution (lesser of 60% of benchmark or full plan cost)	Employee contribution (List rate minus employer contribution)
Plan A	$32	Worker 1	$32	$0
Plan B	na			
Plan C*	na			
Plan D	$263	Worker 2	$122	$141
Plan F	$474	Worker 3	$122	$352

*Benchmark

2. Composite Rating

The employer would be quoted a composite (group) rate for each available plan as they are now—reflecting the average premium per member, calculated as if the entire group would enroll in each plan. Each employee's contribution would be calculated against the *composite rate* for the plan he selected.

In Figure 2, each of ABC's employees would select a plan, and each would pay a contribution based on the composite rate for the plan he selects. Note that the rate each employee pays no longer reflects his own age. Instead, it reflects the *average* age of workers in the group as well as differences in plan benefits and cost sharing.

FIGURE 2
ILLUSTRATION OF COMPOSITE SMALL-GROUP RATING IN THE HIP

ABC Hauling Co.	Employee Age
Worker 1	25
Worker 2	40
Worker 3	60

	Composite rate pmpm	Employee choice	Employer contribution (lesser of 60% of benchmark or full plan cost)	Employee contribution (Composite rate minus employer contribution
Plan A	$76	Worker 1	$76	$0
Plan B	$102			
Plan C*	$204			
Plan D	$254	Worker 2	$120	$134
Plan F	$305	Worker 3	$120	$185

*Benchmark

Composite rating for small groups (example #2), which would cross-subsidize workers within the group, would appear to both employers and employees most like the current market. However, employee choice would pose two fundamental problems for carriers in the HIP:

(a) The age distribution of employees who enroll in a particular plan may bear no resemblance to the mix of employees that selected that plan when the employer's composite rate was established.

(b) There will be additional adverse selection in more comprehensive plans associated with unrestricted employee choice.

To address these problems, some system of risk adjustment would be needed. Simple prospective risk adjustment could address demographic error in composite rates, associated with (a) above. However, additional, retrospective risk adjustment (based on diagnoses associated with the enrolled population) or reinsurance would be needed to address the problem of adverse selection associated with employee choice, associated with (b).

Note that this latter problem—anticipating adverse selection in employee choice—is not different from what carriers do now in the individual market. However, small group coverage is guaranteed issue, while carriers can deny individual coverage. Because small-group coverage is guaranteed issue, carriers might want risk adjustment or reinsurance to manage unrestricted employee choice in the HIP, even if small-group coverage were list-rated. However, there would be a greater need for risk adjustment or reinsurance if small-group coverage were composite-rated.

B. Employer Contributions to Premiums

With respect to how the employer contribution is calculated, there appear to be two alternatives. Both are consistent with either rating method described above.

1. Percent of Benchmark

As in the examples above, the employer could pay a defined contribution, regardless of what plans employees may ultimately select. In this case, the employer would identify a benchmark plan against which the contribution amount for each employee would be calculated. Employee contributions would vary by the plan he or she selected under list or composite rates; contributions would vary also by employee age under list rates. Employers might prefer this approach, as it would allow them to budget contributions to coverage without potentially costly surprises associated with employee choice.

2. Percent of Premium for Employee's Plan

The employer might agree to pay at least 40 percent of whatever plan the employee selected. After employees selected their plans, the HIP would present the employer with the bill equal to at least 40 percent of the premium aggregated across all selected plans. It seems likely that employers would not prefer this approach, simply because they could not anticipate their expenditure for health benefits, although there is precedent to expect that some would.[3] If employee contributions were calculated against list rates, this approach would reduce "premium shock" for older workers as they move from the current case to the HIP.

A simple example of premiums and employee contributions to premiums associated with alternative carrier rating and employer contribution rules is provided in Table 1. Under simple assumptions about possible variation in list rating for a 2-person group, list rating would produce variation in employee contributions to coverage under either employer contribution rule.[4] The combination that would be the simplest for both employers and the HIP to administer—list rating with defined employer contributions—would produce the greatest variation in employee contributions to coverage (in the example, 7.9 to 1 for Plan A, and 4.6 to 1 for Plan B).

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[3] Connecticut's Business and Industry Association Health Connections, a private-sector purchasing organization, allows employers to make either defined contributions to coverage per worker or to pay a percent of premium for any plan that the worker chooses. About half of employers use define contribution, and half pay a percentage of premium for any selected plan (Phil Vogel, personal communication with Amy Lischko). Operated as a division of the Connecticut Business and Industry Association (CBIA) for more than 12 years, Health Connections serves employers with three to 100 employees and provides choice among plans offered by four participating health insurance companies. Currently, more than 6,000 businesses with 88,000 covered lives participate.

[4] Employer contributions might be calculated to offset rate variation by age, but age-adjusted contributions would be difficult to calculate when there is employee choice and it seems likely that most employers would not take this step.

TABLE 1

EXAMPLE OF LIST AND COMPOSITE RATING WITH ALTERNATIVE EMPLOYER CONTRIBUTION RULES FOR A HYPOTHETICAL GROUP OF TWO EMPLOYEES

	Small-group list rating		**Small-group composite rating**[a]	
	Plan A	**Plan B**	**Plan A**	**Plan B**
Total premium				
Employee age 25	$100	$250	$238	$594
Employee age 60	$375	$938	$238	$594
Employer contribution				
(1) Employer pays percent of benchmark (defined contribution = $60 pmpm). Employer pays:				
Employee age 25	$60	$60	$60	$60
Employee age 60	$60	$60	$60	$60
Total employer contribution	$120	$120	$120	$120
(2) Employer pays 60 percent of employee choice. Employer pays:				
Employee age 25	$60	$150	$143	$356
Employee age 60	$225	$563	$143	$356
Total employer contribution	$285	$713	$285	$713
Employee contribution				
(1) Employer pays percent of benchmark (defined contribution = $60 pmpm). Employee pays:				
Employee age 25	$40	$190	$178	$534
Employee age 60	$315	$878	$178	$534
Ratio of high to low within group	*7.9*	*4.6*	*1.0*	*1.0*
(2) Employer pays 60 percent of employee choice. Employee pays:				
Employee age 25	$40	$100	$95	$238
Employee age 60	$150	$375	$95	$238
Ratio of high to low within group	*3.8*	*3.8*	*1.0*	*1.0*

Note: Bold-print cells, with small-group composite rating with employer contribution as a percent of coverage, are most similar to the current case.

[a] Composite rate does not include the cost of a risk adjustment and/or reinsurance system.

II. Merging the Small Group and Individual Markets

In a merged market, carriers would be required to rate small group employees and individuals in the same way under small group regulations. However, the HIP rating rules do not require carriers to spread risk within a small group by using composite rating. (Carriers and employers choose to use composite rating in the current small group market.) Depending on how small-group coverage is rated in the HIP, older enrollees especially will experience “rate shock” when moving to individual coverage, much as they do today. Therefore, portability between group and individual coverage in the HIP could be less than might have been anticipated.

How rates are set in the small-group market and how employers contribute will affect the magnitude of the rate shock when moving from small group to individual coverage in the HIP. If small-group is list rating, carriers would offer individuals and small-group employees identical rates for the same products, and employers could pass the list rates on to their employees (as the example in Figure 1 assumed). Because individual coverage also is list rated, the difference in the amount that a worker would pay for the same coverage in a small group would differ from his individual premium only by the amount of the employer contribution.

However, if small-group coverage is composite-rated, small-group rates would appear to differ from the rate charged to individuals: small-group employees would see a rate that pools age-related risk within their group, while individuals would see a rate related to their own age. The rate differences for comparable coverage that workers experience now when moving from group to individual coverage would continue to exist.

An example of the differences in rates that might occur for a worker at age 60 under these alternative rules for small-group and individual rating is presented in Table 2. The example carries over the same premium levels for 60 year-olds from Table 1.

If small-group coverage is list-rated and employers used a *defined-contribution* approach to funding their small group plans, a 60-year old worker moving from small group to individual coverage in the HIP would experience a premium increase of 19 percent for Plan A and 7 percent for Plan B. If employers pay a *percent of premium* for the employee's chosen plan, then the change in premium will be greater when the employee moves to individual coverage. In our example, premiums paid by individuals in Plans A and B would be 150 percent greater than the contributions they paid as covered workers. In both cases, regardless of the contribution rule, the larger the employer contribution, the larger the jump in employee payments when moving from group to individual coverage. However, when both employees and individuals are list rated, the employee is not *also* moving from a composite rate to an individual list rate.

If carriers use small-group composite rating in the HIP and employers pay a percent of the benchmark plan (*defined contribution*), then premiums for a 60-year-old employee moving from group to individual coverage in the HIP (in our example) would increase 211 percent for plan A and increase 176 percent for Plan B. If employers paid a *percentage of premium* for any plans that their employees selected, premiums would increase 295 percent when moving from small group to individual coverage. *Note that this scenario is most similar to the current small group market, without the HIP.* If employers paid a still higher percentage of premium (not shown), the increase would be still greater.

Note that, when moving to individual coverage, the difference between a lower increase (in our example, 150 percent) and a much higher increase (295 percent) for an older worker is entirely due to use of composite rating. To eliminate that difference, HIP would need to apply list rating to small groups, although alternative options also exist for reducing rate shock when moving from small-group to individual coverage. These would include pure community rating

or compressing the allowable difference between rates for old and young enrollees. The Board might choose to discuss these rating options when it reviews the results of the Preliminary Study.

TABLE 2

EXAMPLE OF ALTERNATIVE RULES FOR SMALL-GROUP RATING, EMPLOYER CONTRIBUTIONS AND INDIVIDUAL LIST RATES FOR A HYPOTHETICAL WORKER AT AGE 60

	Small-group list rating		Small-group composite rating	
	Plan A	Plan B	Plan A	Plan B
Total premium				
Employee age 60	$375	$938	$238	$594
Individual age 60	$375	$938	$375	$938
Employer contribution				
(1) Employer pays percent of benchmark (defined contribution = $60 pmpm). Employer pays:				
Employee age 60	$60	$60	$60	$60
Individual age 60	$0	$0	$0	$0
(2) Employer pays 60 percent of employee choice. Employer pays:				
Employee age 60	$225	$563	$143	$356
Individual age 60	$0	$0	$0	$0
Employee/individual contribution				
(1) Employer pays percent of benchmark (defined contribution = $60 pmpm). Employee/individual pays:				
Employee age 60	$315	$878	$178	$534
Individual age 60	$375	$938	$375	$938
Increase from group to individual rate	*19%*	*7%*	*111%*	*76%*
(2) Employer pays 60 percent of employee choice. Employee/individual pays:				
Employee age 60	$150	$375	**$95**	**$238**
Individual age 60	$375	$938	**$375**	**$938**
Increase from group to individual rate	*150%*	*150%*	***295%***	***295%***

Note: Bold-print cells—with small-group composite rating with employer contribution as a percent of coverage, and individual list-rating—are most similar to the current case.
[a] Composite rate does not include the cost of a risk adjustment and/or reinsurance system.

Reviewing a similar example for a 25-year old raises an additional issue: incentives for young workers to take group coverage versus buying individual coverage in the HIP. Table 3 presents the same kind of example as in Table 2, but for a 25-year old worker and an individual of the same age. Note that with composite rating for small groups and list-rating for individuals, individual coverage would be either approximately as expensive or much less expensive for a 25-year-old worker, depending on the employer contribution method. This circumstance is not different from the small-group and individual markets currently. In contrast, with small-group list rating, the worker moving from small-group to individual coverage in the HIP would pay more only because he would lose his employer contribution; otherwise, he would pay the same premium as an individual as he did as a covered worker.

TABLE 3

EXAMPLE OF ALTERNATIVE RULES FOR SMALL-GROUP RATING, EMPLOYER CONTRIBUTIONS AND INDIVIDUAL LIST RATES FOR A HYPOTHETICAL WORKER AT AGE 25

	Small-group list rating		Small-group composite rating	
	Plan A	Plan B	Plan A	Plan B
Total premium				
Employee age 25	$100	$250	$238	$594
Individual age 25	$100	$250	$100	$250
Employer contribution				
(1) Employer pays percent of benchmark (defined contribution = $60 pmpm). Employer pays:				
Employee age 25	$60	$60	$60	$60
Individual age 25	$0	$0	$0	$0
(2) Employer pays 40 percent of employee choice. Employer pays:				
Employee age 25	$60	$150	$143	$356
Individual age 25	$0	$0	$0	$0
Employee/individual contribution				
(1) Employer pays percent of benchmark (defined contribution = $60 pmpm). Employee/individual pays:				
Employee age 25	$40	$190	$178	$534
Individual age 25	$100	$250	$100	$250
Increase from group to individual rate	*150%*	*32%*	*-44%*	*-53%*
(2) Employer pays 60 percent of employee choice. Employee/individual pays:				
Employee age 25	$40	$100	**$95**	**$238**
Individual age 25	$100	$250	**$100**	**$250**
Increase from group to individual rate	*150%*	*150%*	***5%***	***5%***

Note: Bold-print cells—with small-group composite rating with employer contribution as a percent of coverage, and individual list-rating—are most similar to the current case.
[a] Composite rate does not include cost of a risk adjustment and/or reinsurance system.

The incentive for younger workers to forego composite-rated group coverage for list-rated individual coverage demonstrates the importance of tax incentives for holding groups together with composite rating. We assume that employers that offer a Section 125 plan and group coverage will allow eligible workers to use the Section 125 plan *only* to pay contributions and cost sharing in the group plan, as they typically do now—although employees not eligible for the group plan would have access to a premium-only plan for the purpose of paying individual premiums. Absent this assumption, how small-group coverage is rated in the HIP could affect the ability of employers to retain young workers in small group (versus individual) coverage.

Finally, in our conversations with carriers, it was noted that merging the market for small groups and individuals would substantially increase premiums for individuals for at least two reasons:

(1) Individuals are now underwritten and denied coverage in Washington, and the same underwriting would continue in the HIP. In contrast, small groups are guaranteed issue, and would continue to be guaranteed issue. Therefore, individuals—offered the same products at the same prices—would subsidize small groups in the HIP.

(2) Products available in the HIP may be more generous than those now available in the market—which can have deductibles well above HSA-qualification standards.

The increase in benefits, together with subsidization of small groups would predictably cause a very high increase in premiums for individuals in the HIP.

For the purpose of the Board studies, offering individuals and small group enrollees in the HIP the same products at the same premiums—but retaining individual underwriting—may be a provision that cannot be altered. However, the Board should anticipate that a very high increase in individual premiums could result.

III. ADDITIONAL HIP BOARD GUIDANCE NEEDED FOR MODELING HIP

We request additional guidance with respect to the following three questions:

1. **What small-group rating method should be assumed?**
   a. List rating
   b. Composite rating with risk adjustment/reinsurance

2. **If small-group composite rating is assumed, should the cost of administering prospective and retrospective risk adjustment and/or reinsurance be included in the estimated premium, as it would be clearly necessary to sustain this rating method?**

3. **What rule for employer contributions to premium should be assumed?**
   a. Defined contribution
   b. Percentage of premium, regardless of employee choice
   c. Either, as determined by the employer

To assist in considering these questions, we distill the information presented in this memorandum in Table 4.

TABLE 4

SUMMARY OF LIKELY EFFECTS FROM RATING AND EMPLOYER CONTRIBUTION RULES IN THE HIP

Small-group rating: *Individual rating:*	**List** **List**	**Composite** **List**
Small group rate levels relative to baseline	Workers within group will pay different rates unless employer contribution offsets age-adjusted rate. Otherwise, older workers may take reduced coverage.	No change
Individual rate levels relative to baseline	No change	No change
Portability: Rate shock moving from small group to individual coverage		
Employer contribution is:		
Defined contribution	Minimum rate change	Medium rate change
Percent of chosen plan premium	Low-medium rate change	Maximum rate change (similar to current case)
Burden of administration		
Employers	Moderate change	No change
HIP	Low, although higher if carriers would want risk adjustment and/or reinsurance to manage small-group employee choice.	High: risk adjustment and/or reinsurance needed.

cc: Amy Lischko, Vicki Wilson, MPR project team

Washington State
Health Care Authority

Health Insurance Partnership Board
June 5, 2008

Timeline for Studies: Board *and* Citizens' Work Group on Health Care Reform

Date	Action
by **Dec 1, 2008**	**Health Insurance Partnership Board** Preliminary Report due to Governor and Legislature. Merged individual and small group plans offered through an Expanded Partnership.
by **Dec 15, 2008**	Legislature, on behalf of **Citizens' Work Group,** evaluates proposals: • Modification to insurance regulations for benefit design (e.g., mandates) and rating (e.g., adjusted to reflect health status). • Massachusetts-style reform: connector, individual mandate above an income level, and standards for employer contributions to coverage. • Healthy Washington: comprehensive, standardized benefit package offered by health carriers or networks through a competitive procurement process. • Single-payer health care system similar to Canada. • Validate actuarial analysis of Insurance Commissioner's proposal for guaranteed benefits for all Washingtonians above a specific deductible.
Jan 30, 2009 through Nov 1, 2009	13-member (9 citizens, 4 legislators) **Citizens' Work Group** conducts public process on improving access to quality, affordable health care. Report with recommendations on health care reform proposals due to Governor and Legislature by November 1, 2009.
by **Sep 1, 2009**	**Health Insurance Partnership Board** Final Report due to Governor and Legislature. • Individual and small group plans, Public Employees Benefits Board and K-12 employees, high risk pool, and Basic Health Plan offered through the Partnership. • Individual mandate.

DRAFT

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Washington State
Health Care Authority

HIP Meeting Schedule 2008

9:00 a.m. – 4:00 p.m.

January 3, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA

February 7, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA

March 6, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA

April 3, 2008
Doubletree Hotel Seattle Airport
18740 International Blvd
Seattle WA

May 1, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA

June 5, 2008
Seattle Marriott Airport Hotel
3201 S 176th St
Seattle WA

July 10, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA

August 7, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA

September 4, 2008
Hilton Seattle Airport & Conference Center
17620 International Blvd
Seattle WA