A Publicly-Owned Health Insurance Plan: Strategic Options

For discussion with the
Oregon Health Policy Board

Bill Kramer, Principal
Kramer Health Care Consulting
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What Makes a Health Plan a "Public Plan"?

- Owned by a public authority
- Accountable to the general public
- Insurance risk held by a public authority
- Managed by a public organization, although some functions may be outsourced
- Not necessarily a "government-run" delivery system
- Examples: Medicare, Medicaid

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Some Assumptions about a Publicly-Owned Health Insurance Plan

- Offered only within the Exchange.
- Operating "under the same rules and regulations as all health insurance plans offered through the exchange" [HB 2009]
- Expected to be self-sustaining
  - Operating expenses and ongoing capital covered by premiums
  - Start-up costs repaid over a reasonable period

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Environmental Analysis

- Customers' needs
- Competitive landscape
- Regulatory environment

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Environmental Analysis: Customer Needs

- #1 need: *Affordability*
- Other needs:
  - Good value: good quality of care and customer service for the price
  - Reasonable choice of providers
  - Choice of health plans

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Environmental Analysis: Competitive Landscape

Individual Market:

- 196,137 members (2008); will increase dramatically under PPACA
- Regence BCBS is market leader; six other major insurers are offered
- Medical loss ratios (2008):
  - Average: 94%
  - Range: 85-105%
- Wide range of benefit plans and premiums (will be affected by PPACA)

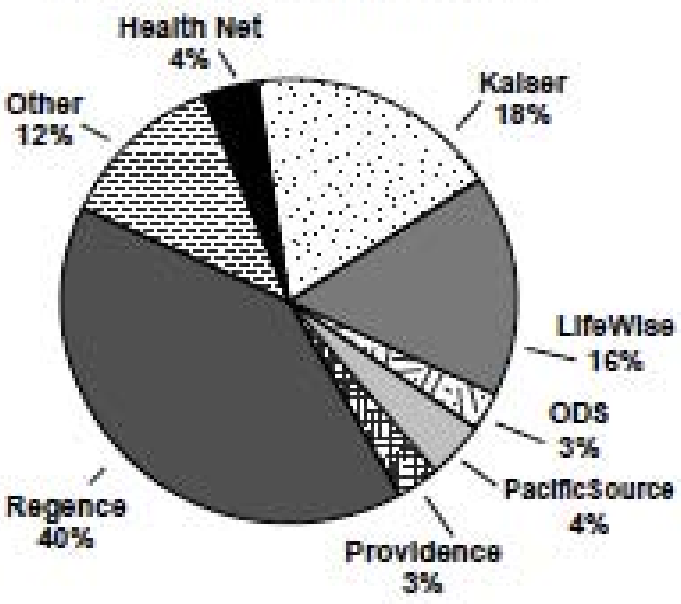

Figure 4-4. Market share by premium, individual market in 2008

Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports

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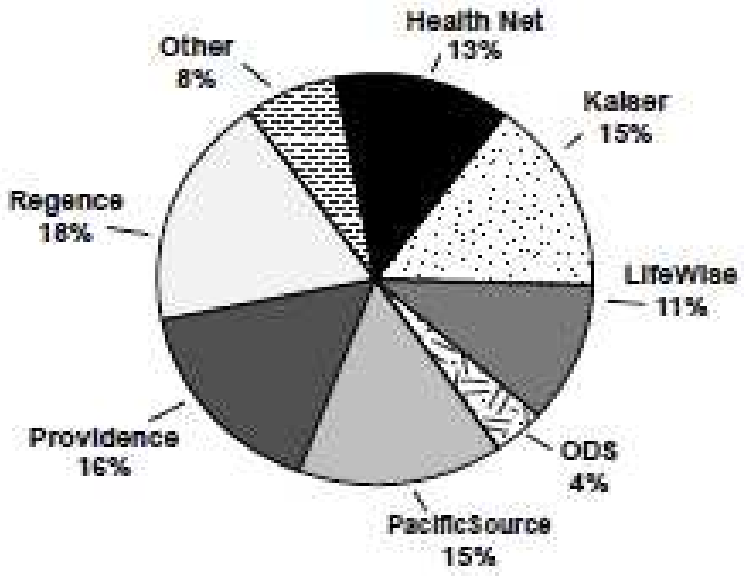
Environmental Analysis: Competitive Landscape

Small Group Market:

- 255,851 members (2008); will increase under PPACA
- Seven major insurers – none dominant
- Medical loss ratios (2008):
  - Average: 89%
  - Range: 81-96%
- Less range of benefit plans and premiums than in individual market

Figure 4-10. Market share by premium, small group market in 2008



Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports

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Environmental Analysis: Regulatory Environment

Significant changes in PPACA:

- Individual mandate requires insurance coverage for all citizens (with some exceptions)
- Insurance reforms remove barriers to coverage, e.g., guaranteed issue and renewability
- States establish Exchanges for individuals and small employer groups with <100 employees (starts 2014)
- HHS defines minimum benefit package to be offered in Exchange
- Federal premium tax credits and cost-sharing reductions
- Tax credits to low-wage small employers to purchase coverage (2010- 2013) and purchase through the Exchange (starts 2014)

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Environmental Analysis – Summary

- Customer needs - #1 is affordability
- Competitive landscape – many private plans currently offered
- Regulatory environment – PPACA likely to increase the number of enrollees and encourage healthy competition within the exchange

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Key Strategic Issues

- Organization and governance
  - Standalone plan or "piggy-back" on existing plan (OHP or PEBB)?
- Provider network strategy
  - Broad or narrow network? Payments at market or below? Use of innovative payment mechanisms?
- Administrative functions and expenses
  - How much for medical management? Marketing & sales? Opportunities for efficiencies?

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The Basic Question: Can a POHIP deliver better value?

- Medical Costs
  - Generally, there are great opportunities to slow the growth in medical spending, but it's not easy for one insurer to do it.
  - A POHIP will be limited in its ability to negotiate lower provider payment rates (compared to private insurers) unless it uses a narrow provider network.
  - A POHIP may be able to reduce overuse of services by using innovative provider payments and medical management tools, but there's no obvious advantage vs. private insurers.

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The Basic Question: Can a POHIP deliver better value? (cont.)

- Administrative Costs
  - Average admin costs among Top 7 Oregon Insurers = 10%
  - Generally, there's a trade-off between administrative and medical costs.
    - Stronger network management, development of innovative payments and use of medical management tools may reduce medical costs but increase administrative costs.
  - Lower spending on marketing and sales would limit enrollment.
  - Overall, there are only modest opportunities for a POHIP to have lower administrative costs.

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The Basic Question: Can a POHIP deliver better value? (cont.)

- Profit (Net Underwriting Gain)
  - Average profit among Top 7 Oregon insurers = 2% (5 year average)
  - A POHIP will also need to generate some profit in order to build reserves as it grows, set aside funds for future capital projects, and pay back start-up costs.

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Strategic Options: Potential Models

A) Standalone Plans

1) Broad Provider Network

2) Narrow Provider Network

B) “Piggy-back” Plans

1) Link with PEBB

2) Link with OHP

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Assessment of Models: A1: Standalone Plan, Broad Network

- Requires creation of new organization and infrastructure, probably higher administrative costs than "piggy-back" option.
- Broad network would attract more enrollees.
- Provider payment levels probably would have to be close to market (i.e., levels paid by other insurers).
  - May be opportunity to get discounts if plan is "provider friendly", e.g., fast claims processing, simple contracts, limited UM. Potential 0-3% savings?
  - The opportunities for innovative provider payments – at least initially – are probably limited due to broad network, added complexity, and higher administrative costs.

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Assessment of Models: A2: Standalone Plan, Narrow Network

- Requires creation of new organization and infrastructure, probably higher administrative costs than "piggy-back" option.
- Narrow network would attract fewer enrollees.
- Better opportunity to negotiate provider payment below levels paid by other insurers
  - Greater opportunities for innovative provider payments – resulting in lower medical costs overall. Potential savings: initially 1-5%, eventually 5-7%.
  - More sophisticated provider contracting function will add administrative costs.

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B1: Description of "Piggyback" Plan – with PEBB

- POHIP members would be allowed to enroll in the PEBB Statewide Plan (currently administered by Providence Health Plans).
- POHIP members would have access to the providers in the Statewide Plan.
- The risk pools for POHIP members and PEBB members would be kept separate; premiums would differ based on the experience of the pools.
- The base benefits would comply with the PPACA's essential benefits package. (The benefits would not be the same as in the current PEBB Statewide Plan.)
- Administrative services would be managed primarily by PEBB. Certain functions (e.g., marketing) may be managed directly by the POHIP or outsourced.
- Governance of the POHIP would be separate from the PEBB Board, but many administrative decisions would be delegated to the PEBB Board.

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Assessment of Models:
B1: "Piggyback" Plan – with PEBB

- Would avoid the need to create a new infrastructure.
- May enable the POHIP to minimize its administrative costs due to economies of scale.
- Broad network would attract more enrollees.
- Provider payment rates would be close to market levels, since they are negotiated by Providence Health Plan.
- Would allow the POHIP to take advantage of PEBB's provider network standards and innovations in benefit design.

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B2: Description of "Piggyback" Plan – with OHP

- POHIP members would be allowed to enroll in a new category within OHP.
- POHIP members would have access to providers through enrollment in one of the MCOs.
- The risk pools for POHIP members and OHP members would be kept separate; POHIP premiums would be based on the experience of its pool.
- The base benefits would comply with the PPACA's essential benefits package. (The benefits would not be the same as in the current OHP.)
- Administrative services would be managed primarily by OHP. Certain functions (e.g., marketing) may be managed directly by the POHIP or outsourced.
- Governance of the POHIP would be separate from the OHP, but many administrative decisions would be delegated to the OHA/OHP.

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Assessment of Models: B2: "Piggyback" Plan – with OHP

- Would avoid the need to create a new infrastructure.
- May enable the POHIP to minimize its administrative costs due to economies of scale.
- Narrow network would attract fewer enrollees.
- Provider payments would be probably be set above the current rates paid by MCOs for OHP enrollees, but they may be lower than for commercially-insured enrollees in private plans. Potential savings: 5-8%?
- MCOs would hold the insurance risk, which may reduce the level of required reserves for POHIP.
- Some of the MCOs currently may not have sufficient reserves to take on this new line of business; they would have to increase reserves substantially.

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Summary Assessment of Models

	# enrollees	Medical Costs	Administrative Costs & Profits	Other Issues
A1: Standalone, Broad Network	High	Perhaps 0-3% below market?	May be slightly lower than other insurers	
A2: Standalone, Narrow Network	Low-Medium	Eventually 5-7% below market?	Higher than A1 due to network development and management	
B1: "Piggyback" - PEBB	High	Eventually 2-5% below market? (using innovative payments)	Low – use of PEBB infrastructure	
B2: "Piggyback - OHP	Low	Perhaps 5-8% below market?	Low – use of OHP infrastructure	Lower reserve requirement; impact on MCOs?

Developing the Business Plan: Key Issues and Preliminary Analysis

1. Enrollment projections
   - Total enrollment in exchange: 190K (2015) → 360K (2019)
   - POHIP market share depends on model selected: broad or narrow network, expected price advantage (if any), marketing effort, etc.

Potential POHIP enrollment	**2015**	**2019**
Low Market Share (10%)	19,000	36,000
High Market Share (33%)	63,000	119,000

Developing the Business Plan: Key Issues and Preliminary Analysis

2. Economies of Scale
   - There are some economies of scale, but fixed costs for an insurer are relatively low.
   - As a result, an insurer can achieve reasonable administrative costs at a relatively small size. (Rule of thumb: minimum of 40,000 enrollees.)

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Developing the Business Plan: Key Issues and Preliminary Analysis

3. Start-up Costs
   - POHIP will incur costs prior to 1/1/2014:
     - Infrastructure development, e.g., IT systems for enrollment, claims, financial management, contracting
     - Sales and marketing
     - Management
   - Preliminary estimate: $20-30 million for standalone plan (to be refined)

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Developing the Business Plan: Key Issues and Preliminary Analysis

4. Reserve Requirements
   - Insurance Code requires minimum $2.5 million in surplus + $0.5 million for new insurer.
   - DOI uses risk-based capital (RBC) standards to evaluate insurer solvency; amount grows with enrollment.
   - Preliminary estimates of reserve requirements:
     - 2014: $11-30 million
     - 2019: $38-100 million

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Developing the Business Plan: Key Issues and Preliminary Analysis

5. Financing of Reserves and Start-up Costs
   - Initial financing would probably need to be an appropriation from the Legislature.
   - Assumption: Start-up costs would be repaid over a reasonable period.
   - Options to be explored further.

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Developing the Business Plan: Key Issues and Preliminary Analysis

6. Adverse Selection
   - CBO and HHS analyses of public plan in federal reform bills (2009) assumed that less healthy people would be more likely to enroll in POHIP.
   - PPACA contains many mechanisms to minimize and offset adverse selection.
   - Could affect POHIP premiums and reserve requirements.
   - Net effect? to be explored further.

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Developing the Business Plan: Key Issues and Preliminary Analysis

7. Risks and Uncertainties – *Most of the key factors have a very high degree of uncertainty*:
   - Total enrollment in exchange
   - POHIP market share
   - Ability to negotiate lower provider payment rates
   - Vulnerability to adverse selection

CBO: "Given all of the factors at work, however, [these] estimates are subject to an unusually high degree of uncertainty." (7/22/10 analysis of H.R. 5808)

CMS: "The actual percentage [of people choosing the public option] could be substantially different." (11/15/09 analysis of H.R. 3962)

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Appendix

History and Legislative Background

2002: CHOICE proposal – California

2007-08: Presidential primary campaigns

2009: Oregon legislation (HB2009): specific language re "publicly-owned health benefit plan" within the exchange

2009-10: National health reform

- Included in initial House bills and Senate HELP bill
- Excluded from Senate Finance bill and final ACA

July 2010: Reintroduced in Congress

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Advocates' Rationale for a Publicly-Owned Health Insurance Plan

[from interviews with and articles by advocates – not reviewed for credibility]

- ✓ Increases choice
- ✓ Promotes competition – incentive for private health insurers to improve value
- ✓ Sets a standard for best practices: model for improved delivery of care, customer service, reduction in disparities, value-based benefit design, etc.
- ✓ Counters the adverse effects of market concentration

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Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Lower costs → lower premiums
  - Lower administrative expenses
    - Less marketing and advertising
    - Lower executive compensation
  - Lower payment rates set or negotiated with providers
  - Innovative provider payment mechanisms
  - No need to generate returns for shareholders

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Advocates' Rationale for a Publicly-Owned Health Insurance Plan (cont.)

- ✓ Since there is an individual mandate, people should have a choice of public as well as private health plans
- ✓ Accountability to the general public, not just to shareholders
- ✓ Offers a trusted choice, improves transparency, builds public confidence

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Opponents' Arguments against a Publicly-Owned Health Insurance Plan

(from interviews with and articles by opponents – not reviewed for credibility)

- ✗ Unfair competition to private health insurers; it wouldn't really be a "level playing field"
- ✗ Would eventually eliminate the private insurance market
- ✗ Simply a path to a "single payer" system

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Opponents' Arguments against a Publicly-Owned Health Insurance Plan (cont.)

- ✗ Misuse of government power to underpay providers
- ✗ Danger of cost shift to privately insured patients, if POHIP pays providers & hospitals less
- ✗ Even if POHIP is set up to be self-sustaining, the government wouldn't let it fail – would step in to bail it out

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