Options for a Publicly Owned Health Insurance Plan for Oregon

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A Publicly Owned Health Insurance Plan for Oregon
Assessment and Business Plans for Three Potential Models
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In 2009, the Oregon Legislature passed HB 2009 establishing the Oregon Health Authority (OHA) and beginning the planning of comprehensive health reform. The OHA was tasked with the following:

> Develop and submit a plan to the Legislative Assembly by December 31, 2010, with recommendations for the development of a publicly owned health benefit plan that operates in the Exchange under the same rules and regulations as all health insurance plans offered through the Exchange, including fully allocated fixed and variable operating and capital costs.[i]

This report fulfills the OHA's responsibility as laid out in HB 2009, and it includes the history and legislative background of publicly owned health insurance plans, a summary of the arguments for and against publicly owned plans, an environmental analysis, a list of key strategic issues and options, a description of the assumptions used in the forecasts, and assessments and financial projections for three potential business models.

History and Legislative Background

The concept of a publicly owned health insurance plan (POHIP) as described in HB 2009 was developed over the previous decade.[ii] One of the earliest detailed plans was the CHOICE proposal, developed by a group of California health care leaders as part of the Health Care Options Project (HCOP) in 2002.[iii] During the next several years, the concept became part of a much larger discussion of potential health reform approaches at the state and federal level.

The POHIP concept gained additional exposure when it was included in the primary campaign proposals of the major Democratic candidates in 2007-08. John Edwards, Hilary Clinton, and Barack Obama all included a POHIP in their health reform proposals.[iv] After the Presidential election, a series of papers by Jacob Hacker elaborated the case for a POHIP in national health reform[v], and many other experts contributed their ideas to the proposal. During this time, advocates in Oregon were successful in adding language to the state's health reform bills regarding a publicly owned health plan.

At the national level, a POHIP was included in the initial House health reform bill and the Senate Health, Education, Labor and Pensions (HELP)

Committee bill in the summer of 2009. The Senate Finance Committee bill later that year, however, did not include a POHIP, and a revised House bill in October 2009 weakened several elements of the original proposal. Ultimately, a POHIP was not included in the Patient Protection and Affordable Care Act (ACA) that passed Congress in March 2010.

Publicly Owned Health Insurance Plan: Definition and Assumptions

Publicly owned health insurance plans exist in the current health system. The most obvious examples are Medicare and Medicaid, which are government-owned health insurance plans for the elderly and poor, respectively. Unlike government-owned health care delivery systems such as the Veterans Health Administration, Medicare and Medicaid are insurance plans that contract with private hospitals, physicians and other suppliers to provide services to beneficiaries. In the current context, a POHIP can be defined as a health insurance plan that is:

- Created by legislative action and owned by a public authority;
- Accountable to the general public through a legislatively defined governance structure;
- Self-insured, i.e., insurance risk is held by a public authority and not transferred to a private entity; and
- Managed by a public organization, although some administrative functions may be outsourced to private service contractors.

The POHIP is not expected to be the sole source of health insurance for a specific segment of the population. It is offered as a choice along with private health insurers, thus the common label of "public option".

For the purposes of this report, there are other assumptions about the design of a POHIP. Specifically:

- The POHIP would be offered only within a state Health Insurance Exchange, which will be created under the framework defined in the ACA. It will not be offered outside the Exchange to individuals, small employers or large employer groups.
- The POHIP would operate "under the same rules and regulations as all health insurance plans offered through the Exchange", per the language of HB 2009.[vi] This is interpreted to mean that the POHIP would not use government authority to set payment rates to hospitals, physicians and other providers, and it would be required to maintain the same level of financial reserves as private plans.

- The POHIP would be expected to be financially self-sustaining. Operating expenses and ongoing capital requirements would be covered by premiums charged to enrollees. Initial financing for start-up costs and other needs would be repaid over a reasonable period.

The Arguments For and Against a Publicly Owned Health Insurance Plan

Advocates have advanced a series of arguments in favor of a POHIP. They believe a POHIP would:

- **Increase choice**. Some rural and small town markets are dominated by one or two health insurers. A POHIP could offer a new choice to people in those areas.
- **Promote healthy competition**. By offering an option that is attractive to enrollees, a POHIP could be an effective competitor and create stronger incentives for private health insurers to improve the value they offer to enrollees, such as lower costs, improved quality and better customer service.
- **Set a standard for best practices**. A POHIP could become a model for the improved delivery of care, good customer service, improved health outcomes, reductions in health disparities, the use of value-based benefit designs, and other best practices.
- **Counter the adverse effects of market concentration.** As described in a 2009 Urban Institute report, " . . . health insurance markets today, by and large, are simply not competitive. And as such, these markets are not providing the benefits one would expect from competition, including efficient operations and consequent control over health care costs. . . . The role of the government plan is to counter the adverse impacts of market concentration and, in doing so, slow the growth in health care costs.[vii]
- **Lower costs, leading to lower premiums[viii].** Advocates suggest that a POHIP might be able to achieve lower costs due to:
  - Lower administrative expenses than private health insurers, due to less marketing and advertising and lower executive compensation;
  - Lower payment rates set or negotiated with providers;
  - Innovative provider payment mechanisms, leading to a reduction in the unnecessary use of health services, as well as an improvement in health outcomes; and
  - No need to generate returns for shareholders.
- **Offer the option of a publicly owned plan.** In the context of an individual requirement to have health insurance, many believe that

people should have a choice of publicly owned plan as well as private health plans.

- **Establish accountability to the general public**. Many people believe that private health plans do not operate in the public interest, since they are accountable to shareholders. A POHIP would be accountable to the general public.
- **Offer a trusted choice**. A POHIP could be more responsive to its enrollees, improve transparency, and build public confidence.

Opponents have articulated a series of concerns about a POHIP. They believe a POHIP would:

- **Create unfair competition.** Despite the requirement in HB 2009 that a POHIP would operate under the same rules and regulations as private plans, opponents are skeptical that this would be the case. They believe that any government-owned plan would receive certain benefits or exemptions from laws and regulations that apply to private plans.
- **Eventually eliminate the private insurance market.** As a result of competitive disadvantages, private insurers might withdraw or be forced out of the market. Ultimately, the market could evolve to a single payer system, with everyone enrolled in a government insurance plan.
- **Be a misuse of government power.** Opponents fear that a POHIP could use the government's authority to set the rates paid to hospitals and providers at levels below those paid by private insurers. This was an element of the original House and Senate HELP Committee bills in 2009, and it is part of a new bill introduced in Congress in July 2010.
- **Create a cost shift.** If the POHIP were to pay hospitals and providers significantly below the rates paid by private insurers, some fear that hospitals and providers would simply increase the rates charged to private insurers. As a result, private health insurance premiums would go up faster than underlying medical cost trends. The savings from a POHIP would be illusory, since the lower costs would be offset by increased costs to private plans.
- **Not be allowed to fail.** Opponents are skeptical of the assurances that a POHIP would be required to be financially self-sustaining. If the POHIP runs into financial difficulties in future years, opponents expect the government to step in to "bail it out."

The remainder of this report is an assessment of these claims and an analysis of the financial feasibility of a publicly owned health insurance plan.

Environmental Analysis

The first step in the development of a business plan is an analysis of three key factors: customer needs, the competitive landscape, and the regulatory environment. The following is a brief overview of each of these elements.

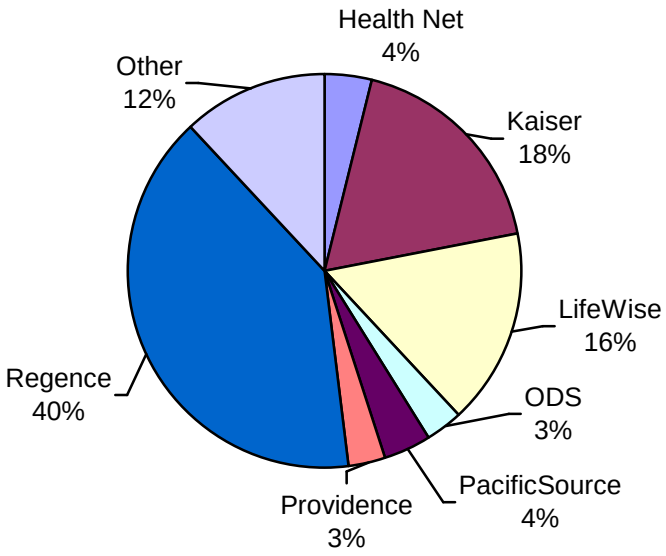
Customer Needs

Virtually every analysis indicates that the primary need for most customers is *affordability.* The costs of health care and health insurance have been rising rapidly for at least the past ten years, and many people feel report serious challenges in paying for health care.[ix] Other customer needs include good value (good quality of care and customer service for the price), a reasonable choice of providers, and a choice of health plans.

Competitive Landscape – Individual Market

The individual market in Oregon has 196,137 enrollees (2008). This will increase dramatically under the ACA due to the individual requirement to have health insurance and premium subsidies for low-income people. The largest seven insurers have 88% of the individual market, with 40% controlled by Regence Blue Cross Blue Shield of Oregon (see chart below)[x].

Market share by premium, individual market in 2008



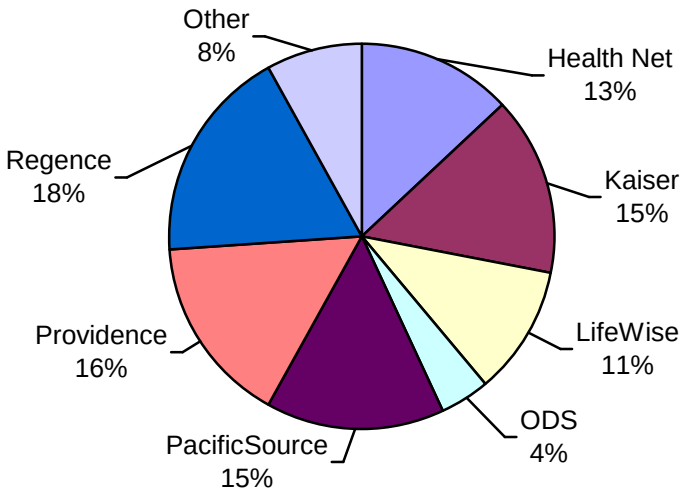
Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports
Note: percentages may not add to 100% due to rounding.

In the individual market, the average medical loss ratio in 2008 was 94%, and the range was 85-105%. There is a wide range of benefit plans and premiums in this market; this also will be affected by the ACA.

Competitive Landscape – Small Group Market

The small group market in Oregon consists of 255,851 members (2008); this also will increase under the ACA due to the individual requirement to have health insurance and tax subsidies to small employers with low-wage workers. Seven major insurers participate in the market, with none of them dominant (see chart below)[xi].

Market share by premium, small market in 2008



Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports
[Note: percentages may not add to 100% due to rounding.]

In the small group market, the average medical loss ratio in 2008 was 89%, with a range of 81-96%. In this market, there is a smaller range of benefit plans and premiums compared to the individual market.

Regulatory Environment

The individual and small group markets are highly regulated in Oregon, and the ACA will introduce additional significant changes, including:

- The individual mandate will require insurance coverage for most citizens.
- Insurance reforms such as guaranteed issue and renewability will remove barriers to coverage.
- A Health Insurance Exchange will be established in each state for individuals and small employer groups with less than 100 employees beginning in 2014.
- The federal government will define a minimum benefit package to be offered in Exchange.
- There will be federal premium tax credits and cost-sharing reductions for low-income people.
- Tax credits to will be available to small employers with low-wage workers to purchase coverage.

In summary, a POHIP will operate in an environment with the following characteristics:

- Strong customer demand for affordable health plans, with a secondary demand for provider choice;
- Multiple health insurance competitors in the individual and small group markets;
- Expanded markets under the ACA; and
- Competition based less on risk selection, and more on price and value.

Key Strategic Issues

In the development of a business plan for the POHIP, a number of key strategic issues will need to be addressed.

- *Core Business Strategy*. What will be the POHIP's strategy for achieving superior value compared to private health plans? For example, will it offer lower cost with the same quality and service, or higher quality and service at the same cost? It is difficult for any product or service to offer superior customer value on all dimensions; choices will need to be made.
- *Provider Network Strategy*. Will the POHIP offer a wide range of providers, or will it be more selective? How much will the POHIP pay hospitals and providers? A wide provider network would be more attractive to potential enrollees, but this strategy may make it more difficult to negotiate lower payments with providers.
- *Administrative and Management Functions*. Is there an opportunity for the POHIP to achieve lower administrative costs? Most of the administrative functions of a private insurance plan -- claims processing, customer service, provider contracting, accounting and financial management – will also be incurred by a POHIP. Are there some functions that a POHIP will not need or could accomplish at lower cost? How much should be spent on medical management, marketing and sales?
- *Medical Management*. How strong should the POHIP's medical management function be? There is a trade-off: a strong utilization management function will incur higher administrative costs but lower medical costs, while a weaker UM function will have lower administrative costs but incur higher medical costs.[xii]
- *Size*. Many feel that the POHIP's size (number of enrollees) is important. Increased size can help the POHIP use economies of scale to keep administrative costs low. In addition, size may help to attract providers and provide some degree of negotiating leverage with providers. How big should the POHIP be to achieve these goals?
- *Adverse Selection*. Some experts feel that a POHIP would be subject to adverse selection, meaning that sicker people would be more likely

to join a POHIP than a private plan, thereby driving up the medical costs and premiums for the POHIP.[xiii] Although risk adjustment mechanisms in the ACA may offset this, the Congressional Budget Office (CBO) believes that they will be insufficient to fully compensate the POHIP for adverse selection.[xiv] How serious is this risk, and what could be done to avoid or mitigate the danger of adverse selection?

Strategic Options: Potential Models

In its discussion of a POHIP, the Oregon Health Policy Board considered two basic options, each with two sub-options.

A. Standalone plan. A POHIP would be established as a standalone public entity, either as a state agency or public corporation, with a board accountable to the general public.

- It would contract directly with a wide range of providers in a so-called "open" network (option A1) or a narrow range of providers in a "selective" network (option A2).
- The base benefits would comply with the ACA's essential benefits package.
- Administrative services would be managed directly by the POHIP or outsourced as appropriate.

B. "Piggyback" on existing plan. One way to offer a publicly owned plan is to "piggyback" on to existing public plans.[xv]

B1 – Piggyback with PEBB (Public Employees Benefit Plan). In this option, POHIP members would be allowed to enroll in a plan that mirrors the PEBB Statewide Plan, currently administered by Providence Health Plans.

- POHIP members would have access to the providers in the PEBB 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 ACA's essential benefits package. (The benefits would not be the same as in the current PEBB Statewide Plan.)
- Most administrative services would be managed 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 could be delegated to the PEBB Board.

B2 – Piggyback with OHP (Oregon Health Plan, Oregon's Medicaid program). In this option, 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 Oregon Health Plan's MCOs (Managed Care Organizations).
- 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 ACA's essential benefits package. (The benefits would not be the same as in the current OHP.)
- Most administrative services would be managed 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 Oregon Health Authority.

After a preliminary analysis, the Oregon Health Policy Board asked for detailed analyses of options A1, B1 and B2. The Board felt that option A2 (Standalone plan with a narrow provider network) was less likely to be feasible due to limited market attractiveness and higher start-up costs. Other options discussed but not pursued included "piggyback" plans linked with the Oregon Educators Benefit Board (OEBB) and the State Accident Insurance Fund (SAIF).

One other option was discussed but not pursued in detail: the co-op model. The ACA (Sec. 1322) creates the opportunity to develop Consumer Operated and Oriented Plans (CO□OPs) with the following characteristics:

- They must be "organized under State law as a nonprofit, member corporation".
- "The governance of the organization is subject to a majority vote of its members."
- "Profits inure to benefit of members"

Furthermore, Sec. 1322 of the ACA excludes certain organizations from the definition of CO-OPs:

- Any organization that is currently a health insurer.
- Any organization sponsored by a State or local government.

The ACA makes available $6 billion in loans (for start-up costs) and grants (to meet solvency requirements) to finance CO□OP plans. Regulations and the distribution formula for CO□OP appropriations have not yet been established.

The co-op model was not analyzed further, because it is not strictly a "publicly owned health insurance plan," although it might achieve some of the same objectives.

The Business Plan: Financial Projections for the Three Models

For each of the three models, a detailed financial projection was developed. Key inputs and assumptions included:

- Membership;
- Target premium rates;
- Medical/hospital/other claims costs (and the effect of adverse selection);
- Administrative costs; and
- Start-up costs (2013).

Key outputs from the projections included:

- Total revenue, total expenses, and net income or loss;
- Reserve requirements; and
- Initial financing requirements for start-up costs, initial losses and reserves.

Summary of Key Assumptions (see Appendix for detailed description):

- Membership – The market shares for the models with large, open provider networks and with premiums slightly below the average of private plans (A1: Standalone, and B1: PEBB Piggyback) are expected to be 25% of total Exchange members in 2019. For the model with a narrow, selective network and with premiums somewhat below the average of private plans (B2: OHP Piggyback), the market share is expected to be 10%.
- Target Premium Rates -- In order to meet affordability goals and membership targets, premiums are set slightly or somewhat below the average of private plans after year 1 (2014).
- Medical/Hospital/Other Claims expenses -- The ability to manage medical expenses is expected to be affected primarily by:
    - Size and type of provider network: open (A1 (Standalone) and B1 (PEBB Piggyback)) vs. selective (B2 (OHP Piggyback)).

- Degree of medical management: moderate (A1, B1) vs. strong (B2)

  A POHIP is expected to be limited in its ability to negotiate lower provider payment rates (compared to private insurers) unless it uses a narrow provider network.

- Adverse Selection – The analyses of the public plan in national health reform bills by CBO and the Department of Health & Human Services/ Centers for Medicare & Medicaid Services (HHS/CMS) in 2009 assumed that less healthy people would be more likely to enroll in a POHIP. The ACA, however, contains many mechanisms to minimize and offset adverse selection. These financial projections assume *no adverse selection*, but this is a significant potential risk.
- Administrative Costs – In general, there are only modest opportunities for a POHIP to have lower administrative costs. Generally, there is 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; the models assume that spending on marketing and sales would be similar to private plans. Costs are relatively high in the first year (2014) as a percent of premium due to small initial membership.
- Start-up Costs – The POHIP will incur costs prior to January 1, 2014, for infrastructure development, including information technology (IT) systems (for enrollment, claims, financial management and other business processes), contracting, sales and marketing, planning and management. Start-up costs are less for B1 and B2 (PEBB and OHP Piggyback) compared to A1 (Standalone), due to use of existing infrastructure.

- It should be noted that most of the key factors have a *very high degree of uncertainty*. In particular, the use of different assumptions regarding the following factors could result in significantly different financial outcomes:
  - Total enrollment in the Exchange;
  - The POHIP's market share;
  - Ability to negotiate lower provider payment rates; and
  - Vulnerability to adverse selection

Results of Financial Projections

A1: Standalone Plan

Based on the assumptions described above, the Standalone Plan would achieve a membership of 70,175 in 2016, with a net income of $4.2 million. It would have start-up costs of $19.5 million in 2013, and financial losses in the first two years of operations. The results are displayed below.

	2013	2014	2015	2016
Membership - YE	0	27,700	55,400	70,175
Revenue - $ million	$0	$135.7	$291.5	$396.6
Expenses - $ million	$19.5	$154.0	$296.2	$392.4
Net Income (Loss)	$(19.5)	$(18.2)	$(4.7)	$4.2

B1: PEBB Piggyback

The PEBB Piggyback Plan would achieve a membership of 70,175 in 2016, with a net income of $6.3 million. It would have start-up costs of $14.2 million in 2013, and financial losses in the first two years of operations. The results are displayed below:

	2013	2014	2015	2016
Membership - YE	0	27,700	55,400	70,175
Revenue - $ million	$0	$135.7	$288.6	$392.6
Expenses - $ million	$14.2	$147.8	$291.2	$386.3
Net Income (Loss)	$(14.2)	$(12.1)	$(2.6)	$6.3

B2: OHP Piggyback

The OHP Piggyback Plan would achieve a smaller membership (28,070) than the above options, with a small net loss ($0.6 million) in 2016. Its

start-up costs in 2013 would be lower – only $8.7 million – and it would have losses in the first three years of operations. The results are displayed below:

	2013	2014	2015	2016
Membership - YE	0	11,080	22,160	28,070
Revenue - $ million	$0	$54.3	$114.3	$153.8
Expenses - $ million	$8.7	$62.2	$120.9	$154.4
Net Income (Loss)	$(8.7)	$(8.0)	$(6.7)	$(0.6)

Reserve Requirements – The Oregon Insurance Code requires minimum reserves of $2.5 million in surplus plus $0.5 million for a new insurer. The Division of Insurance normally uses risk-based capital (RBC) standards to evaluate insurer solvency, based on size (enrollment), risk profile (populations to be served, services covered, provider payment arrangements) and potential sources of additional funds if needed. In the absence of a detailed RBC analysis, however, the financial projections use 10% of premium, based on pre-RBC guidelines and conversations with DOI staff.

Based on these assumptions, the reserve requirements for the three models are shown below:

	Day 1	2014	2015	2016
A1: Standalone	$3.0M	$13.6M	$29.2M	$39.7M
B1: PEBB Piggyback	$3.0M	$13.6M	$28.9M	$39.3M
B2: OHP Piggyback	$3.0M	$ 3.8M	$ 8.0M	$10.8M

Financing Requirements -- Initial financing will be required to pay for:

- Start-up costs
- Losses in years 1-2 (and potentially beyond)
- Contributions to reserves – until net income is sufficient

The total financing requirements for the three models are shown below:

Minimum Initial Financing	
A1: Standalone	$78M
B1: PEBB Piggyback	$62M
B2: OHP Piggyback	$35M

It should be noted that the financing options for a POHIP appear to be limited:

- An appropriation from the Legislature is very unlikely in the current state fiscal environment.
- A new General Obligation (GO) Bond is possible, but the State Treasurer has recommended a temporary halt to new GO bonds until state's financial situation improves.
- A new Direct Revenue Bond (non-tax supported) appears to be the most viable option:
  - It would be fully self-supporting from enterprise revenues.
  - It would not draw on General Fund or require special taxes.

  A Direct Revenue Bond proposal would require detailed cash flow projections and a thorough risk assessment, which are beyond the scope of this report.

Summary of Financial Projections

The key outputs from the financial projections are shown in the table below:

	2016 Membership	Breakeven Year	Initial Financing Requirement
A1: Standalone	70,175	2016	$78M
B1: PEBB Piggyback	70,175	2016	$62M
B2: OHP Piggyback	28,070	2017	$35M

Appendix

Description of Assumptions used in Developing Financial Projections

Policy Assumptions

- The POHIP will be offered only within the Exchange.
- The POHIP will operate "under the same rules and regulations as all health insurance plans offered through the Exchange" [HB 2009]. For example, the POHIP will not use government authority to set payment rates to hospitals, physicians and other providers, and it will be required to maintain the same level of financial reserves as private plans.
- The POHIP is expected to be self-sustaining:
  - Operating expenses and ongoing capital will be covered by premiums; and
  - Initial financing for start-up costs and other needs will be repaid over a reasonable period.

Membership Forecasts

- The estimated market shares in 2019 are driven primarily by the size of the provider network and secondarily by the POHIP's premiums compared to private plans, given the relatively small difference in premiums – see below. A larger network will attract more members, while a smaller network will attract fewer members, because many people prefer to keep their own doctor when switching insurers.
  - Open network, premiums slightly below average of private plans (A1: Standalone, and B1: PEBB Piggyback): 25% of total Exchange members
  - Selective network, premiums somewhat below average of private plans (B2: OHP Piggyback): 10% of total Exchange members
  - References for market share estimates:
    - The CBO analysis of HR 5808 (July 2009) estimated a 33% market share for a public option, assuming a wide network and premiums 5-7% lower (on average) than private plans. (The report noted that this estimate had an "unusually high degree of uncertainty".)
    - The CBO analysis of HR 3962 (October 2009) estimated a 20% market share for a public option, assuming a wide network and premiums "somewhat higher" (on average) than private plans.

- Phase-in

- The market shares in 2015 are estimated to be 20% for A1: Standalone and B1:PEBB Piggyback), 8% for B2: OHP Piggyback.
- Membership estimates are interpolated (straight line) between 2015 and 2019.
- Memberships in 2014 are estimated to be one-half of 2015 memberships.

	2014	2015	2016		2019	Mkt. Share
A1: Standalone	27,700	55,400	70,175		114,500	25%
B1: PEBB Piggyback	27,700	55,400	70,175		114,500	25%
B2: OHP Piggyback	11,080	22,160	28,070		45,800	10%
Total Exchange	*207,500*	*277,000*	*327,500*		*458,000*	

Target Premium Rates vs. Private Plans

- The financial forecast model uses target premium rates as an input, and net income (or loss) as an output. (A different approach would have set net income targets (i.e., used them as inputs), and then calculated the premiums needed to meet those targets.) In order to meet customers' needs for affordability and to achieve reasonable membership growth, premium targets are set below the average of private plans after year 1 (2014), as shown in the following table.

% below private plans	2014	2015	2016
A1: Standalone	0	-1%	-2%
B1: PEBB Piggyback	0	-2%	-3%
B2: OHP Piggyback	0	-3%	-5%

- The potential for negotiating lower provider payments is greater with a selective provider network, which is the case in option B2: OHP Piggyback.
- The forecast of average premiums in the Exchange is based on the actual average per member per month (pmpm) premium ($286) in the small group market in 2008 (Source: DCBS *Health Insurance in Oregon,* January 2010), inflated at 8.5% annually.
- References for premium inflation rate forecasts:
  - CBO's scoring of the national health reform Reconciliation bill (March 2, 2010) estimated a 9.25% annual compound growth rate in the average cost of premium and cost sharing per enrollee in the Exchange, 2016-19.

- The Kaiser Family Foundation-Health Educational & Research Trust's *Health Benefits Survey 2010* showed an 8.2% annual compound growth increase in average family premiums, 1999-2010.

Medical/Hospital/Other Claims Expenses

- The ability to manage medical expenses is affected primarily by the:
  - Size and type of provider network: open (A1: Standalone and B1: PEBB Piggyback) vs. selective (B2: OHP Piggyback).
  - Degree of medical management: moderate (A1, B1) vs. strong (B2)
- 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 is no obvious advantage compared to private insurers.
- Average claims expense for private plans is assumed to be 85% of premium, based on the minimum loss ratio target in the ACA and a sample of rate increase requests in Oregon in the fall of 2010.
- The estimate assumes a normal risk pool (see next section for analysis of potential adverse selection impact).

% below private plans	2014	2015	2016
A1: Standalone	0	-1%	-2%
B1: PEBB Piggyback	0	-1%	-2%
B2: OHP Piggyback	0	-3%	-5%

Adverse Selection

- The CBO and HHS/CMS analyses of public plan in national reform bills (2009) assumed that less healthy people would be more likely to enroll in POHIP.
- The ACA, however, contains many mechanisms to minimize and offset adverse selection.
- This model assumes *no adverse selection*, but this is a significant potential risk. (The HHS/CMS report in Nov 2009 estimated the potential effect to be +10%.)

Administrative Costs

- Overall, there are only modest opportunities for a POHIP to have lower administrative costs.
    - Generally, there is 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; the financial projections assume that spending on marketing and sales would be similar to private plans.
- Average administrative expenses for private plans are assumed to be 13% of premium in year 2; these include General Administrative expenses as well as Claims Adjustment expenses. These estimates are based on average administrative costs among the largest seven Oregon insurers for all lines of business (10%; source: DCBS *Health Insurance in Oregon,* January 2010), adjusted upward by 3% based on a sample of rate increase requests for small group products in Oregon in the fall of 2010.
- It is assumed that there will be high administrative costs (as a percent of premium) in first year (2014) due to small membership.
- Administrative costs for option A1: Standalone are estimated to be slightly lower than the private plan average in 2016.
- Administrative costs for option B1: PEBB Piggyback are estimated to be slightly lower than A1: Standalone due to the opportunity to use PEBB's infrastructure for certain administrative functions.
- Administrative costs for option B2: OHP Piggyback are estimated to be lower due to smaller size and the opportunity to use OHP's infrastructure for certain administrative functions, but these costs are high as a percent of premium due to lack of economies of scale.

	2014	% of prem.	**2015**	% of prem.	**2016**	% of prem.
A1: Standalone	$24.4M	18%	$29.4M	10%	$36.4M	9%
B1: PEBB Piggyback	$20.4M	15%	$26.5M	9%	$32.4M	8%
B2: OHP Piggyback	$10.9M	20%	$17.7M	15%	$19.4M	13%

Start-up Costs

- The POHIP will incur costs prior to January 1, 2014 for:
    - Infrastructure development, including IT systems for enrollment, claims, financial management, and contracting;
    - Sales and marketing;
    - Planning; and
    - Management.

- Start-up costs in 2013 are estimated as a percent of administrative costs in 2014:
    - A1 (Standalone): 80% of 2014 costs.
    - B1 (PEBB Piggyback): 70% -- lower due to use of existing infrastructure.
    - B2 (OHP Piggyback): 80% -- lower due to use of existing infrastructure, but offset by small size (high fixed costs).

	2013
A1: Standalone	$19.5M
B1: PEBB Piggyback	$14.2M
B2: OHP Piggyback	$ 8.7M

Reserve Requirements

- The Oregon Insurance Code requires a minimum of $2.5 million in surplus plus $0.5 million for a new insurer.
- The Oregon Division of Insurance uses risk-based capital (RBC) standards to evaluate insurer solvency. The RBC calculation is based on size (enrollment), risk profile (populations to be served, services covered, provider payment arrangements) and sources of additional funds if needed.
- In the absence of a detailed RBC analysis, the financial forecast in this report uses 10% of premium (7% for OHP Piggyback due to risk assumed by MCOs), based on pre-RBC guidelines and conversations with DOI staff.

	Day 1	2014	2015	2016
A1: Standalone	$3.0M	$13.6M	$29.2M	$39.7M
B1: PEBB Piggyback	$3.0M	$13.6M	$28.9M	$39.3M
B2: OHP Piggyback	$3.0M	$ 3.8M	$ 8.0M	$10.8M

Financing Requirements

- Initial financing will be required to pay for:
    - Start-up costs
    - Losses in years 1-2 (and perhaps beyond)
    - Contributions to reserves – until net income is sufficient

- The expense projections include non-operating costs for principle and interest (P&I) payments on initial financing, assuming a 1:1 debt

service coverage requirement. If the debt service coverage requirement is higher (due to higher uncertainty/risk), the projected net income would be less and the initial financing requirement would be higher. P&I payments are based on an assumption of 5% interest, to be paid back over 10 years.

Minimum Initial Financing	
A1: Standalone	$78M
B1: PEBB Piggyback	$62M
B2: OHP Piggyback	$35M

[i] House Bill 2009, Sec. 9 (1)(L), 75th Oregon Legislative Assembly--2009 Regular Session

[ii] Much of this section is based on an excellent summary of the policy and political debates about the public option in this article. Halpin HA and Harbage P. The origins and demise of the public option. Health Affairs 29, No. 6 (2010): 1117-1124.

[iii] Schauffler HH. CHOICE. California Health Care Options Project. Sacramento (CA): Health and Human Services Agency; 2002.

[iv] Edwards '08: Universal health care through shared responsibility. Feb. 5, 2007; Clinton '08: American health choices plan: quality, affordable health care for every American. Sep 17, 2007; Obama '08: Barack Obama's plan for a healthy America. May 7, 2007.

[v] Hacker JS. The case for public plan choice in national health reform. Berkeley (CA): Campaign for America's Future and UC Berkeley Center for Health, Economic, and Family Security; 2008. Hacker JS. Healthy competition: how to structure public health insurance plan choice to ensure risk sharing, cost control, and quality improvement. Berkeley (CA): Campaign for America's Future and UC Berkeley Center on Health, Economic, and Family Security; 2009.

[vi] House Bill 2009, Sec. 9 (1)(L), 75th Oregon Legislative Assembly--2009 Regular Session

[vii] Holahan J and Blumberg LJ. Is the public plan option a necessary part of health reform? Washington (DC): Urban Institute Health Policy Center; 2009. Available from: http://www.urban.org/publications/411915.html

[viii] There are many analyses of the potentially lower costs and premiums of a POHIP. The most recent is the CBO analysis of H.R. 5808, the public plan bill introduced in Congress in July 2010. CBO concluded that the public plan's premiums would be 5-7% lower, on average, than private plans in the Exchanges. The key factors were rates paid to providers, administrative costs, the effects of utilization management, and the impact of adverse selection. (Elmendorf DW. Analysis of a proposal to offer a public plan through the new health insurance Exchanges. Letter to the Honorable Fortney Pete Stark, July 22, 2010. Available from: http://www.cbo.gov/doc.cfm?index=11689

[ix] The Henry J. Kaiser Family Foundation. *Kaiser Health Tracking Poll,* December 2010. Available from: http://kff.org/kaiserpolls/8127.cfm.

[x] Oregon Department of Consumer and Business Services. *Health Insurance in Oregon,* January 2010.

[xi] Oregon Department of Consumer and Business Services, *op cit*.

[xii] Halpin HA and Harbage P, *op cit.*

[xiii] Holahan J and Blumberg LJ, *op cit.*

[xiv] Elmendorf DW, *op cit.*

[xv] It should be noted that in the eyes of some advocates, a "piggyback" plan might not meet the definition of a pure "public plan". For example, some advocates believe that contracting with a private health insurer to establish and manage the provider network – as Providence Health Plan does for the PEBB Statewide Plan – would be inconsistent with the principles of a public plan.