A Publicly-Owned Health Insurance Plan: Business Plans for 3 Options

For discussion with the
Oregon Health Policy Board

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Definition of 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

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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
  - Initial financing for start-up costs and other needs will be repaid over a reasonable period

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Environmental Analysis – Summary

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

[Detailed analysis presented at October OHPB meeting – see Appendix]

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Key Strategic Issues

- Organization and governance
  - Standalone plan or "piggy-back" on existing public program?
- Provider network strategy
  - Selective or open 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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Strategic Options: Potential Models

A) Standalone Plans

1) Open Provider Network – used for baseline analysis

2) Selective Provider Network – not evaluated further

B) "Piggy-back" Plans

1) Link with PEBB – selected for detailed analysis

2) Link with OHP – selected for detailed analysis

[Detailed descriptions presented at October OHPB meeting – see Appendix]

Other options not evaluated: link with OEBB, SAIF

Issue: In the eyes of some advocates, a "piggy-back" plan might not meet the definition of a "public plan".

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The Co-op Option

- ACA created Consumer Operated and Oriented Plans (CO-OPs)
  - Must be nonprofit
  - "The governance of the organization is subject to a majority vote of its members."
  - "Profits inure to benefit of members"
- *Not strictly a "public plan", but might achieve some of the same objectives*
- $6 billion in loans (for start-up costs) and grants (to meet solvency requirements) will be available to finance CO-OP plans
- Regulations and distribution formula for CO-OP appropriations – TBD.

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The Business Plan: Key Assumptions

1. Membership projections

- Ultimate market share driven by size of provider network: open (A1, B1) vs. selective (B2); phased in over time.
- Total Exchange includes individuals *and* small employers [revised from October preliminary figures]

	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*	

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The Business Plan: Key Assumptions

2. Target Premium Rates vs. Private Plans

- In order to meet affordability goals and membership targets, premiums set below average of private plans after year 1 (2014)

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

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The Business Plan: Key Assumptions

3. Medical/Hospital/Other Claims Expenses

- Ability to manage medical expenses is affected by
  - Size and type of provider network: open (A1, B1) vs. selective (B2).
  - Degree of medical management: moderate (A1, B1) vs. strong (B2)

[Rationale for these assumptions presented at October OHPB meeting – see Appendix]

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

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The Business Plan: Key Assumptions

4. 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.
- But ACA contains many mechanisms to minimize and offset adverse selection.
- Model assumes *no adverse selection*, but this is a potential risk.

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The Business Plan: Key Assumptions

5. Administrative Costs

- High costs in first year (2014) due to small membership.
- Standalone slightly lower than private plan average in 2016
- PEBB Piggyback lower than Standalone
- OHP Piggyback lower due to smaller size (but high as % of premium)

[Rationale for these assumptions presented at October OHPB meeting – see Appendix]

	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%

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The Business Plan: Key Assumptions

6. 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

(cont.)

The Business Plan: Key Assumptions

6. Start-up Costs (cont.)

- Start-up costs are less than Standalone for PEBB and OHP "Piggyback" options due to use of existing infrastructure.
- OHP Piggyback costs are lowest due to smaller size.

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

The Business Plan: Key Assumptions

7. Reserve Requirements
   - Insurance Code requires min. $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.*
   - In absence of detailed RBC analysis, the model uses 10% of premium (7% for OHP Piggyback due to risk assumed by MCOs)

The Business Plan: Key Assumptions

A Reminder about 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

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The Business Plan: Financial Projections

Key Inputs and Assumptions:

- Membership
- Premium rates
- Medical/Hospital/Other Claims costs (and effect of adverse selection)
- Administrative costs
- Start-up costs (2013)

Outputs

- Net income or loss
- Reserve requirements – based on premium revenue
- Initial financing requirement for start-up costs, initial losses and reserves

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Financial Projections A1: Standalone Plan

	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

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Financial Projections
B1: PEBB Piggyback

	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

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Financial Projections
B2: OHP Piggyback

	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)

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Financial Projections
Reserve Requirements

	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

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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

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

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Financing

Financing Options are Limited:

1. Appropriation from the Legislature – unlikely in current fiscal environment
2. General Obligation Bond – State Treasurer has recommended a temporary halt to new GO bonds until state's financial situation improves
3. Direct Revenue Bond (non-tax supported)

Option 3 appears to be the most viable option:

- Fully self-supporting from enterprise revenues
- Would not draw on General Fund or require special taxes
- Will require detailed cash flow projections and risk assessment

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Summary Assessment of Models

	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

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Next Steps

- Select preferred model(s)
- Finalize business plan(s)
- Submit report to the Legislative Assembly by December 31, 2010.

Appendix

Materials presented at the
August and October meetings of the
Oregon Health Policy Board

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

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.)

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

- ✓ 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.)

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

- ✓ 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.)

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

✗ 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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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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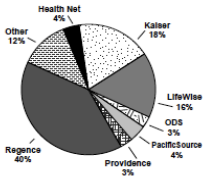
Environmental Analysis: Competitive Landscape

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



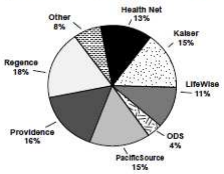
Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports

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

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)

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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A1: Description of Standalone Plan (for baseline analysis)

- POHIP would be established as a standalone public entity, with a board accountable to the general public.
- POHIP would contract directly with a wide range of providers, i.e., an "open" network.
- The base benefits would comply with the PPACA's essential benefits package.
- Administrative services would be managed directly by the POHIP or outsourced as appropriate.

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B1: Description of "Piggyback" Plan – with PEBB

- POHIP members would be allowed to enroll in a plan that mirrored 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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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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