State Coverage Initiatives

Considering a Health Insurance Exchange

Lessons from the Rhode Island Experience

By Deb Faulkner, Amy Lischko, and Deborah Chollet

Massachusetts' landmark health care reform law offers many lessons for states considering comprehensive reform. One key element introduced by the Massachusetts reform plan is the concept of a health insurance exchange. Named the "Connector," this new model transforms the way health insurance is packaged, subsidized (for low income individuals and families), and purchased in Massachusetts.

Policymakers in many states continue to closely watch Massachusetts, particularly now that the economy has weakened. Because of economic circumstances facing every state, most are only considering incremental reform at this time. A number of states are interested in establishing some form of a health insurance exchange.

Lt. Governor Elizabeth Roberts of Rhode Island proposed legislation in 2008 to establish an exchange-like organization called "HealthHub RI." While the legislation did not pass, she proceeded to convene a public process and study, beginning in the fall of 2008, to identify and evaluate options for a future exchange in Rhode Island. Many different stakeholders participated in this public process including carriers, brokers, employers, consumers, legislators, and other interested parties. The process was staffed by the state's Office of the Health Insurance Commissioner and facilitated by consultants familiar with the state's insurance markets and the Massachusetts Connector.

This *Issue Brief* describes the process followed in Rhode Island and provides some lessons for other states. During the study, the broad concept of an exchange was clarified, separated, and evaluated by its core functional areas, in order to address three key questions:

1. What are the goals for HealthHub RI? What specifically do stakeholders want this entity to accomplish?
2. How can HealthHub RI best meet these goals?
   What minimum administrative structure is needed? Are mandates to have insurance needed? What specific target population should this entity serve?
3. What are some options for HealthHub RI, and how do these options "stack up" against the goals?

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The public process required stakeholders to identify and prioritize their goals, after which the goals were linked to the specific functional areas of an exchange. This process gave participants a greater understanding of which policy goals could be accomplished by the various functional components and finally led them to three primary conclusions:

- The highest priority goal for HealthHub RI, as defined by stakeholders, was cost containment. Yet stakeholders agreed that implementing HealthHub RI would not, by itself, constrain the growth of health care costs in Rhode Island.
- Some of the Connector functions only made sense in the context of an individual mandate. Strong stakeholder interest in an individual mandate was tempered by state budget realities, concern over public acceptability, and a lack of available subsidy funds. However, there was general agreement among stakeholders that an affordability-based individual mandate, whereby anyone with access to "affordable" health insurance as defined by the HealthHub Board would be required to purchase insurance, was worth pursuing as a mechanism to increase take-up of both employer and individual insurance.
- The potential market-organizing function of the Connector offered less value in Rhode Island, which has only a few carriers. The group agreed that a Web site like the Connector's in Massachusetts with simple purchase options and tiers of coverage could help facilitate comparison shopping and purchase of insurance by individuals and small employers alike. This was complicated by the fact that merging the individual and small group markets was not desirable in Rhode Island, because the rating rules were too different between the individual and small group markets and a merger would not have driven down prices in the individual market as it did in Massachusetts.

Connectors—while being a "hot issue" in health reform circles—are not very well understood. That vagueness can be a political asset but is not necessarily beneficial for policy development. It may be helpful for other states to consider the steps taken in Rhode Island and described below in order to quickly identify whether a Connector would meet the policy goals being pursued in that state.

In Rhode Island, this process revealed that a "full" exchange, modeled after the Massachusetts reform, was not recommended or needed to accomplish most of the goals. In fact, some key elements of the exchange concept could be implemented with minimal investment in infrastructure and disruption of the market. However, it was also acknowledged through the process that, while such a step would accomplish the secondary goals of better market organization and basic benefit standards, it would not achieve the primary policy goals of increased access and affordability. Finding the right mix of Connector elements to produce meaningful benefits while acknowledging policy constraints is a critical challenge. Emerging from this process, and given the economic situation in many states, Rhode Island's proposal of a more narrow reform focused on a core set of goals with more limited infrastructure changes may provide a useful Connector model.

Steps in Analyzing an Exchange Model

In Rhode Island, four basic steps were identified in analyzing the potential options for an exchange: 1) determine and prioritize goals; 2) evaluate the component parts of an exchange; 3) apply a basic understanding of specific market characteristics of the state; and 4) frame and select options. Each step is described below.

Step 1: Determine and Prioritize Goals

It is important to determine why a state is interested in establishing an exchange. In Rhode Island, the core goals of the exchange were identified as follows:

1. To better organize the health insurance market;
2. To provide access to affordable health insurance for all Rhode Islanders; and
3. To drive system affordability and cost containment.

Those broad goals needed to be described in more detail and were then prioritized by the stakeholder group. This was an iterative process and Step 2 began before stakeholders had fully articulated and prioritized their goals. However, through a facilitated discussion, it was determined that most stakeholders believed system affordability/cost containment and improving access to affordable insurance were the highest priorities. Although organizing the market was important to some stakeholders, there was a fair amount of discussion about what was meant by the phrase "organize the market," how it could be achieved, and whether an exchange was necessary to accomplish that goal in Rhode Island.

Step 2: Evaluate the Component Parts of an Exchange

The broad concept of an exchange (as in the Massachusetts Connector) is appealing to states for a number of different reasons. However, most states are not in a financial position to establish an exchange that has all the functionality of the Massachusetts Connector. Breaking apart the exchange into its core functional elements and evaluating each component regarding what resources are required to establish that function and examining the value of each function is critical. For Rhode Island, five key functional components of an exchange were identified. These components can be easily linked back to the goals described in Step 1.

- **Organize the Market: Transparency and Standardization**
  This function is served by development of a Web-based tool helping consumers to compare product descriptions and pricing across carriers in actuarially defined categories of insurance products such as those established by the Massachusetts Connector: "gold," "silver," and "bronze" product tiers.

- **Organize the Market: Simplify Purchasing, Improve Choice and Portability**
  This functional area includes a broader definition of market organization. Here the exchange would not just improve the presentation of choices to the consumer, but would actually conduct enrollment of individuals and/or employer groups. With this type of functionality in the exchange, employers could contribute to health insurance via the exchange, and employees would have choices among exchange products. Ideally, employees could combine contributions from multiple employers (a particularly important feature for part-time employees) to purchase coverage through the exchange. If most employers purchase through the exchange, employees could keep their insurance coverage even if they changed employers facilitating portability of insurance. It also would simplify the purchasing process for employers, as they could specify a contribution amount and allow their employees to choose the carrier and product that best fit their needs.

- **Access: Establish Benefit Standards and Incentives (Individual Mandate)**
  Although an exchange is not necessary for the establishment of a mandate, it could prove helpful in the implementation stage. In Massachusetts, for example, the legislature delegated important policy functions to the Connector. The Connector Board had the responsibility for establishing a minimum benefit standard, which defines "creditable coverage" for the purpose of satisfying the individual mandate. The standard applies to all Massachusetts residents, *and indirectly to all employers* (including self-insured employers), who now likely consider whether the benefit package they offer enables their employees to meet the state-mandated minimum benefit requirements.

  The Connector Board is also responsible for determining what level of premium relative to income constitutes affordability. The "affordability-based mandate" is important as only those residents *for whom affordable options are available* are required to meet the mandate.[1] Establishing what determines "minimum creditable coverage" for all state residents through a public process is important for two reasons. First, in most states, any existing benefit standards have typically been established through legislation and, therefore, are not regularly reviewed and modified to address current market needs. Second, existing standards do not apply to self-insured employers, who typically account for between one-third and one half of the commercial market (and growing). Because decisions around what constitutes "affordability" and "minimum creditable coverage" can be controversial, placing them with a broad-based board and having extensive public debate is probably wise. As states consider the concept of an exchange, it is important to consider which policy functions will be delegated to the exchange.

- **Access: Location for Subsidies**
  An important functional area of the Massachusetts Connector is its use as a location for subsidies. Subsidies are necessary to move any state toward universal coverage. Conceptually, if an individual mandate included standards for affordability, then those residents for whom no options were deemed "affordable" could be eligible for subsidized coverage. Thus, the exchange board, in defining a minimum benefit standard (creditable coverage) and setting affordability standards, would be setting de facto eligibility standards for subsidized coverage.

  Subsidies could also be provided through (and located within) a state's Medicaid program. In Massachusetts, however, negotiations with the Centers for Medicare and Medicaid Services (CMS) led to the decision that Medicaid subsidies be applied to private insurance. The Connector was created, in part, to facilitate use of public funds to subsidize private insurance. The continuation of significant federal financial participation (FFP) was essential for the success of the reform. It is unclear whether CMS will continue to encourage the use of federal Medicaid funds to purchase private coverage under the Obama administration and whether an exchange would be needed for this purpose.

- **Cost Containment**
  Establishing an exchange that drives system affordability is often cited as a critical goal by state policymakers. However, it is important to recognize that none of the exchanges established to date have focused on this as a primary goal. In fact, there is little evidence regarding how an exchange can help with cost containment. Policymakers must be careful to set appropriate expectations about the mechanisms needed to drive system affordability and whether the exchange could and should be a vehicle and location for this activity.

Step 3: Adapt to Basic Market Characteristics

The range of options to consider for an exchange can vary based on key characteristics of the state's insurance markets. The following characteristics were important in the development of options in Rhode Island: individual and small group market structure and effectiveness, declining employer-sponsored coverage, and the state's fiscal condition.

- **Individual Market Structure and Effectiveness**
  A key element of the Massachusetts reform was the merger of the small group and individual markets, which allowed individuals to access more affordable product choices with little impact on small employer rates. In Massachusetts, before the merger, the individual market was composed of sicker individuals and richer benefit products than the small group market. This is partly due to the fact that Massachusetts did not allow medical

underwriting and had guaranteed issue in its individual market. The individual market in Massachusetts was also characterized as opaque and difficult to navigate with consumers needing to contact individual carriers for premium quotes, making it difficult to comparison shop. Premium rates were about 40 percent higher in the individual market for the same product offering in the small group market. The small group market was a large, relatively healthy market with many product choices and similar rating rules as the individual market (e.g., no health underwriting, guaranteed issue, etc.).

In Rhode Island the starting point was very different. A detailed study of small and individual market premiums showed that the premiums for individual insurance were already on par or slightly lower than the average premiums in the small group market.[2] In addition, there is only one carrier that writes coverage in the individual market in Rhode Island, Blue Cross/Blue Shield of Rhode Island (BCBSRI). The BCBSRI Web site already provides a single, relatively simple venue for individuals to identify and evaluate insurance coverage options.

Two key lessons can be drawn from these distinct market characteristics. First, states with a poorly functioning individual insurance market with rating rules that are similar to the small group market can consider merging the two markets as one possible strategy to address premium costs for individuals. Importantly, this merger can be accomplished without an exchange – in this instance, the exchange would simply provide the transparency functions of Web-enabled insurance options and purchasing for individuals. However, since most states are more like Rhode Island than Massachusetts in allowing medical underwriting in their individual markets, a merger will drive costs up for individuals in most cases. An actuarial analysis will provide the information that a state requires to make this decision. Second, the value of the market-organizing functions may be very different, depending upon a state's starting point. In a state like Rhode Island, with a single carrier in the individual market, there is much less need for increased organization and simplified purchasing.

- **Small Group Market Structure and Effectiveness**
  The concept of an exchange, and particularly the market-organizing goals explained above are not "one size fits all;" instead, they must be tailored to meet the specific state market characteristics. Three small group market characteristics that would likely lead states toward very different exchange models include small group rating rules, market size, and number of carriers.

  Consideration of current rating rules in both the individual and small group markets is important. A lesson learned from the failures of earlier state purchasing pools and exchanges is that the rating rules must be the same, or virtually the same, inside and outside the exchange. This avoids selection bias, which could lead an exchange into a death spiral.[3] In Massachusetts, the decision to merge markets and allow the Connector to offer products in both markets was made somewhat easier by the fact that both markets already had guaranteed issue and rating factors that were nearly identical. Both markets had adjusted community rating, prohibiting underwriting of any kind based on health status; and rates were compressed within a fairly tight 2-to-1 overall band with age and geography as the primary rating factors. States with very different rating rules across the two markets would not be able to merge markets as easily.

  Market size is another important factor for states to consider. The Massachusetts Health Insurance Connector is offered as a purchasing option alongside existing market options – so employers and individuals can choose to purchase insurance through the Connector or through traditional channels. However, in Rhode Island, with only approximately 100,000 small-group covered lives, and 14,000 individual participants, an optional health insurance exchange may not generate sufficient volume to be cost effective.

  The number of carriers in the particular state should also be considered. The market-organizing functions are conceptually appealing but the value may be limited depending upon the number of carriers in a particular market. In Rhode Island, with only three insurance carriers in the small group market, this function was deemed significantly less important than it was in Massachusetts.

- **Declining Employer Sponsored Coverage**
  The decline in employer-sponsored coverage is not unique – almost every state reports declining coverage levels over the past several years. The relative size of the decline and the dominant source of erosion may be more state-specific and should be closely monitored. Massachusetts was unique with respect to this trend and had an advantageous starting point, with relatively low levels of uninsured.[4]

  Rhode Island was more like other states. The dominant source of coverage erosion was declining eligibility for employer-sponsored health insurance. Between 1999 and 2006 there was a substantial shift in the composition of the Rhode Island employer base, away from professional services and toward retail industries. These retail industries appear to be much more reliant on part time workers (who are not typically eligible for coverage).[5] If the exchange was to address the decline in employer-based coverage, it needed to address declining eligibility – and encourage employers to offer coverage to a broader range of employees.

- **State Fiscal Situation**
  The Massachusetts reform began before the economic downturn and included increased eligibility for subsidized programs funded by new state and federal revenue. In addition, Massachusetts redirected a substantial amount of its safety net funds away from institutions and toward the subsidies for individuals. The subsidies are administered through the Health Insurance Connector and through an administrative fee provide most of the funding for Connector infrastructure and operations. Most states will not have the amount of federal funds available for reprogramming that Massachusetts had. In addition, in the current economic conditions, it seems unlikely that increased funds will be available in most states in the short or intermediate term for coverage expansion.

Step 4: Frame Options

Once a state has identified, and prioritized the goals for a health insurance exchange, evaluated the various functions of an exchange and considered its unique market characteristics, the next step is to determine whether and how an exchange would best help to meet those goals. That is, what core characteristics and functions of a health insurance exchange would be needed to achieve the goals? Rhode Island's stakeholder group considered many different characteristics and functions, but focused on three primary dimensions:

1. **What are the minimum structural requirements needed to meet the goals of the exchange?**
   The Massachusetts Connector includes a public board, plus a new administrative entity responsible for implementing the subsidy and enabling a new purchasing model for employers and individuals. In Rhode Island, the stakeholder group agreed that a public board with some analytic capacity would serve most goals—it was not recommended that Rhode Island pursue the establishment of a new administrative structure at this time. Nevertheless, stakeholders did not preclude the establishment of a new entity in the future.

2. **Will any mandates be needed to support the exchange goals as defined?**
   An individual mandate and employer requirements are key elements of the Massachusetts reform. The Connector Board is responsible for two key decisions related to the individual mandate: standards of affordability and minimum benefit limits.

   In Rhode Island, high priority was placed on the goal of "improving access through benefit standards and incentives." Consequently, an individual mandate became a key element of most options considered. The stakeholder group recognized that any benefit standard would be most meaningful in the context of a mandate requiring all Rhode Islanders to have health insurance coverage that meets the standard, as long as it is deemed "affordable." These are difficult policy discussions to have during hard financial times. However, as more employers and individuals drop coverage, insurance premiums could become even less affordable for those who remain covered. It was therefore recommended that some form of a mandate be pursued in Rhode Island.

3. **Target Population: Who should the exchange serve?**
   The stakeholders acknowledged that, because Rhode Island is a small state, any new policies will have the most influence if they are broadly applied. Small employers have some difficulty navigating the health insurance marketplace. A targeted approach to simplifying the small group market seems possible. The goals of cost containment and access, however, are broader goals. Therefore, any policies to pursue those goals through the exchange should be broadly targeted, applying to as many state residents as is feasible.

In Rhode Island, the group considered many combinations of characteristics and functions for the exchange, but ultimately narrowed them down to four options that represented the range of options that could be taken recognizing Rhode Island's unique starting point and goals for reform.[6] From the least to the most aggressive, those reform options are noted below.

- **Rhode Island Option 1: Mandate**
  This option would take an incremental approach, based on two critical elements. First, it would establish a minimum benefit standard applicable to all Rhode Islanders. This was important to many stakeholders who believed that the benefit levels offered by Rhode Island employers were somewhat variable, and such a standard would provide a more equitable base of coverage. Second, it would establish an individual mandate, which would apply only to Rhode Islanders who have access to "affordable" coverage. In the short term, the mandate would not be supported by a subsidy program, as those individuals who did not have access to affordable coverage would be exempt. This option requires a decision-making board with some analytic capacity but no large infrastructure investment. The board would be responsible for decisions about benefit standards, creditable coverage, and affordability.

- **Rhode Island Option 2: Market Transparency and Standardization + Mandate**
  In addition to the individual mandate described in option 1, this option would create a new source of market information for individuals and small employers. The exchange would organize and post all carrier/product options on a single Web site. This option would require a board as in option 1 and a small investment in infrastructure for the development and maintenance of a Web site.

- **Rhode Island Option 3: Full Exchange + Mandate (Pilot)**
  In addition to the other features noted in options 1 and 2, this option assumes that all small employers (under a certain size to be determined) purchase insurance through the exchange. It would therefore require the establishment of a new administrative structure to manage enrollment, billing, and customer service. This option would begin to restructure how health insurance is purchased in Rhode Island and would introduce choice and portability into the marketplace.

- **Rhode Island Option 4: Full Exchange + Mandate**
  This option assumes all the features of option 3 except that it would change the purchasing model for all individuals and small employers. Rhode Island's small size (approximately 100,000 small group lives) dictated that an exchange model could not feasibly be offered as an alternative alongside the existing small group market and still achieve sufficient scale to be cost effective. This option would require infrastructure investments similar to option 3 but would need to be large enough to be financially viable.

Conclusions

In Rhode Island, the options for reform that were examined ranged from a mandate only to a full exchange model. Ultimately, the stakeholder group was not asked to develop a consensus for one model over the rest; however, the stakeholders expressed support for moving option 1 or 2 based on the belief that either of those would allow for incremental steps toward reform and involve little or no immediate investment.

Throughout this process, some members of the stakeholder group were disappointed to learn that the development of a full exchange model, as established in Massachusetts, would not meet their primary goals for Rhode Island, increased access and affordability. Because of all the interest in the Massachusetts Connector, it

Lessons for Other States

Given the economic situation in many states, consideration of a more narrow reform – one focused on a core set of goals with a more limited exchange infrastructure may make the most sense at this time. The Connector in Massachusetts had numerous responsibilities and functions delegated to it because of the extensive legislation and the need for an accountable, coordinating entity. States considering an exchange could consider the roles of the Connector separately – that is, a board could be established with minimal administrative infrastructure, which could be responsible for setting policy such as determining eligibility rules, while program administration could be facilitated through other existing state infrastructure. States should carefully consider their starting point, and the pros and cons of different approaches. A number of lessons were learned through this process that may be useful to other states considering similar reforms. They include:

Definition, Goal Setting and Prioritization

It is important that an exchange be defined, that its goals and objectives are clearly articulated and that all parties participating in the development of the reform understand them. If there are multiple goals, it may be necessary to prioritize them. This may be an iterative process and goals may need to be revisited at each step of the process.

Size

Any state considering an exchange must first consider which populations to target. It is clear that the financial success of the model depends on sufficient enrollment in the exchange. In Massachusetts, most of the covered lives in the Connector are subsidized, so without a subsidy, states need to think carefully about whether the infrastructure they build can be financially viable.

Mandates

By themselves, exchanges developed thus far have done little to increase the offer or take-up of health insurance. To ensure that the risk pool remains healthy, it may be necessary to require the offer and/or purchase of some level of health insurance. In Massachusetts, the individual mandate increased take-up of both individual and employer-based coverage. States considering an exchange will probably want to consider mandates for people with access to affordable coverage. An "affordability based" mandate, requiring all state residents to have health insurance coverage that meets an exchange-specified standard, as long as it is deemed "affordable," might provide an interim step for states considering more comprehensive reform but lacking state resources to support low income subsidies.

Cost Containment

To date, exchanges have done little to constrain the growth of health care costs. They have had little role regarding product pricing, and the rate determination process is quite similar to what occurs in the outside markets. It is conceivable that a large exchange with market exclusivity could help drive system affordability through creative benefit design and product standards but an exchange is not a necessary or sufficient element to constrain the growth of health care costs.

was important for the stakeholder group to hear about each of the functional areas of the Connector.

The group generally agreed that movement toward individual responsibility via requiring the purchase of insurance was important to increasing access and that discussion around benefit standards and affordability could begin before subsidy funds were available. The group recognized that subsidies were unlikely at this time so the discussion of an individual mandate would need to be sensitive to current economic circumstances. A board could be convened to begin discussions around what level of minimum creditable coverage and affordability schedules makes sense for Rhode Islanders and whether it makes sense to pursue a mandate at higher income levels now.

In terms of options 3 and 4, there was some agreement (although not full consensus) among stakeholders regarding the value of the market-organizing functions. Rhode Island has relatively few carriers in both its individual and small group markets, so many of the market organizing functions are much smaller scale. Most members of the stakeholder group believed that increasing transparency of the insurance purchase process was important and that the process for purchasing insurance is somewhat opaque. There are lessons to be drawn from Rhode Island's single-insurer individual market, which functions with only five products, intense rate regulation and direct distribution by the insurer. The group agreed that a Web site like the Connector's in Massachusetts with simple purchase options and tiers of coverage could help facilitate comparison shopping and purchase of insurance by individuals and small employers alike.

The recommendation implicit in options 3 and 4 that the Connector be the exclusive market for whatever population was targeted, while making actuarial and policy sense, is a political challenge and could face concerns from both the existing distribution and insurance company stakeholders. Developing those would require political leadership, in addition to administrative resources. In effect, the policy options represent a series of incremental steps with a fairly high initial hurdle of an individual mandate. Once that step was taken, the rest may follow, one after another.

About the Authors

Deb Faulkner is an independent consultant with substantial health insurance experience including commercial and Medicaid benefit design; health insurance business models and market structure; and health plan financial structures. Ms. Faulkner currently serves as project lead for the Affordable Health Insurance Initiative for the State of Rhode Island. This initiative is focused broadly on two major areas: developing and implementing short term initiatives aimed at stabilizing the market for individual and small business health insurance in Rhode Island, and designing longer-term strategies to address health insurance access and affordability in the state. She has a master's degree in public policy from the Kennedy School of Government at Harvard University and an undergraduate degree in economics from Dartmouth College.

Amy M. Lischko has more than 15 years of experience working for the Commonwealth of Massachusetts in senior-level positions. Dr. Lischko led a 100-person agency within the Office of Health and Human Services and was concurrently the health policy advisor to the secretary under Governor Mitt Romney. She was one of the key authors of the administration's health care reform legislation. Dr. Lischko is currently the principal investigator on a Commonwealth Fund grant to evaluate the Connector's role in health care reform. She holds a doctorate degree in health services research from Boston University and is currently an assistant professor at Tufts University School of Medicine.

Deborah Chollet is a senior fellow at Mathematica Policy Research in Washington, D.C. where she conducts and manages research on private health insurance markets and coverage, hospital financing, state health care reforms, and employee and retiree health benefits for state and federal government clients and foundations. Dr. Chollet serves as a senior advisor to the State Coverage Initiatives program. She was appointed to serve the Massachusetts Commission to Study the Merger of the Small Group and Non-Group Markets. She holds a Bachelor of Science degree from the University of Missouri at St. Louis, and M.A. and Ph.D. degrees in economics from Syracuse University.

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About SCI

State Coverage Initiatives (SCI), a national program of the Robert Wood Johnson Foundation administered by AcademyHealth, provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI offers an integrated array of policy and technical assistance services and products to help state leaders with coverage expansion efforts as well as with broader health care reform. Our team of policy experts tailors its approach to meeting state decision makers' needs within the context of each state's unique fiscal and political environment. Learn more at www.statecoverage.org.

Endnotes

1 We make a distinction between an "affordability-based mandate" and an income-based mandate. Linking the mandate to "those with access to affordable insurance" offers two advantages: First, it allows it to update with changes in minimum benefits and benefit costs. And, second, it captures a broader range of residents, who may have incomes below 300 percent of the federal poverty level (FPL) but who have access to employer based coverage at very low premiums.

2 Deweese Consulting, 2006, RI Small Group and Individual Market Merger Study. See also, www.ohic.ri.gov/Committees_marketmergertaskforce.php.

3 Curtis, R. and E. Neuschler. "What Health Insurance Pools Can and Can't Do," *The California Health Care Foundation*, 2005. www.chcf.org/documents/insurance/WhatHealthInsurancePoolsCanAndCantDo.pdf; Long, S.H. and M.S. Marquis. "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs*, Vol. 20 No. 1, 2001, pp. 154-63; Wicks, et al. "Barriers to Small-Group Purchasing Cooperatives," Economic and Social Research Institute, March 2000. www.esresearch.org/Documents/HPC.pdf; Curtis, R. et al. "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?" *Health Affairs*, Vol. 20 No. 1, 2001, pp. 164-8; Wicks, E.K. "Health Insurance Purchasing Cooperatives," The Commonwealth Fund, 2002. www.cmwf.org/usr_doc/wicks_coops.pdf; "Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Price," Government Accounting Office, March 2000. www.gao.gov/new.items/he00049.pdf.

4 Massachusetts Employer Health Insurance Survey. See www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/er_2005_comp_results.pdf.

5 Office of the Health Insurance Commissioner, State of Rhode Island, unpublished analysis of the Medical Expenditure Panel Survey employment and health insurance enrollment trends, 1999-2006. See also www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp.

6 A detailed assessment of each option can be found in the final report at www.ohic.ri.gov/Committees_HealthHub%20RI.php.