



National Association of
Insurance Commissioners

Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act



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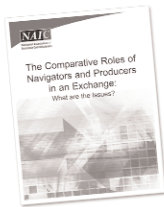
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ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT

Background

Adverse selection is a phenomenon that is endemic to insurance of any kind, including health insurance. It occurs whenever people make insurance purchasing decisions based on their own knowledge of their insurability or likelihood of making a claim on the insurance coverage in question. This can happen in a variety of ways. For example, the applicant might have information about the risk that is not known to the insurer, or the insurer might have access to the information but be unable to incorporate it fully into the price of coverage, due to factors such as antidiscrimination laws or the limitations of the insurer's rating system.

Health insurance may be particularly susceptible to adverse selection where adverse selection can even occur in a fully transparent and competitive pricing environment. Members of the public can and will make decisions about when, whether and what to purchase based on knowledge of their own personal health. For example, a health insurer might offer two different plans, one with comprehensive coverage and another with a high deductible and more limited benefits ("catastrophic plan"). The population buying the catastrophic plan will likely be younger and healthier than the population buying the comprehensive plan. In addition, a wide range of consumer protection laws limit the ability of insurers to consider health risk in underwriting and rating.

Adverse selection can also take place between insurers, between benefit plans and between markets. In an environment that allows adverse selection to occur unchecked, the insurance-buying public, will in large part, delay the decision to purchase health insurance until, in their estimation, coverage is needed: *If I am allowed to get a homeowner's policy while my house is burning, why should I pay for one earlier?* Therefore, instead of a large number of individuals purchasing and paying for health insurance to cover the claims of a relatively small number who incur substantial health care costs, far fewer individuals are paying premiums to cover those same health insurance contingencies. Most high-risk consumers remain in the insurance pool to collect benefits, while younger and healthier consumers might leave the pool and stop paying premiums, thereby raising the unit cost of health insurance considerably. It is imperative to minimize adverse selection in order for health insurance to remain a financially viable product.

As the new health insurance market reforms take effect in 2014, adverse selection will remain a factor. The remainder of this paper reviews the tools health insurers typically use today to minimize adverse selection, the tools included in the federal Patient Protection and Affordable Care Act (the "Affordable Care Act," or ACA), and additional tools and options available to the states to further minimize the impact of adverse selection when Exchanges become operational in 2014.

Today's Marketplace

Just as consumers will act in their own financial self-interest, insurers will as well. When permitted by law, insurers will use a variety of tools to lessen their susceptibility to high-risk individuals. In the individual market today, in most of the states, applicants can be underwritten to determine their insurability, and can be charged higher or lower premiums based on age and health status. In the event of an intentional misstatement of a material fact, that policy can generally be rescinded by the insurer. Insurers also apply preexisting condition waiting periods during which no coverage is provided for those preexisting conditions. Some policies impose waiting periods, during which there is coverage only for accidents and no coverage for costs incurred due to sicknesses. In the absence of regulation designed to create more balanced risk pools, these tools lessen the risk for insurers and, depending on the age and health status of the consumer, might lower or raise their premium rate accordingly. In employer group health insurance adverse selection is minimized because employees often sign up for coverage regardless of health status due to insurer participation requirements and employer contributions. Large employers in particular are able to get a more balanced risk profile because of this, and, therefore, it is relatively safe for them to self-insure¹. Small employers, however, do not have the critical mass of enrollees to shelter them if an employee gets sick. This limits their ability to self-insure their risk, and can result in significant premium costs in those states where insurers are allowed to consider claims experience or health status in small group rating.

Adverse Selection Issues and Exchanges

As mentioned above, adverse selection can take place between insurers, between benefit plans and between markets. With the establishment of health insurance exchanges, adverse selection can take place in all of these ways. As outlined later in this

¹ Because self-insured private employers are exempt from state insurance regulation under ERISA, the relative ease of migrating between commercial insurance and self-insurance limits the ability of the states to regulate large group insurance.

paper, the ACA puts in place a number of mechanisms to minimize the risk of adverse selection. In order to use these mechanisms effectively, it is essential to understand the ways in which adverse selection might occur in a marketplace that includes Exchanges:

1. Consumers will have a choice between two health insurance markets—an Exchange or a traditional health insurance market outside the Exchange—and the rules for these markets must be crafted carefully to avoid one market (probably the Exchange) becoming the equivalent of a state high risk pool. This would likely happen if one market is able to offer stripped-down plan designs while the other is required to offer more robust options. Ultimately, the more healthy population will select a lower priced plan option while the less healthy will choose the more comprehensive plan. The ACA includes some provisions to address the adverse selection issues between these markets; however, the ACA also allows the states to maintain an outside market in which insurers may offer less comprehensive plans. In both markets, the ACA requires all non-grandfathered individual and small group plans to include the essential health benefits package. However, a key difference is that, to participate in the Exchange, an insurer must offer at least one silver plan (70% actuarial value) and one gold plan (80% actuarial value). The ACA does not apply this requirement to the outside market, meaning that insurers that do not offer coverage in the Exchange can provide less comprehensive plans compared to those operating within the Exchange.
2. Exchange network adequacy requirements, if they vary from those outside the Exchange, could be a potential source of adverse selection. The U.S. Department of Health and Human Services (HHS) is required under the ACA to develop standards to ensure that there is a sufficient choice of providers and that essential community providers, such as community health centers, are included in an Exchange plan's networks. The insurance-buying public frequently makes purchasing decisions based on the availability of their chosen medical providers within the insurer's network. A younger, healthier consumer might be less concerned about the availability of specific providers than an older consumer with pre-existing conditions might be. Therefore, if a more robust network exists for Exchange plans than for those offered outside of the Exchange, it is likely that consumers seeking specific health care services will choose to purchase coverage inside the Exchange.
3. Although there is a requirement that plans offered in the Exchange must receive the same pricing if sold outside the Exchange, that requirement does not affect products that are not sold in the Exchange. For rate relativities between different products, the ACA establishes only the more limited requirement that an insurer must treat all non-grandfathered plans in the individual market as a single risk pool and must do the same for the small group market. However, this only applies to plans sold by the same insurer. Given this, the states will need to establish effective risk-adjustment mechanisms and, perhaps, other risk-spreading mechanisms to address the potential for adverse selection between insurers that participate in the Exchange and insurers that do not participate in the Exchange.
4. Although the "single risk pool" requirement will greatly assist with minimizing adverse selection, the ACA prohibits the states from including grandfathered plans in those risk pools. If the number of participants in grandfathered plans remains significant in 2014, the removal of these members from the risk pool could result in adverse selection.
5. Differentials in insurance producer commissions or user/insurer fees inside and outside the Exchange can result in producers steering consumers into the market that best compensates their services.
6. Small Business Health Options (SHOP) Exchanges, either as a stand-alone Exchange or as part of a merged individual and small group Exchange, might experience adverse selection based on employers' decisions to retain grandfathered status, self-insure or purchase insurance through the Exchange. Employers with favorable risk demographics might have an incentive to self-insure, while those with less desirable risks would tend to opt for fully insured plans either through the Exchange or in the outside market. The likelihood of this type of adverse selection occurring increases as the size of an employer increases, as self-insuring is much more prevalent in large group plans.
7. Exchanges might be designed to introduce individual choice for employees of small groups. Currently, a small employer will typically choose one plan for its employees, and the only choice for employees is whether or not to enroll. Under an ACA SHOP Exchange, in addition to the employer choice option, small employers will be able to choose a tier—bronze, silver, gold or platinum—and the employee may choose any plan within that tier. This can result in adverse selection between insurers and plans within the Exchange. If employers decide to move to a defined contribution arrangement within the Exchange (i.e., allowing the employee to make the choice of which tier of coverage to buy) the greater the possibility of adverse selection taking place between insurers and plans. These scenarios are recognized by the ACA and will be lessened to some extent through the risk-spreading mechanism provided for in the ACA.

8. Benefit design can be used to attract or deter enrollment by consumers. While the ACA addresses the adverse selection risks of benefit design in a number of ways—such as requiring the inclusion of the essential health benefits in all individual and fully-insured small group plans and requiring Exchanges to offer plans in specified actuarial value tiers—opportunities will still exist for insurers to attract healthier consumers while deterring sicker ones. A number of studies document that through benefit design, even with similar safeguards as those in the ACA, certain Medicare Advantage plans were able to draw healthier enrollees into their plans, while discouraging those with greater health problems from enrolling.
9. As noted earlier, differences in benefit design might drive adverse selection between the Exchange and the outside market. Such differences can also drive adverse selection within an Exchange. Individuals and employers will choose products in an Exchange annually based on the price of coverage and the benefits offered. This will likely create a retail market that is much more prone to adverse selection. Individuals purchasing coverage on an Exchange could purchase the lowest level (bronze) coverage while healthy, and then switch to more generous coverage at the next open enrollment period if they become sick. In addition, differences in the breadth of qualified health plan provider networks could also occur within an Exchange, with less healthy individuals likely to gravitate to broader network products. If certain health plans exclude certain specialists or include high levels of cost-sharing, this could drive selection against more comprehensive plans.

Key ACA Provisions Addressing Adverse Selection

Several sections of the ACA address the issues of adverse selection. Those provisions and their potential effects are summarized below.

- **Requirement to maintain minimum essential coverage, §1501.** Designed to bring a more balanced risk profile to the entire marketplace, the purchase mandate is perhaps one of the most important checks on adverse selection in the ACA. Although many of the states have challenged its constitutionality, the individual responsibility requirement is considered by health policy experts across the spectrum as a strong tool to minimize adverse selection. In order for this tool to work, individuals must decide that purchasing coverage is a better value for them as opposed to remaining uninsured and paying a penalty. Many have criticized the penalties as being too low to fully realize the intent of the individual mandate.
- **Financial assistance with purchasing coverage, §1401.** Individual premium tax credits and small business tax credits are another important tool for encouraging people to buy insurance. Like employer contributions to group coverage, these credits bring down the cost of coverage for healthy individuals. This has the potential to lower prices for everyone by reversing the adverse selection spiral, because these healthy individuals remain in the pool. Furthermore, by making these credits available only for coverage purchased through the Exchange, the ACA also addresses adverse selection between the outside market and the Exchange. While the individual premium tax credits are permanent, the small business tax credits are not and, beginning in 2014, are only available to employers for two consecutive tax years during which benefits are offered to employees through the Exchange.
- **Same plan, same premium, §1301(a)(1)(C)(iii).** The premium rate for qualified health plans must be the same, without regard as to whether it is sold through the Exchange or whether the plan is offered directly from the insurer or through an agent.
- **The same rating rules apply, regardless of market, §1252.** Non-grandfathered plans inside and outside the Exchange must use the same rating factors, which are limited to age (3:1 ratio), geography, family size and tobacco use.
- **Organizing coverage levels by tier, §1302(d); and requiring all non-grandfathered small group and individual plans to include the “essential health benefit package,” §1302.** As mentioned earlier, by establishing tiers of benefits based on actuarial value, and by requiring all plans to include the essential health benefits, the ACA will not only assist consumers with purchasing decisions, but it also will help to minimize adverse selection. Concerns remain, however, that this safeguard does not sufficiently deal with adverse selection. Even within the same actuarial value, insurers would still be able to use cost-sharing levels and the addition or limitation of certain benefits to differentiate their plans in order to entice or deter certain consumers from enrolling. State policymakers should be cognizant of the fact that large groups and self-insured plans do not need to meet the same essential health benefits standard required of individual plans and fully-insured small group plans. If the employer makes little or no contribution to the plan, this could result in older or sicker employees choosing to purchase coverage in the

individual market, where a richer level of coverage and, perhaps, subsidies might be available. In this case, the employer's group plan would become a healthier pool, and the individual market would become a sicker one. The ACA anticipates the potential for "employer dumping" of risk and assesses a penalty on large employers (with an average of at least 50 full-time employees) who either 1) do not offer minimum essential coverage; or 2) whose employee(s) are eligible for, and enroll in, subsidized coverage through the Exchange because the employee's share of the premium for the employer-sponsored coverage exceeds 9.5% of income or the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. However, there is no employer penalty if the employee seeks coverage without the help of a subsidy.

- **The creation of single risk pools, §1312(c).** The ACA mandates single risk pools. This means that a health insurance issuer must combine the experience of all of its individual plans into one risk pool—and do the same for all of its small group plans, regardless of whether they are offered on the Exchange. Grandfathered plans are expressly prohibited from inclusion in either risk pool, §1312(c)(4).
- **Marketing requirements, §1311(c)(1)(A).** The ACA requires qualified health plans to meet certain marketing requirements. They are not allowed to use marketing practices or activities that might encourage healthier consumers to enroll and/or discourage those with health conditions from enrolling.
- **Exchange market participation requirements, §1301(a)(1)(C)(ii).** Health insurance issuers must offer at least one silver level and one gold level plan in order to participate in the Exchange. This provision is designed to minimize adverse selection by insurers that might otherwise offer only bronze level or catastrophic coverage in the Exchange, in an effort to enroll primarily young and healthy consumers. It should be noted, however that there is no similar requirement for insurers in the outside market. This could lead to significant adverse selection happening between the markets, as insurers would be allowed to offer higher deductible plans outside the Exchange and not be required to participate inside the Exchange at all. Potential state policy solutions are addressed later in this paper.
- **Expanding the definition of small group, §1304(b).** In 2016, the definition of "small employer" will be expanded nationally to include firms with 100 or fewer employees, thereby expanding the risk pool for those states that had previously defined a small employer as a group of 50 or fewer employees. However, a larger pool does not necessarily mean a more stable pool. Including mid-size employers in the small group market might offer other problems with adverse selection, because self-insurance is more likely to be a meaningful option. If so, mid-size employers might self-insure when they perceive their risk to be better than the insured market, and buy insurance if plan participants get sick or they hire people with more health care needs.
- **Level playing field, §1324.** Health insurance plans may not be made subject to many state or federal laws unless Consumer Operated and Oriented Plans (CO-OP plans) and Multi-State plans are required to meet them. These include guaranteed renewal, preexisting conditions, non-discrimination, quality improvement and reporting, solvency and financial requirements, market conduct, appeals and grievances, licensure, and benefit plan material or information. Multi-State plans may have different medical loss ratios, profit margins or premiums based on the standards that are set by the Director of the federal Office of Personnel Management (OPM). §1334(c)(5). If, however, a state has an age rating limit lower than 3:1, then that state may require a Multi-State plan offered through the Exchange to meet the state's standard. §1334(a)(4).
- **Risk-spreading mechanisms, such as interim reinsurance, temporary risk corridors, and risk adjustment.** These three mechanisms are designed to make the new marketplace more predictable, stable and less risky for insurers, encouraging them to participate with business models that compete based on quality, service and price and— not on risk selection.
 - **Interim reinsurance program, §1341.** All health insurance issuers and group health plans (through their third-party administrators) will be required to participate in an interim reinsurance program for the individual market to address high-risk individuals. This provision might allow implementation of a gradual phasing out of state high risk pools instead of an immediate transition of all high risk pool members into the Exchange. However, there are specific provisions governing transition of federal high risk pools pursuant to §1101(g)(3).
 - **Temporary risk corridors, §1342.** All qualified health plans in the individual and small group markets will be required to participate in a risk corridor mechanism. This could increase plan participation in the Exchange by reducing risk to insurers.
 - **Risk adjustment mechanisms, §1343.** All health plans and health insurance issuers in the individual and small group markets, regardless of whether they are offering plans through the Exchange, will be required to participate in a state's risk adjustment mechanisms. The goal is to share risk among insurers offering

coverage within and outside the exchange. Large group, self-insured and grandfathered plans are not required to participate. Insurers might be inclined to avoid the individual and small group markets in order to avoid assessments.

While there are a number of identifiable shortcomings or gaps, the ACA lays out a number of provisions designed to minimize adverse selection and its impact on consumers and insurers. However, many of these important protections are only effective if state insurance regulators play a prominent role in monitoring and enforcing them.

State Options to Minimize Adverse Selection Effects

The ACA allows the states flexibility to consider additional policies beyond those described above. Each state should consider the goals of its Exchange when weighing policy options for addressing adverse selection. These decisions will depend, in part, on whether a state views its Exchange as a clearinghouse, organized marketplace or active purchaser.

Many of the options listed below could also be phased in over time, in order to mitigate any market disruption or rate impact. For many of these options, implementation could begin in advance of 2014, and implementation could continue for some number of years after the Exchange is operational.

Market Participation Rules

The most important thing the states can do is to help facilitate a “level playing field” between participants inside and outside of the Exchange. The ACA does not require insurers to participate in the Exchange; and plans offered by insurers outside the Exchange do not have to meet all of the same Exchange plan standards. The states may establish stronger requirements.

Allowing some variance between the marketplaces allows insurers to design and innovate plans in order to meet consumer needs. However, the more choices a market provides, the greater the opportunity for adverse selection, either directly or indirectly. If allowed, consumers and insurers will follow their own economic interests: consumers will purchase based on the benefits they need or perceive they will need; insurers will market to those they perceive to have a lower risk, or charge prices commensurate with the risk profile of their target market.

The states might consider a number of policy options to address these challenges. For example, insurers could be required to operate in both markets and/or be compelled to offer products at certain levels in order to operate in a particular market. The states might require plans sold outside the Exchange to meet the same standards as those offered inside the Exchange.

Consumer Choice

Determining a manageable level of coverage options that provide consumers with a robust yet easy-to-understand shopping experience should be the goal of state policymakers. Too few options is undesirable, but too many can lead to choice that is counterproductive and confusing for consumers, in addition to opening the door to adverse selection. State policymakers will need to evaluate the advantages and disadvantages of standardization. For example, state policymakers could decide to create a minimum level of benefits that is standard across all plans and coverage levels similar to standardized Medicare supplemental coverage plans. It is incumbent upon the states to analyze coverage in their current insurance market, their current uninsured population and the overall goals of the Exchange in order to tailor their policies to serve their citizens.

State-Mandated Benefits

Many of the states currently require that plans include particular benefits. The ACA allows the states to continue doing so. Under the ACA, if a state decides to require certain benefits that are above and beyond the essential health benefits, then the state may require qualified health plans operating in the Exchange to include some or all of those benefits. In doing so, however, the ACA requires the states to pay the additional cost of those benefits. In order to create a level playing field between the markets, state policymakers should consider making their mandated benefit requirements, if any, the same inside and outside of the Exchange.

Qualified Health Plan Designation

The ACA identifies minimum requirements that all plans will need to meet beginning in 2014, regardless of whether they are sold inside the Exchange or in the outside market. In order to be certified as a qualified health plan and sold through the Exchange, a plan must also meet additional federal requirements, and possibly additional state requirements. This could make these plans more expensive than plans offered outside of the Exchange and drive enrollment away from the Exchange.

Additional requirements might also hinder competition and/or inhibit new insurers from entering a state's Exchange or health insurance marketplace. State policymakers should consider this dynamic when further defining a qualified health plan and determining what plans must do to sell their products, both inside and outside of the Exchange.

Participation Requirement Consistency

As expressed earlier in this paper, one advantage large employers have is the ability to create a more balanced risk pool. This happens, in part, due to insurer participation requirements; i.e., the insurer will offer the product(s) only if a certain percentage of employees enroll, thereby excluding those who are already covered through another plan. Currently, insurers' minimum participation requirements are typically between 50% and 75%. If there are different participation requirements between insurers inside or outside the Exchange, those employers with low participation (usually the less healthy) will certainly move to the market with the lower participation requirement.

Producer Commissions/Navigators

The compensation structure for producers and navigators (a new consumer assistance program established under §1311 of the ACA) inside and outside of the Exchange could have a significant effect on the market. The states should consider the effect of different commission structures inside and outside the Exchange and how that could impact the market. The effects could vary between the individual and small group markets. The states might choose to minimize these effects by regulating how compensation is structured inside and outside the Exchange, including consideration of whether navigators should be salaried employees of the Exchange.

Exchange Administrative Fees

A state Exchange must be financially self-sufficient beginning in 2015. The states have flexibility in determining which mechanisms they want to use. If the addition of administrative fees increases the cost of coverage and exists only on Exchange-offered plans, consumers might be more inclined to purchase from the outside market. To ensure the financial sustainability of the Exchange, the states will need to enroll enough participants to make the operations of the Exchange worthwhile. The basic principle of a level playing field applies here; i.e., if a state decides to charge an administrative fee to cover the costs of the Exchange, it should also consider charging the same fee on products sold outside the Exchange. This would ensure that neither market would have an advantage over the other and broaden the assessed population, thus making the fees lower overall.

Structured Enrollment Periods

Significant adverse selection will take place in a guaranteed issue market that prohibits discrimination based on health status if individuals can purchase coverage when they need it and drop it when they do not. This precise issue has played out in Massachusetts as a result of its health care reform law, which was enacted in 2006. As a result, Massachusetts has implemented stricter rules regarding enrollment periods. In 2011, individuals are able to enroll during two open enrollment periods. In 2012, this will be reduced to one open enrollment period. Furthermore, individuals in Massachusetts are not eligible to enroll in the non-group market if they are eligible for employer-sponsored coverage that is at least actuarially equivalent to minimum creditable coverage, as defined by the Commonwealth Health Insurance Connector. Under the ACA, the requirement for most individuals to have coverage will address some of this concern. The ACA also calls for an initial open enrollment period and ongoing annual open enrollment periods, as well as special enrollment periods specified in §9801 of the Internal Revenue Code (IRC) of 1986 and under part D of title XVIII of the Social Security Act (Medicare Part D), all of which have yet to be more fully detailed in federal regulations. The states might want to consider adopting additional policies similar to the Massachusetts approach. Outside of special enrollment periods, as required under the ACA, the states could prohibit individuals from purchasing coverage, whether inside or outside of the Exchange, only during a specified time period each year. In considering this option, the states will need to weigh the impact it would have on the market and consumer access to coverage. The states also could institute a penalty for late enrollment or limit the number of times a person can change coverage to once a year to limit the adverse selection due to a consumer "buying up" once faced with a health problem. When considering these policy options, state policymakers will need to consider the penalties imposed under the ACA for individuals who fail to maintain minimum essential coverage. State policymakers also should recognize that, if an individual can only purchase or change coverage during a limited period of time each year, an aggressive outreach and education program should be in place to help ensure that consumers are informed about their choices and the consequences of their decisions. Enrollment periods should be sufficiently long to give consumers time to understand the requirements and their options, particularly prior to 2014. As already noted, Massachusetts addressed this by allowing two annual open enrollment periods in 2011 before reducing it to one annual open enrollment period in 2012.

Other Considerations

If insurers are allowed under federal regulations to sell coverage to individuals and small groups outside of the individual or small group markets, as defined by the ACA, through non-traditional plans, including association, trust, union or self-insured plans, among others, significant risk of adverse selection could result. State policymakers will need to consider the availability of these other health insurance products in their individual states and how these products interact with other traditional plans offered in the non-Exchange market, as well as these products offered within the Exchange. The states should evaluate their health insurance markets with respect to these products and take steps necessary to mitigate any potential adverse selection, while being careful to avoid unnecessary disruptions in coverage. This could result in regulatory changes for association, union, trust and self-insured plans based on the unique needs within each state. The states might also want to consider adopting and enforcing the NAIC *Stop-Loss Insurance Market Model Act* (#92), or its equivalent protections, to ensure that self-insured plans are truly self-insured. The states should be aware that the NAIC's Limited Medical Benefit Plan (B/D) Working Group is looking into the issue of association plans. At the conclusion of its work, additional guidance might be available to assist the states on this issue.

Conclusion

The success of an Exchange is directly linked with its ability to attract a sufficient cross-section of risk to balance high- and low-cost consumers. If the market outside of the Exchange is perceived as more attractive to younger and healthier people, the Exchange could become a "risk magnet" and will ultimately fail due to adverse selection. Adverse selection can take place between insurers, between plans and between markets. Simply addressing potential adverse selection between the Exchange and the outside market is not sufficient to foster a healthy marketplace. The states need to recognize and address the potential for adverse selection between insurers and plans, as well.

There are numerous options the states may use to facilitate a level playing field between the markets inside and outside of the Exchange. Many of these options may be phased in—either in advance of 2014 or some number of years after the Exchange is operational—in order to mitigate any market disruption or significant rate impact. The stated goals and intentions of each state's Exchange should determine the manner and degree of involvement state policymakers engage in when establishing market rules aimed at minimizing adverse selection. Because market response could vary across the states, as could each state's goals for its Exchange, flexibility and continual review will likely be the best tools for a state to facilitate and sustain the success of its Exchange.

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