Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

Moving Forward with Health Reform

August 17, 2010

STATES SHOULD STRUCTURE INSURANCE EXCHANGES TO MINIMIZE ADVERSE SELECTION

by Sarah Lueck

The health reform law (the Affordable Care Act) relies primarily on states to establish health insurance exchanges — marketplaces that provide affordable, good-quality coverage options to individuals and small businesses. But it gives states substantial flexibility in how they structure the exchanges. This paper recommends four steps that states should take when setting up their exchanges to minimize the risk of "adverse selection," which could prevent the exchanges from operating effectively and which has been one of the principal reasons that some past state-based exchanges have been unsuccessful.

Adverse selection — the separation of healthier and less-healthy people into different insurance arrangements — will occur if a disproportionate number of people who are in poorer health and have high health expenses enroll in coverage through the insurance exchanges, while healthier, lower-cost people disproportionately enroll in plans offered through the individual and small-business markets *outside* the exchanges. If that occurs, the cost of exchange coverage will be higher than the cost of plans offered in outside markets. That would drive up costs not only for consumers and small firms purchasing coverage through the exchanges, but also for the federal government, which must provide premium subsidies to enable low- and moderate-income people to afford coverage in the exchanges.

Higher premiums would depress participation in the exchanges by individuals and small businesses, particularly by those people and firms that can obtain better deals in outside markets. That, in turn, could raise premiums even higher in the exchanges and could ultimately result in their failure over time.[1]

While the health reform law contains provisions to help guard against adverse selection, states can provide further protection by undertaking several actions that the health reform allows but does not require them to take:

[1] This paper focuses on the risk of adverse selection between a health insurance exchange and outside health insurance markets. Another type of adverse selection could occur among plans within an exchange; this will be the subject of a future analysis.

- making the rules for any insurance markets outside the exchange consistent with the rules that apply inside the exchange;
- requiring insurers to offer the same products inside and outside the exchange;
- merging the individual and small-group markets over time; and
- ensuring that risk-adjustment and risk-pooling requirements work effectively.

Adverse Selection Poses Significant Risks for Insurance Exchanges

Adverse selection is not merely a theoretical risk; experience shows it could cause instability in, and even failure of, insurance exchanges over time. Some prior attempts by states to establish health insurance pools similar to the new exchanges have suffered from high premiums and faltering insurer participation after sicker people with greater health costs concentrated in them.

For example, a small-business pool that operated in California from 1993 to 2006, called PacAdvantage, ultimately ceased operation due to growing adverse selection. At its peak, PacAdvantage provided health insurance for 150,000 enrollees. But it tended to attract people with

Adverse Selection Poses a Serious Threat to Exchanges, Health Law and Policy Expert Timothy Jost Explains

In a recent analysis issued by the Commonwealth Fund, Washington and Lee University School of Law Professor Timothy Stoltzfus Jost observes: "The single most important reasons why some exchanges have not succeeded in the past is that they became the victims of adverse selection — they were unable to capture a large enough share of the healthy participants in the insurance market. . . .

Indeed, as long as small-group or non-group coverage is easily available outside the exchange, the potential exists for healthy individuals and groups to find policies cheaper than those available through the exchange. . . .

In this way, an exchange can essentially turn into a high-risk pool, with its coverage becoming unaffordable and its enrollees becoming very unattractive to insurers. The most successful exchanges have featured a large and diverse population (such as the FEHBP [a]), have barred outside competition, or have made available significant advantages only to individuals participating in the exchange (for example, in Massachusetts,[b] premium subsidies are available only through the state's Health Connector)."[c]

---

[a] The Federal Employees Health Benefits Program, which covers federal workers and retirees.

[b] As part of Massachusetts' health reform law, the state created the Health Connector, which operates two exchanges in the state that serve individuals and small employers, including Commonwealth Care, which provides a choice of plans to people who qualify for premium subsidies based on their incomes.

[c] Timothy Stoltzfus Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," The Commonwealth Fund, July 2010.

high medical costs, in part because its rules regarding pricing insurance policies were more favorable than the rules in the regular small-group market for firms whose workers had health problems. PacAdvantage initially did not permit insurers offering PacAdvantage coverage to charge higher premiums to small firms with less-healthy workers, while insurers in the outside small-group market could to some extent. Such factors helped cause sicker people to concentrate in plans offered through PacAdvantage, while small businesses with healthier workers continued to purchase coverage in the regular small-group market.

According to Peter Lee, a former official at the Pacific Business Group on Health (which operated PacAdvantage), adverse selection "drove up premiums inside the exchange, causing healthier people to drop out. This is known in the insurance business as a classic 'death spiral.' "[2] As sicker people continued to concentrate in PacAdvantage, premiums climbed ever higher compared to the regular market, making the exchange even less attractive to small firms with healthier workers. Eventually, the pool was shut down because PacAdvantage was no longer viable.

Risk Adjustment and Risk Pooling Will Reduce But Not Prevent Adverse Selection

Some elements of the Affordable Care Act will help protect against adverse selection. One important factor is that the federal premium tax credits to help low- and moderate-income people buy insurance can be used only within an exchange. This will help ensure that the exchange is an attractive place to buy coverage — and not just for people who are more likely to have high health costs. In addition, once exchanges are up and running, the tax credit now available to certain small businesses to help them defray the cost of contributing to their workers' premiums will be available only if they provide coverage to their workers through the exchanges. This, too, will likely help attract a more typical risk pool to the exchange. These credits will not, however, lower the risk of adverse selection between outside markets and the exchange among those individuals and small businesses that are *not* eligible for such subsidies.

The law also requires use of a risk-adjustment system, in which plans with sicker-than-average overall enrollments receive payments to compensate them for their resulting higher costs. The payments would come from plans that enroll healthier-than-average people that do not cost as much to cover. Under the Affordable Care Act, the risk-adjustment system will apply both to the plans inside an exchange and the plans in external markets that compete with the exchange. This can help integrate these markets and reduce adverse selection against the exchange, by reducing the opportunity for plans outside an exchange to profit from luring healthier enrollees and by compensating exchange plans if they attract sicker-than-average populations.

But while risk adjustment will reduce adverse selection, it is unlikely by itself to fully protect against it. The Congressional Budget Office (CBO) has noted that existing risk-adjustment systems "tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high health spending." In other words, risk adjustment is very difficult to do with sufficient accuracy to ensure that insurers are actually compensated based on the populations they enroll. Even when done well, it generally compensates

[2] Peter Lee, "What People Don't Know about Health Insurance Exchanges," *Health Affairs* blog, August 12, 2009. See also, Elliot K. Wicks, "Building a National Health Insurance Exchange: Lessons from California," California HealthCare Foundation, July 2009.

for only *some* of the differences in health costs between healthier and less-healthy groups of beneficiaries.

As CBO has warned, the inability of current risk-adjustment systems to fully adjust for differences in health care costs between low- and high-cost groups means that, among plans in the same risk-adjustment system, "premiums for enrollees in plans that attract higher-cost beneficiaries [could] rise substantially over time."[3] Moreover, implementing effective risk adjustment under the Affordable Care Act will initially be hampered by the lack of comparable data on the health status of enrollees in the myriad of plans inside and outside the exchanges.

Another potentially helpful provision of the Affordable Care Act requires a "single risk pool," meaning that each insurer operating inside and outside of an exchange will be required to treat all of its enrollees as a single group when setting premiums. (In states where the individual and small-group markets are not merged, insurers will pool enrollees separately in each of these two markets.) Requiring a single risk pool could reduce insurers' ability to "cherry pick" healthier enrollees, since insurers operating in both the exchanges and the outside markets will not be able to charge lower prices in the external markets to attract healthier people. Similarly, the Affordable Care Act requires insurers that offer an identical plan inside and outside the exchange to charge the same premium in both places.

These pooling requirements, however, have significant limitations — for example, the risk-pooling requirement would apply only to insurers that choose to sell products *both* inside and outside an exchange. And as noted below, even in cases when insurers do sell products in both markets, it is likely to be difficult to enforce the requirement and ensure that risk is actually being pooled. In addition, the requirement that insurers offering identical plans in both markets charge the same premium in both places is weakened by the fact that the Affordable Care Act does not require insurers participating in both markets to offer the same plans inside and outside the exchange.

Except in the case of grandfathered plans and certain catastrophic plans for young adults and others, insurers are permitted to offer only plans that fall within one of four tiers of coverage in the individual and small-group markets: what the Affordable Care Act labels the Bronze, Silver, Gold, and Platinum coverage tiers. Bronze is the least comprehensive level of benefits and Platinum is the most comprehensive. Although the Affordable Care Act requires insurers operating *inside* an exchange to offer at least one plan in each of the Silver and Gold coverage tiers, insurers operating outside the exchange are not required to offer a plan in any particular tier. This will allow an insurer to operate only *outside* an exchange and to offer only Bronze coverage, which would be likely to attract healthier people because it is less comprehensive and hence will carry lower premium charges than plans in other coverage tiers.[4] Insurers *within* an exchange, on the other hand, will be required to offer more comprehensive Silver and Gold plans, which are more likely to attract people with significant health care needs.

---

[3] Congressional Budget Office, "Designing a Premium Support System for Medicare," December 2006.

[4] Bronze plans are required to have an actuarial value of 60 percent, while the other levels of coverage — Silver, Gold, and Platinum — have actuarial values of 70 percent, 80 percent, and 90 percent, respectively.

Some Elements of the Affordable Care Act Leave Exchanges at Risk for Adverse Selection

Under the Affordable Care Act, the existing individual and small-group markets can continue to operate outside the exchanges. Many of the law's requirements relating to individual and small-group insurance plans will apply regardless of whether the plans are offered inside or outside the exchanges. For example, all *new* plans offered — whether through the exchanges or through outside markets — will have to provide a package of "essential benefits" and a minimum level of coverage (as measured by actuarial value). In addition, the law's new "rating rules," including those that prevent insurers from charging different prices based on a person's health status, will apply to new individual-market and small-group plans regardless of whether the plans are offered inside or outside the exchanges.

But various other Affordable Care Act requirements apply *only* to health plans offered through an exchange, such as requirements related to the adequacy of provider networks, reporting on health care quality, grievance procedures, marketing practices, and benefit design. In addition, the law allows the Secretary of the U.S. Department of Health and Human Services to set additional standards for plans offered through the exchange, which plans sold outside an exchange are not required by federal law to meet.[5]

This leaves substantial opportunity for adverse selection because insurers in these external markets will effectively be competing for enrollees against the exchange plans, but will not have to comply with standards that are as strict. Insurers operating outside the exchanges could seek to take advantage of these looser rules to attract healthier people and businesses, while leaving sicker people to enroll in coverage through the exchanges. As a result, the differences in rules would likely create an unlevel playing field and thereby increase the likelihood of adverse selection against the exchanges unless states institute protective measures.

In addition, under the Affordable Care Act, states have the option of setting up two separate exchanges — one for individuals and another for small businesses. States that do so may find that the exchanges lack the necessary volume to attract a sufficient number of insurers, ensure a large enough pool of enrollees that is well-balanced between the healthy and the sick, and achieve the economies of scale that can keep an exchange's administrative costs low.

States Can Take Steps to Better Protect Exchanges from Adverse Selection

The Affordable Care Act relies on states to establish insurance exchanges and to make health plans available through them that meet certain federal standards. Within this general framework, the law leaves a number of policy choices about the structure of an exchange up to states, without mandating which choices states must make. How states respond will help determine whether the exchanges prove effective and sustainable. The following are steps that states can take to help the exchanges limit the risk of adverse selection and thereby better enable them to provide affordable and sustainable coverage to individuals and businesses as the health reform law intends.

[5] See PPACA Section 1311(c).

Make the Rules for Any External Markets Consistent with Those for the Exchange

Under the health reform law, states retain their current authority to regulate the individual and small-group markets (so long as state rules do not conflict with federal standards). States can ensure that the rules for markets outside the exchange and rules for the exchange are consistent. This would eliminate any disparities that might discourage insurers from participating in the exchange or permit insurers operating outside the exchange to design benefit packages and marketing campaigns to attract healthier people away from the exchange.

States can simply apply the same standards that HHS sets for qualified health plans offered in an exchange to plans offered in competing markets outside the exchange. For example, states can prohibit plans offered outside the exchange from using marketing and benefit design to avoid costly enrollees and require them to have adequate provider networks, contract with safety net providers, and obtain accreditation on clinical-quality measures.[6] If plans outside an exchange do *not* have to meet such requirements, exchange plans could end up enrolling sicker populations compared to the outside market because features such as a wider array of specialists and higher quality standards for treating certain illnesses would be more attractive to people with greater health care needs. Applying consistent rules to outside markets would create a more level playing field.

States should also ensure that rules that affect plan pricing are the same inside and outside the exchange so individuals and small businesses looking for coverage will not pay more to enroll through an exchange. For example, once the federal funding to help operate the exchanges expires in 2015, the Affordable Care Act envisions that the exchanges will support themselves by assessments on participating insurers or other means. States are free to charge such fees to insurers participating in *all* markets — for example, by instituting a surcharge based on the total number of people a carrier covers, whether inside or outside an exchange — or to otherwise ensure that fees to conduct the activities of an exchange do not unduly increase the price of exchange coverage for consumers, relative to the price for coverage outside the exchange.

It will also be important for states to ensure that insurers do not pay insurance-broker commissions in ways that provide incentives for brokers to steer healthier, lower-cost enrollees into plans offered outside the exchanges, such as by furnishing higher fees or bonuses to brokers who direct healthy individuals in that way. (This does not mean, however, that if brokers are permitted to enroll people into exchange coverage, the fees they are paid for doing so cannot be set lower than the fees they charge to enroll people outside the exchange, if the exchange takes on various administrative functions and costs that brokers otherwise provide when enrolling people in non-exchange coverage.)[7]

Finally, states should enforce rules for insurers consistently inside and outside an exchange. A state may decide that the regulatory agency that normally oversees health insurance will also monitor insurers participating in an exchange, or it may charge the entity that operates an exchange to regulate the exchange as well. Either way, the state must make sure that enforcement of consumer protections and other standards for insurers is uniform inside and outside an exchange. Otherwise,

---

[6] PPACA Section 1311(c).

[7] Jost, *op cit.* See also Mike Russo, Laura Etherton, and Larry McNeely, "Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform," U.S. PIRG Education Fund, June 2010.

insurers could take advantage of weaker enforcement outside the exchange to circumvent the rules and try to enroll healthier-than-average beneficiaries in the external markets.

Require Insurers to Offer the Same Products Inside and Outside an Exchange

As noted, the Affordable Care Act does not require insurers to participate in an insurance exchange, and plans offered in the outside markets need not meet the same standards as exchange plans. A problem with this approach is that some insurers may decide not to offer coverage through an exchange because it is easier to operate in the external markets if the rules there are weaker. They also may wish to offer products inside and outside the exchange that differ in ways that result in adverse selection against the exchange.

Some states, however, may wish to create a selective or competitive process to determine which plans can be offered in an exchange. States may, for example, decide which insurers or products will be available on the basis of price, performance on quality measures, and customer satisfaction, in order to improve the affordability and quality of plans offered through the exchange. Such a model would likely lead to different plan offerings within the exchange compared to the outside markets. However, if a state decides not to use a selective process to pick plans for an exchange, it could help protect against adverse selection by requiring all insurers who wish to offer products in outside markets to also offer coverage in the exchange and to offer the same products (priced the same) both inside and out.

At the very least, states (including those using a selective or competitive process to pick plans for an exchange) can require insurers outside the exchange to offer products in at least the Silver and Gold coverage levels, as they must do inside the exchange. As noted, the Affordable Care Act establishes the requirement to offer Silver and Gold plans only within the exchange; applying that rule outside the exchange as well would help to ensure more of a basic level of consistency in the products offered inside and outside the exchange and reduce insurers' ability to offer only less comprehensive products — which attract healthier people — outside of the exchange.

In addition, states should bar insurers from offering *only* Bronze plans or *only* catastrophic plans (as defined by the Affordable Care Act) outside of the exchange. Both of these types of plans will provide less comprehensive coverage than Silver and Gold plans and will cost less, are thus are likely to attract healthier people with lower health care costs. The catastrophic plans, for example, will have very high deductibles and only be available to people who are younger than 30 or exempt from the requirement to have health insurance (because they lack access to affordable coverage or have experienced a hardship).[8] States should not allow insurers to use catastrophic or Bronze plans to lure healthy people outside the exchange, particularly if an insurer has no products within an exchange and therefore would not be subject to the "single risk pool" requirement.

Merge the Individual and Small-Group Markets over Time

Merging the small-group and individual insurance markets within a state can allow one exchange to serve both individuals and small businesses, substantially increasing its potential enrollment volume. While larger enrollment does not guarantee a risk pool for the exchange that is well-

[8] PPACA, Sec. 1302(e).

balanced between the healthy and the sick, it does make it more likely. Greater enrollment also will promote more robust competition among insurers within an exchange. Depending on the nature of the insurance market in a state, merging the individual and small-group markets may increase prices for non-grandfathered plans in either the individual or small-group market to some extent. In Massachusetts, merging the individual market with the larger and more stable small-group market helped bring down premium costs for people purchasing coverage on their own,[9] though it may have raised prices modestly for some small-group purchasers.

Merging the markets would mean that insurers would establish the same base prices for products sold to both individuals and small businesses, prior to applying premium differentials related to age and other allowable factors. In other words, insurers would treat their individual and small-group enrollees as one pool when setting their prices and offer them the same products.

States considering whether to merge these markets have many factors to weigh, and some states may be reluctant to do so immediately in 2014. States may wish to focus first on instituting the Affordable Care Act's major changes in the premium rating rules in both their individual and small-group markets. Starting in 2014, the health reform law bars non-grandfathered plans in the small-group and individual markets from considering health status and gender when setting premiums for individuals or small businesses, and insurers will face new limits on how much they can take age into account. This is likely to initially cause some substantial shifts in premiums, whether up or down, for individuals and small firms. Once the new rules are in place in both the individual and small-group markets, however, it would likely be easier for a state to merge these markets. Therefore, a state could merge the markets several years after the Affordable Care Act's major changes in rating rules are implemented in 2014. Because the new premium rating rules will be consistent across the individual and small-group markets and will have been in effect for several years, these markets could be merged within an exchange at that time with less risk of market disruption.

Ensure that the Risk-Adjustment and Risk-Pooling Mechanisms Work Effectively

As noted, several elements of the Affordable Care Act are intended to protect exchanges and the insurers that participate in them from adverse selection, including the risk-adjustment system and the "single risk pool" requirement.

To work effectively, these requirements must be subject to careful monitoring and enforcement. In Medicare Advantage, for example, one significant problem that has impeded effective risk adjustment has been "upcoding," where the information that insurers report about enrollees' health status makes their enrollees appear sicker than they actually are (so that the insurers receive higher payments).[10] In the case of the Affordable Care Act's risk-pooling requirement, some analysts have expressed concerns that insurers may set up affiliates or subsidiaries that sell coverage only outside the exchange, as a way both to attract healthier enrollees and to keep them outside the insurer's risk pool (by claiming that the affiliates or subsidiaries are separate insurers and thus their enrollees do

[9] Nancy Turnbull, "Individual Market Reforms: Data for a Few More PowerPoint Slides," CommonHealth blog at commonhealth.wbur.org, September 15, 2008.

[10] January Angeles and Edwin Park, "Upcoding Problem Exacerbates Overpayments to Medicare Advantage Plans," Center on Budget and Policy Priorities, September 14, 2009.

not have to be pooled with the insurer's other enrollees).[11] As exchanges are established, states and the federal government will need to conduct monitoring to ensure that insurers are providing accurate information about the health status of their populations and that risk is actually being pooled across all of an insurer's plans as the law requires. This is likely to necessitate periodic audits of insurer data and close examinations of rate filings and other information that insurers provide to regulators, as well as rules to ensure that setting up an affiliate or subsidiary does not allow an insurer to avoid the "single risk pool" requirement.

[11] Jost, *op cit*.