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Comments are being requested on this draft White Paper. Comments should be sent only by email to Jolie Matthews at jmatthew@naic.org.

Adverse Selection

Background

Adverse selection is a phenomenon that is endemic to insurance of any kind, including health insurance. It occurs whenever insureds or applicants for insurance make decisions relative to the purchase of insurance based upon their own unique knowledge of their insurability or likelihood of making a claim on the insurance coverage in question.

Health insurance may be particularly susceptible to adverse selection. In the absence of underwriting or regulatory impediments, the public can and will make decisions on when and whether to purchase based upon knowledge of their own personal health. 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 (while my house is on fire, I call to get a home owner's policy). Therefore, instead of a large number of individuals purchasing and paying for health insurance to cover the claims of those that incur health care costs, far fewer individuals are paying premiums to cover those same health insurance contingencies, 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.

Today's Marketplace

Just as a consumer will act in their own financial self interest, insurers will as well, utilizing a variety of tools to lessen their susceptibility to high risk individuals. In the individual market applicants are underwritten to determine their insurability. In the event of an intentional misstatement of a material fact, that policy can be rescinded by the insurer. Insurers also apply preexisting condition waiting periods during which no coverage is provided for those preexisting conditions. Insurers also use waiting periods in policies during which there is coverage only for accidents and no coverage for costs incurred due to sicknesses. In employer group health insurance adverse selection is minimized because employees often sign up for coverage regardless of health status, enabling large employers in particular to get a more balanced risk profile. Small employers, however, do not have the critical mass of enrollees to shelter them if an employee gets sick.

Adverse Selection Issues in Exchanges

While Exchanges may represent an alternative method of procuring health insurance it is also at risk for adverse selection issues. The following are examples of where adverse selection may have an undesirable effect on Exchanges:

1. The existence of two markets, the Exchange and a traditional health insurance market outside the Exchanges, must be crafted carefully to avoid one from becoming the equivalent of a state high risk pool. This would certainly happen if one market is able to offer stripped down plan designs while the other is required to offer more robust options that include mandated benefits. Ultimately, the more healthy population will select a lower priced option while the less healthy will choose the more comprehensive plan.

2. A comparative lack of network adequacy inside Exchanges compared to what is available in plans sold outside Exchanges could be a potential source of adverse selection. The insurance buying public frequently makes purchasing decisions based upon the availability of their chosen medical providers within the insurer's network.

3. If permitted, a differential in pricing between insurers' products inside and outside the Exchanges could result in adverse selection. Although there is a requirement that a bronze plan offered in the Exchange must receive similar pricing if sold outside the Exchange, it is not clear if this is limited to benefits that are exactly the same or substantially similar.

4. Although the number of participants in grandfathered plans may be minimal by 2014, the removal of these members from the risk pool may also result in adverse selection.

5. Differentials in insurance producer commissions or user/insurer fees inside and outside the Exchange can result in the steerage of purchases away from the exchange.

6. SHOP exchanges, either as stand-alone Exchanges or as part of a single state Exchange, may experience adverse selection based upon employers' decisions to retain grandfathered status, self fund or purchase insurance through the Exchange. Employers with favorable risk demographics have an incentive to self fund 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 funding is much more prevalent in large group plans.

7. If Exchanges are structured so that employers may only offer their employees a defined contribution arrangement whereby the employee/dependent makes the choice of insurer and plan option through the exchange while the outside market allows the employer to make the choice of plan or plans available to covered employees/dependents, adverse selection may occur. Additionally, if an employer may offer employees multiple products through a variety of carriers inside the exchange, while the employee choice is limited outside to only one carrier and one plan, adverse selection in the outside market may occur.

8. By limiting the plan designs to only Platinum, Gold, Silver and Bronze, individuals and employers desiring additional options may be forced outside the Exchanges. State flexibility is key to minimizing adverse selection. High deductible plan designs have historically drawn healthier individuals and allowing insurers to offer these types of plans outside the Exchange with no requirement to offer a similar product inside the Exchange is likely to result in adverse selection.

<u>Key ACA Provisions Addressing Adverse Selection</u>

Several sections of the Affordable Care Act ("ACA") address the issues of adverse selection. Such provisions and potential effects are summarized below.

- §1301(a)(1)(C)(ii) – Issuers must offer at least one silver and one gold level plan in order to participate in the Exchanges. However, no limit is placed on the number of plans issuers may offer outside the Exchanges.
- §1301(a)(1)(C)(iii) – The premium for plans offered inside and outside the Exchanges must be the same. Actual premiums may vary depending on the application of the rating factors to enrollees. ACA appears to anticipate that plans may be structured such that a healthier population is more attracted to plans outside the Exchanges, since it requires an Exchange, in considering premium increases, to "take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange." §1311(e)(2).
- §1201, amending/adding PHSA §§2701- 2705 - Plans inside and outside the Exchanges must use the same rating factors, which are limited to age (3:1 ratio), geography, family size and tobacco use.
- §1201, adding PHSA §§2707 – All plans in the individual and small group markets must cover essential benefits to be later defined by Health and Human Services. However, large group and self-insurance plans not on the Exchange are only required to offer "minimum essential coverage" per §1501. This could create an environment where larger groups could skew the benefits offered so as to drive high risk enrollees to the Exchanges.
- §1304 – Small group will be expanded to 100 employees, thereby expanding the risk pool for states that limited small group to 50 employees previously.
- §1312(c) – The ACA mandates single risk pools. This means that an issuer must combine the experience for all individual plans or all small group plans, regardless of whether they are offered on the Exchanges.
- §1324 - Plans off the Exchange will be subject to the same "playing field" as CO-OP and multi-state plans: plans off the Exchange will not be subject to any federal or state law to which CO-OP or multi-state plans are not subject in the designated categories (including rating, pre-existing conditions, non-discrimination, and benefit plan materials).
- §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. This provision may allow implementation of a gradual phasing out of state high risk pools instead of an immediate transition of all high risk pool members into Exchanges. However, there may be a potential conflict with the federal high risk pools pursuant to § 1101(g)(3).
- §1342 - All qualified health plans in the individual and small group markets will be required to participate in a risk corridor mechanism. This may increase plan participation in the Exchanges by reducing risk.
- §1343 - All health plans and health insurance issuers in the individual and small group markets, whether offering plans through the Exchange or not, will be required to participate in a state's risk adjustment mechanisms. Large group, self-funded and grandfathered plans are not required to participate. Carriers may be inclined to avoid the individual and small group markets in order escape assessments.
- §1401 - Premium tax credits will be available only for coverage purchased through the Exchange. This may invite a broader pool of participants or, conversely, may invite "dumping" of expensive enrollees onto the Exchange.

<u>State Options to Minimize Adverse Selection Effects</u>

The ACA contemplates state flexibility to consider additional policies beyond those described above. States should consider the goals of their Exchanges when weighing their policy options. Whether a state views its Exchanges as clearinghouses, organized marketplaces or active purchasers, will shape states' decisions concerning implementing adverse selection policies.

Many of the options listed below could also be phased in; either in advance of 2014 or some number of years after the exchange is up and running in order to mitigate any market disruption or rate impact. The first overriding decision that a state must make is if the Exchanges will be the sole marketplace for health insurance. Establishing one marketplace has its benefits and detractions. For the purposes of this paper we are assuming states will choose a dual marketplace, at least initially.

<u>Market Participation Rules</u>

The most important thing that states can do is to help facilitate a level playing field between participants in and out of the Exchanges. ACA does not require insurers to offer Exchange products; and the health plans offered by insurers outside Exchanges do not have to meet all of the same exchange plan standards. States may choose otherwise.

Allowing some variance between the marketplaces allows issuers 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. Clearly if allowed, both consumers and insurers will follow their own economic interests: consumers will purchase based on the benefits they need or perceive they will need; and insurers will market to those they perceive to have a lower risk.

States may consider a number of policy options to address these challenges. For example, insurers could be required to operate in both markets and/or compelled to offer products at certain levels in order to operate in a particular market. States may require disclosures and rankings similar to the ACA actuarial standards for products outside Exchanges. Additionally, states may choose to allow products beyond the Silver and Gold required to the extent carriers wish to offer bronze or catastrophic plans.

<u>Consumer Choice</u>

Determining a manageable level of coverage options that provide consumers with a robust yet easy to understand shopping experience should be the goal of policymakers. Too few options is undesirable, and too many can lead to choice that is counterproductive and confusing for consumers. State policymakers will need to decide the level of appropriate standardization both in and out of Exchanges. It is incumbent upon states to analyze their current insurance market, their citizens who are currently uninsured and the overall goals of the Exchanges in order to tailor their policies to serve their populous.

<u>Merge Small and Individual Markets</u>

Another way to ease the likelihood of adverse selection is to create a level playing field. Merging the risk pools of the individual and small group markets may create a more stable and predictable market over time if the pool is of sufficient size to reflect a balanced cross-section of risks. Careful consideration needs to be taken by state policymakers in this area. In every pool the healthier risks subsidize the unhealthy risks. Depending on the size and risk profile of the individual and small group markets, one will end up subsidizing the other—increasing or decreasing premium levels accordingly. State policymakers will need to determine what an acceptable variance in rates should be in its efforts to create a more stable and predictable market over time.

<u>Additional Mechanisms to Consider</u>

- <u>State Mandated Benefits</u> - States may require plans operating in the Exchange to include state mandated health benefits. In doing so, states will be required to pick up any additional cost. In order to create a level playing field between the markets, state policymakers should consider making the requirements around mandated benefits 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. In order to be considered a Qualified Health Plan (QHP) and therefore eligible for sale in the exchange, a plan must meet additional requirements that could make them more expensive than plans offered outside of the exchange. Additional requirements may also hinder competition and/or inhibit new insurers from entering a state's Exchange or health insurance marketplace. Policymakers should consider this dynamic when further defining a QHP and determining what plans must do to sell outside of the exchange.

- Participation Requirement Consistency - Currently insurers require at between 50% and 75% of all employees to enroll for coverage to be placed. Participation requirements vary by state. If there are different participation requirements, 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 both producers and navigators in and out of Exchanges could have a significant effect on the market. States should consider the effect of different structures in and out and how that will drive the market in or out of Exchanges. The effect may vary between the individual and small group markets. States may choose to minimize these effects by regulating how compensation is structured both in and out of the Exchanges.
- Penalties for Non-Enrollment – Depending on regulations when drafted, states may consider open enrollment periods and penalties if individuals enroll outside of that period. To minimize adverse selection, states may consider requiring enrollment periods inside and outside the Exchanges.

Conclusion

The success of Exchanges is directly linked with their ability to attract a sufficient cross section of risk to balance high and low cost consumers. If the market outside of Exchanges 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.

There are numerous options states may use to facilitate a level playing field between the markets in and out of Exchanges. Many of these options may be phased in; either in advance of 2014 or some number of years after Exchanges are up and running 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 policymakers engage in when establishing market rules aimed at minimizing adverse selection. Because market response may vary across states, as may the state's goals for Exchanges, flexibility and continual review may be the best tools for a state to facilitate and sustain the success of Exchanges.

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