

Market Rules to Stabilize Risk Pools – Draft Policy Options and Questions

Purpose of this Issue Brief

Beginning in 2014, tens of thousands of enrollees will become insured through Washington State’s Health Benefit Exchange (Exchange). If the appropriate balance is not maintained between enrollees in the Exchange with low health care needs, and those with high health care needs, premiums will rise and many enrollees will have difficulty retaining coverage. The Affordable Care Act (ACA) includes regulations designed to maintain such a balance (referred to as “stabilizing the risk pool”). The purpose of this issue brief is to discuss whether Washington State needs to adopt regulations in addition to those under federal law to further stabilize risk pools inside the Exchange.

Definitions

These definitions should help clarify the policy discussions in this issue brief:

Issuer: Issuers are otherwise referred to as: health insurance companies, insurers, managed care organizations, or carriers. An issuer is the company that issues a health insurance plan. The full definition of “health insurance issuer” is in subsection 2791 of Public Law 104-191.

Health plan: Plans are referred to as: the health policy, contract, or “the product.” The health plan is the product that offers specific benefits, cost-sharing, provider networks, and coverage limits. A health plan can be offered by an issuer, and also offered by an employer or trust. The use of the term “health plan” is defined in subsection 1301 of the ACA.

Background: How Adverse Selection Creates Unstable Risk Pools

Large premium increases signal the beginning of an unstable risk pool. Healthier enrollees respond by disenrolling. These healthy enrollees typically find less expensive coverage, bringing more stability to the risk pools they join.

Because the value of their benefits still exceeds their premium, less healthy enrollees typically remain in the risk pool. This causes more instability. The risk pool, consequently, has been “adversely selected” by too many unhealthy, high-cost enrollees. To cover costs, an issuer will increase premiums, and the healthier enrollees again disenroll. Adverse selection leads to a cycle of escalating premiums and disenrollment that is difficult to stop. At its worst, adverse selection severely impacts one or a few issuers and has the potential to destabilize an entire health insurance market and cause issuers to pull-out of that market.

Both enrollees and issuers can respond to incentives that make risk pools unstable. The ACA recognizes that enrollees have a financial incentive to become insured only when they are sick. The ACA also recognizes that issuers have a financial incentive to avoid potentially high-cost enrollees. This brief will first describe how the ACA responded to these adverse incentives with a well-known set of policies and an unfamiliar set of “risk leveling” programs. Then Washington State can begin to discuss if additional regulations are needed.

How the ACA Addresses Enrollee Financial Incentives

The ACA implements three policies in 2014 that reduce the incentive for an individual to wait to sign up for insurance until he or she is sick and in need of services: (1) Issuers may no longer turn away enrollees

with costly medical conditions; (2) adults who can afford insurance under the “individual mandate” will face financial penalties if they do not enroll; and (3) federal subsidies will help people pay for insurance. Concerns persist that the individual mandate will be ignored because the penalties for doing so are too small. However, the three policies and ever-increasing penalties come close to removing the financial incentives for individuals to adversely select a health plan when they become sick. Also, beginning in 2014, consumers will not be able to choose when to enter and exit individual plans purchased in the Exchange, because there is an annual open enrollment period that give people a specific time within the year to enroll in health insurance.

How the ACA Addresses Issuer Financial Incentives

The ACA also includes regulations that reduce the potential for issuers to enroll high-cost enrollees only in plans within the Health Benefit Exchange. In determining premiums, for example, the ACA requires an issuer to pool together all enrollees from its individual market plans both inside and outside of the Exchange. Likewise, an issuer must pool all enrollees from its small group market plans inside and outside of the Exchange.

The ACA also specifies that an issuer will determine premiums for individual and small group plans using “adjusted community rating.” For example, premium increases are determined by pooling together an issuer’s total community of enrollees in the individual market; not on the medical claim costs of the enrollees in a single health plan. The same rating requirements hold for the small group market. The ACA further reduces the potential for an issuer to enroll high-cost enrollees only in the Exchange by specifying that an issuer must charge the same premium for a health plan offered inside and outside of the Exchange.

The ACA also establishes a set of “essential health benefits” that issuers must include in health plans offered inside and outside of the Exchange. This will reduce an issuer’s ability to steer clear of benefits that attract high-cost enrollees.

The ACA also established three risk leveling programs to reduce the risk of a single issuer or health plan being burdened with a disproportionate number of high-cost claims. Two of these programs are temporary. The first is a transitional reinsurance program for the state’s individual market plans offered inside and outside of the Exchange. The reinsurance program shares the cost of covering high-cost enrollees with the issuer by paying federal dollars for most of the claims costs above a threshold amount. The second is a temporary “risk corridor program” for plans in the Exchange. The risk corridor program charges Exchange plans whose total medical claims costs are much lower than anticipated and reimburses plans whose claims costs are much higher than anticipated.

The ACA also directs the implementation of a permanent risk adjustment mechanism for the individual and small group markets. A level playing field in each market is the goal of risk adjustment. An assessment of a plan’s risk is used to compensate issuers that attract more risk than the market average and requires issuers to compensate others when their risk is below the market average.

Despite the policies and programs intended to reduce adverse selection in the Exchange, it is possible that Exchange plans could still enroll an unusually high-cost population. These enrollees will be attracted to the comprehensive coverage of those Exchange plans required to offer minimal cost-sharing. Also, lower-income individuals have greater medical needs and will use federal subsidies to enroll in Exchange

plans. The goal of this brief is to discuss additional market rules that could further stabilize risk in Exchange plans versus the risk in plans outside of the Exchange.

Market rules for discussion

Minimum standards for the Exchange: The ACA directs that issuers participating in the Exchange:

- offer at least one gold and one silver level plan, and
- charge the same premium for a plan offered both inside and outside of the Exchange.

Washington State should discuss if any of these additional market rules are needed to further reduce adverse selection and stabilize risk pools in the Exchange:

- A. Must offer at least one silver and one gold level plan outside of the Exchange.** Issuers participating in the individual or small group markets outside of the Exchange must offer at least one health plan with the actuarial value of a silver level plan and one health plan with the actuarial value of a gold level plan.
- B. Only catastrophic or bronze level plans offered inside of the Exchange could offer the same catastrophic or bronze level plans outside of the Exchange.** Only issuers that offer catastrophic or bronze level plans inside of the Exchange could also offer the same plans outside of the Exchange.
- C. Only issuers participating in the Exchange may offer plans outside of the Exchange.** Only issuers selected to offer health plans inside the Exchange could offer health plans outside of the Exchange. (The health plans offered outside of the Exchange would not necessarily be the same plans that the issuer offers inside the Exchange.)
- D. All health plans offered inside and outside of the Exchange must meet Qualified Health Plan criteria.** Any health plan offered inside or outside of the Exchange in the individual or small group markets would have to meet the criteria of a qualified health plan (see issue brief on criteria for qualified health plans). Every health plan offered outside of an Exchange need not be certified as a qualified health plan but would have to meet the criteria.

Policy Questions: The following questions will be discussed in the brief.

Private Insurance Market Issues

How might these options help implement a stable and sustainable Exchange?

How might these options stabilize the individual or small group markets?

How might these options destabilize the individual or small group markets?

Is there a need for any of these options?

Do any of the options duplicate ACA policies or programs intended to level the playing field?

Are any of these options necessary to complement the implementation of the ACA policies or programs intended to level the playing field?

Where might the greatest risks of adverse selection come from? Do any of the options directly address those sources of risk?

Which of the options might promote further competition based upon price, quality, and service between insurers?

How might these options impact the implementation of ACA's reinsurance, risk corridors, and risk adjustment programs?

How might these options be combined?

Cost and Quality

How might these options increase premiums, and for whom?

How might these options stabilize or decrease premiums, and for whom?

How could these options impact the quality of care delivered?

How might these options impact access to health care providers?

Consumer Outcomes

Which options encourage the development of meaningful choices for consumers, both inside and outside of the Exchange?

How might these options make the Exchange more attractive to enrollees currently covered by individual and small group plans?

Might any of these options harm enrollees?

Might any of these options help enrollees?

How might any of these options support meaningful comparisons when enrollees shop among plans in the Exchange?

Administration

Do any of the options lessen or create undue administrative burden for insurers?

Do any of the options lessen or create undue administrative burden for the Exchange?

Do any of the options lessen or create undue administrative burden for the Office of Insurance Commissioner or others?