OCPP Oregon Center for Public Policy
Because facts matter.

Issue Brief

September 8, 2011

The Active Purchaser Imperative

Unless Oregon's health insurance exchange bargains for low prices, it risks collapsing due to effects of adverse selection

By Janet Bauer

The 2011 Oregon legislative session set in motion the creation of the Oregon Health Insurance Exchange, which — if implemented properly — will play an important role in extending affordable health coverage to the many Oregonians who lack it. The goal of a health insurance exchange is to allow individual and small business purchasers to achieve what many large employers now enjoy: relatively affordable, quality coverage. That advantage comes from risk being spread among many individuals and a sizable market share that can command competitive prices.

If it is to endure as a viable marketplace, the Oregon Health Insurance Exchange will need to take an active role in securing lower prices for consumers. Unless the exchange succeeds in offering high-quality health plans at competitive prices relative to plans outside the exchange, it risks attracting a disproportionate share of less-healthy Oregonians, and succumbing to what economists call "adverse selection." This phenomenon has doomed a number of health insurance exchanges instituted elsewhere.

Adverse selection threatens health insurance exchanges

Adverse selection is a dynamic that occurs when healthy and less healthy individuals separate into different insurance pools, resulting in the concentration of less healthy individuals in some insurance plans. When consumers have a choice among insurance plans — as Oregonians will among plans sold inside and outside Oregon's new exchange starting in 2014 — price will be a major driver of whether plans attract healthy or less healthy individuals. If a disproportionate number of less healthy people choose exchange plans, the stability of the state's exchange will be at risk.[1]

Adverse selection against an exchange is likely to arise unless the exchange can successfully compete with health plans outside the exchange in terms of cost. This is because healthy individuals are more sensitive to premium prices than those who are not as healthy.[2] In contrast, those in poorer health tend to seek plans with more generous coverage, even if it means paying a somewhat higher premium. Given these dynamics, if an insurance company can offer a cheaper (typically skimpier) plan outside an exchange, it is likely to be a plan attractive to relatively healthy people who perceive they will not need much health care. Unless strong protections are in place to prevent plans outside the exchange from "cherry-picking" the healthiest, the exchange risk pool will likely become a less healthy group with greater overall health care expenses.

Healthy individuals play a vital role in keeping an insurance pool sustainable by helping to keep premiums affordable. If the healthiest leave an exchange risk pool, premium prices inside the

exchange will tend to rise, making its plans less appealing to the remaining participants, especially to those in relatively good health who anticipate they will not need many services. As more of the relatively healthy leave the pool for better deals outside the exchange, prices within the exchange will tend to rise even higher.

Even small differences in health expenses among groups can set in motion damaging bias selection dynamics. Researchers at the Kaiser Family Foundation found that the migration of a very small number of individuals with high health care costs from one otherwise identical risk pool to another created substantial disparities in average costs — the costs that drive premium prices. Specifically, they found that just 0.4 percent of individuals (four out of every 1,000) moving from one risk group to another created a 5 percent difference in the average per-person cost between the groups when the individuals who shifted were those with costly health care needs.[3]

Adverse selection has proved fatal to a number of health insurance exchanges operated in other states.

Adverse selection can be fatal to exchanges

An exchange that fails to attract the healthy is destined to collapse when premiums rise to the point that the coverage is unaffordable for those who remain, or when high costs prompt insurers to leave the exchange marketplace, or both. Indeed, adverse selection has proved fatal to a number of health insurance exchanges operated in other states.

A small business exchange initiated by the California legislature in 1992, called PacAdvantage, ultimately collapsed due to its inability to attract enough healthy, low-cost groups.[4] PacAdvantage restricted insurers' ability to reject applicants and banned higher premiums based on the claims histories of individual businesses — policies similar to provisions of the Affordable Care Act for state exchanges. While the goal of the exchange was to boost members' collective market share and bargaining power, insurers didn't offer their best rates to PacAdvantage members. Instead, they vigorously competed against the exchange with lower-cost, less generous plans. Some insurers then dropped their exchange plans, finding the market unprofitable. Finally, in 2006, Blue Shield of California, one of the three remaining statewide carriers in the exchange, withdrew from PacAdvantage citing financial losses. Its exit precipitated the exchange's closure.[5]

The same fatal outcome befell the Texas Insurance Purchasing Alliance, a small business exchange created by the Texas legislature in 1993. Structured similarly to the California exchange in that it pooled small employers into large purchasing groups, the exchange found initial success in offering low-cost products. However, after six years, the exchange collapsed. Its founder explained the demise this way:

> [O]ur exchange failed not because it wasn't needed, and not because the concept wasn't sound. . . . Private insurance companies, which could offer small-business policies both inside and outside the exchange, cherry-picked relentlessly, signing up all the small businesses with generally healthy employees and offloading the bad risks — companies with older or sicker employees — onto the exchange. . . . [A]s a result, our exchange was overwhelmed with people who had high health care costs, and too few healthy people to share the risk.[6]

The new Oregon Health Insurance Exchange, structured to meet the standards of a state exchange established by the federal Affordable Care Act, will be similarly vulnerable to adverse selection. Some provisions of the Affordable Care Act, such as the presence of premium tax credits available only within the exchange and the requirement that insurers pool risk inside and outside the exchange, will help to protect against adverse selection. However, these safeguards have substantial limitations.[7] In addition, a number of requirements of the Affordable Care Act, while meaningful to consumers, will have the effect of making the exchange more vulnerable to this damaging dynamic.[8]

In sum, the Oregon Health Insurance Exchange will be vulnerable to adverse selection. Should such bias occur, it could lead to the collapse of the exchange.

Oregon's exchange must protect against adverse selection by bargaining for low prices

The most successful exchanges in the country have negotiated with insurers.

The 2011 legislature created the Oregon Health Insurance Exchange Corporation with the passage of Senate Bill 99. The public corporation's charge includes operating the exchange in the public interest.[9] Beginning January 1, 2014, the exchange will offer to individuals and businesses with 50 or fewer employees a range of plans that, at a minimum, meet federal benefit standards.

The Oregon legislature could largely remove the risk of adverse selection by eliminating the outside market and require all health insurance to be sold within the exchange marketplace.[10] However, the legislation approved by the 2011 legislature envisions that a non-exchange market will continue to exist in Oregon once the state exchange is operational in 2014.[11]

Given the anticipated existence of an outside market, it will be important that Oregon's exchange plans compete successfully for healthy individuals. As the failure of exchanges elsewhere shows, having a large market share does not assure that insurers will offer their best deals. Therefore, Oregon's exchange will need to play an active role in fostering competition among insurers to offer the highest value plans the industry can possibly produce.

An "active purchaser" role could involve requiring insurers to submit bids or negotiating with insurers for the best possible deals. Indeed, the most successful exchanges in the country have negotiated, at least to some extent, with insurers to lower the cost of the offerings in their exchanges. Examples of successful exchanges that actively bargain are the Federal Employee Health Benefit Plan and the California Public Employees' Retirement System.[12]

Fortunately, the legislation establishing the Oregon Health Insurance Exchange permits the public corporation that operates the exchange to negotiate with insurance companies on plan quality and price. Although SB 99 does not explicitly direct the Oregon Health Insurance Exchange to actively bargain or selectively contract with insurers, nothing in the language prohibits it. During the legislature's deliberations on SB 99, Oregon Legislative Counsel explained that the exchange is "authorized, but not required . . . to act as an active purchaser and to negotiate costs and quality in determining which health plans may be certified as qualified health plans."[13]

Therefore, to adhere to its mission to operate in the public interest and to help ensure the long-term viability of the exchange, the exchange corporation's board should, as one of its first tasks, officially establish that it will operate as an active purchaser to secure high-quality products at the lowest possible price.

Legislature should make explicit the exchange's negotiating power and duty

To support the new exchange corporation in exercising an active purchaser role, in the next legislative session lawmakers should make explicit in the statute the exchange's active purchaser authority. Doing so would remove the possibility that the corporation's power in this regard, as outlined by Legislative Counsel, could be called into question and would ensure the smooth launch of the exchange. In addition, the legislature should specify that the exchange not only has the power but also the obligation to negotiate on behalf of consumers. Ultimately, such action would help protect the exchange from potentially fatal adverse selection dynamics.

Conclusion

As illustrated by the collapse of exchanges in other states, adverse selection poses a mortal risk to state health insurance exchanges being set up to conform with the federal Affordable Care Act. For Oregon's newly-created health insurance exchange to mitigate this risk, it must exercise the authority to bargain for low prices on behalf of consumers. The legislature can assist in that effort by making the exchange's active purchaser power and duty explicit in the statute.

Endnotes:

[1] Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, The Commonwealth Fund, September 2010, p. 8.

[2] Kaiser Family Foundation, *Snapshot: Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models*, November 2006.

[3] Kaiser Family Foundation, *Snapshots: Health Care Costs: Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models*, November 2006. Researchers created a model using medical claims data from the Society of Actuaries. Using medical claims histories of nearly 1.6 million claimants, they formed two risk groups of identical number of claimants (795,869), number of high-risk claimants and total average claims ($1,633). They found that when they moved 3,463 of the high-risk claimants from one pool (now called the favorable selection pool) to the other (now called the adverse selection pool), the average claim of the groups differed by 5 percent ($1,673 for the adverse selection group and $1,592 for the favorable selection group).

[4] Initially called the Health Insurance Plan of California (HIPC).

[5] *San Francisco Chronicle*, "Losses shutter health group: PacAdvantage can't offer pool members enough plan choices," August 12, 2006.

[6] Cappy McGarr, "A Texas-Sized Health Care Failure," *The New York Times*, October 6, 2009.

[7] See OCPP issue brief, *Inoculating Oregon's Health Exchange Against Adverse Selection*, Janet Bauer, September 7, 2011, for discussion of provisions of the Affordable Care Act that help protect against adverse selection, and their limitations.

[8] See OCPP issue brief, *Inoculating Oregon's Health Exchange Against Adverse Selection*, for discussion of provisions of the Affordable Care Act that predispose state exchanges to adverse selection.

[9] SB 99, Section 2, (2) states, "The mission of the corporation is to... (b) Administer a health insurance exchange in the public interest for the benefit of the people and businesses that obtain health insurance coverage for themselves, their families and their employees through the exchange."

[10] Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, The Commonwealth Fund, September 2010, p. 10.

[11] SB 91 describes both exchange and non-exchange markets. SB 99 is silent on the existence of an outside market.

[12] Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, p. 19 notes that the most successful plans, the Federal Employee Health Benefit Plan (FEHBP) and California Public Employees' Retirement System (CalPers) have engaged in some level of negotiation with insurers.

[13] Letter from Dexter A. Johnson, Legislative Counsel and Lorey H. Freeman, Deputy Legislative Counsel to Representative Ben Cannon, dated May 27, 2011 states, "To be certified, a health plan must meet the requirements, standards and criteria established by the corporation by rule. The corporation would be authorized, but not required by the language in section 11 (4), to adopt requirements, standards and criteria that would allow the corporation to act as an active purchaser and to negotiate costs and quality in determining which health plans may be certified as qualified health plans." Available at http://www.ocpp.org/media/uploads/pdf/2011/sb99aLegislativeCouncilCannon20110627.pdf.

This work is made possible in part by the support of the Ford Foundation, the Stoneman Family Foundation, the Strategies to Eliminate Poverty Program of the Northwest Area Foundation, the Oregon Education Association, the Oregon School Employees Association, SEIU 503 and by the generous support of organizations and individuals.

The Oregon Center for Public Policy is a part of the State Fiscal Analysis Initiative (SFAI) and the Economic Analysis and Research Network (EARN).