OCPP Oregon Center for Public Policy
Because facts matter.

Issue Brief

September 8, 2011

Inoculating Oregon's Health Exchange Against Adverse Selection

By Janet Bauer

The 2011 Oregon legislature took an important step toward addressing the lack of affordable, quality health coverage for many Oregonians and small businesses with the enactment of the Oregon Health Insurance Exchange.[1] Provisions of Oregon's health reform law of 2009, as well as the federal Affordable Care Act, helped pave the way for the creation of the exchange, set to begin operating in 2014.

Despite the promise it holds, Oregon's health exchange faces the threat of "adverse selection," a potentially fatal development for an insurance exchange. Adverse selection occurs when healthy and less healthy individuals separate into different insurance pools. Insurance pools saddled with a disproportionate share of less healthy individuals have difficulty competing with pools serving healthier individuals. Indeed, adverse selection has caused the collapse of exchanges operated in several states.

The threat of this dynamic arises in Oregon because a dual marketplace for health insurance — within the exchange and outside — will exist and operate by somewhat different rules. The danger of adverse selection exists in Oregon despite provisions in the Affordable Care Act designed to shield new state exchanges from the problem.

To inoculate Oregon's exchange from the risk posed by adverse selection, policymakers must take steps to ensure the new health insurance exchange attracts Oregon's healthiest individuals.

The Affordable Care Act does not sufficiently protect against adverse selection

Oregon's health exchange will be vulnerable to adverse selection unless it is able to attract healthy individuals with competitively priced health plans relative to those found outside the exchange.

The presence of healthy individuals helps keep an insurance risk pool sustainable by helping to keep premium costs down. Low premium costs, in turn, make health plans attractive to healthy individuals who — anticipating little need — tend to choose health plans based on premium cost. By contrast, less healthy people tend to choose based on how comprehensive the benefits are, so as to minimize potential out-of-pocket costs.[2] Therefore, unless the exchange offers competitively priced plans, healthy individuals will tend to avoid the exchange. And if healthy people leave an exchange for cheaper plans elsewhere, premium costs inside the exchange will rise, making exchange plans even less attractive to the remaining relatively healthy individuals.

Adverse selection is a serious threat to the viability of state exchanges. It has caused health exchanges set up elsewhere to collapse.[3]

Facilitating the creation of state health insurance exchanges is a key component of the historic 2010 federal health reform legislation, the Affordable Care Act. When drafting the act, Congress recognized the threat of adverse selection. To counter it, lawmakers put in place provisions to encourage participation in the exchanges by a broad cross-section of Americans. Unfortunately, those protections are insufficient to fully safeguard an exchange from the risk of adverse selection.

Summarized below are the Affordable Care Act provisions that mitigate against adverse selection and a description of the limits of their effectiveness.

Requiring "essential benefits"

Unfortunately, the Affordable Care Act's protections are insufficient to fully safeguard an exchange from the risk of adverse selection.

Starting in 2014, all individual and small group health plans — whether offered inside or outside the exchange — must offer at least a basic set of comprehensive benefits.[4] This "essential benefits" requirement reduces the opportunity for insurers to offer skimpy, inexpensive plans outside the exchange that would tend to attract healthier people who expect to need few services.

This provision, however, will not prevent cherry-picking by insurers. Federal law does not bar insurers from offering additional services, such as sports medicine clinics, that are particularly attractive to healthier individuals. In addition, the essential benefits requirement will not apply to a substantial share of the market. Large group plans, self-insured plans and "grandfathered plans" — those in existence at the time of the Affordable Care Act's enactment — are not required to offer a package of essential benefits.

Spreading risk among plans inside and outside an exchange

The Affordable Care Act helps protect against adverse selection by requiring each insurer to set premiums based on its entire pool of enrollees inside and outside an exchange.[5] This "single risk pool" requirement reduces an insurer's ability to cherry pick healthy individuals by offering cheaper plans in the outside market based on a healthier risk pool. The law also requires insurers that offer the same plan in both markets to charge the same premium in both.[6]

Unfortunately, these risk pooling requirements will have limited impact. The single risk pool requirement helps protect against adverse selection only to the extent that insurers sell products in both markets. Further, the rule faces enforcement challenges because it is difficult to ensure that insurers pool risk appropriately.[7]

In addition, although the Affordable Care Act requires identical plans sold in both markets to have identical premiums, the Act does not require insurers to *offer* the same plans inside and outside the exchange. Therefore, an insurer can avoid the premium requirement by creating plans that may be similar but not identical.

And again, under the Affordable Care Act, a substantial share of the insurance market — large group, self-insured and grandfathered plans — will not be subject to risk pooling requirements, undermining their effectiveness as tools in preventing adverse selection.[8]

Providing premium tax credits for certain individuals and small businesses

Under the Affordable Care Act, low- and moderate-income individuals will be eligible for a federal premium assistance tax credit when they purchase health insurance through a state exchange, making the exchange attractive to the broad group of those eligible.[9] Small business tax credits available only through the exchange starting in 2014 also promise to encourage a broad risk pool.[10]

However, not all individuals and small businesses will qualify for the benefits. The purchasing behavior of those who do not qualify for the credits poses a risk to the stability of an exchange.

Correcting for differences among risk pools

The Affordable Care Act establishes mechanisms intended to correct for the advantage that plans with healthier individuals have over plans that attract less healthy individuals. So-called "risk-adjustment" provisions allow states to correct for risk disparities among plans by imposing an assessment on plans and insurers with low-risk enrollees and transferring the funds to plans and insurers with higher risk groups.[11]

While the mechanism can help address adverse selection, risk adjustment is difficult to do with sufficient accuracy to ensure that insurers are compensated based on the actual populations they enroll.[12] Indeed, the Congressional Budget Office notes that existing risk-adjustment systems tend to over-predict the costs of those with low health care spending and under-predict the costs of those who end up with high spending.[13]

Last, a substantial share of the insurance market will not participate in risk-adjustment activities. The health status of individuals in large group, self-insured and grandfathered plans will not be taken into account.[14] Their exclusion will undermine the effectiveness of the mechanism designed to address the damaging effects of adverse selection.

Some Affordable Care Act rules increase the risk of adverse selection

Some provisions of the Affordable Care Act make the risk of adverse selection more likely.

Although some provisions of the Affordable Care Act reduce the threat of adverse selection, other elements make it more likely to arise. Below is an outline of Affordable Care Act provisions that heighten the risk of adverse selection.

Requiring standardized plans

To make it easier for consumers to accurately compare plans, the Affordable Act requires that plans, whether sold through an exchange or elsewhere, conform to one of four standardized tiers of coverage.[15] The tiers correspond to the average percent of costs borne by the insurer. Under a "bronze" level plan the insurer pays the lowest share of costs, 60 percent; a "silver" plan, 70 percent; a "gold" plan, 80 percent and a "platinum" plan, 90 percent.[16]

The new federal law requires an insurer participating in an exchange to offer at least gold- and silver-tier plans, but imposes no such minimum for outside plans.[17] Therefore, absent additional state regulation, insurers operating outside

the exchange will be able to offer plans in any tier. In fact, those insurers will be able to offer only the cheaper catastrophic plans — those with high deductibles and fewer benefits — or bronze-rated plans, both of which are likely to attract healthier individuals. This circumstance would leave the exchange vulnerable to adverse selection.[18]

Selling only high-quality plans

The Affordable Care Act requires plans to meet standards in addition to the federally-defined essential benefits in order to be certified as a "qualified plan" eligible to be sold in an exchange. These additional standards include having an adequate network of providers, monitoring the quality of health care provided, having grievance procedures and abstaining from many marketing and benefit-design strategies that allow for cherry-picking of healthy individuals.[19]

The additional standards for exchange plans, while important from a consumer perspective, are likely to make the plans more expensive than plans sold outside the exchange. This disparity predisposes a state exchange to adverse selection.

Administrative fees will disadvantage the exchange unless they also apply to plans sold in the outside market.

Imposing administrative costs only on exchange plans

The Affordable Care Act allows states to impose fees on exchange plans to cover the administrative costs of operating the exchange.[20] Such fees will disadvantage the exchange unless they also apply to plans sold in the outside market. Nothing in the federal law bars states from imposing fees also on plans outside the exchange.

The 2011 Oregon legislature created an exchange vulnerable to adverse selection

In the 2011 session, the Oregon legislature enacted legislation to fulfill the mandates of the previous legislature and the federal Affordable Care Act. Senate Bill 99 formed the Oregon Health Insurance Exchange, which will begin operating in 2014. Senate Bill 91 established new rules for the health insurance marketplace. Although some provisions of the legislation should mitigate adverse selection, others will enhance the risk. Oregon's exchange will remain vulnerable to the harmful dynamic.

On the positive side, SB 91 requires catastrophic plans to be sold exclusively within Oregon's new exchange starting in 2014.[21] Under federal law, starting in 2014, the plans will be available only to people under 30 years of age.[22] They will likely attract the healthiest Oregonians. The legislature's choice to restrict the sale of these plans to Oregon's exchange will prevent insurers from cherry-picking some of the healthiest individuals through catastrophic plans outside the exchange.

Also positive is SB 91's requirement that insurers operating in Oregon's non-exchange marketplace offer plans in the bronze- and silver-tier levels.[23] Since insurers within the exchange will also be required to offer a silver-tier plan, the requirement creates some parity between the two markets.

Still, the requirement for outside plans to offer bronze- and silver-level plans does not create structural equity between the two markets. Federal law requires

exchange plans, but not outside plans, to offer a gold-tier plan. These more comprehensive plans will tend to appeal to less healthy people. The exchange's relative attractiveness to the less healthy will predispose it to adverse selection.[24]

In addition, SB 99 disadvantages the Oregon health exchange by imposing administrative and broker fees only on exchange plans.[25] An early version of the legislation specifically allowed these expenses to be spread among all individual and small group plans sold in the state.[26] Unfortunately, the final bill retreated from the goal of protecting the exchange through establishing a level playing field with regard to these fees.

How policymakers can protect Oregon's health exchange from adverse selection

Under rules set out by the Affordable Care Act and the 2011 Oregon legislature, the newly-created Oregon Health Insurance Exchange remains vulnerable to adverse selection, a dynamic that could eventually lead to the exchange's collapse. There are, however, steps that the Oregon policymakers can take to reduce the risk of such an outcome, including:

Make authority and duty to bargain explicit

One of the most important steps Oregon can take is to strengthen the exchange's hand in bargaining for the best possible deals.

One of the most important steps that Oregon can take to guard against adverse selection is to strengthen the Oregon Health Insurance Exchange's hand in bargaining for the best possible deals on behalf of consumers. Offering highly competitive plans would help make the exchange attractive to healthy individuals.

Although nothing in the 2011 legislation creating the exchange precludes the exchange from undertaking an active purchaser role — *and the exchange should certainly take on that role* — an explicit legislative requirement that the exchange bargain on behalf of consumers would preempt any challenge to its authority and would facilitate a smooth launch of the exchange. (A companion OCPP paper, *The Active Purchaser Imperative: Unless Oregon's health insurance exchange bargains for low prices, it risks collapsing due to effects of adverse selection*, further discusses this issue.)

Level the playing field for plans inside and outside the exchange

Oregon policymakers can reduce the threat of adverse selection by creating parity between plans inside and outside the exchange. They ought to do so in several respects.

- Oregon should require that only plans offered inside the exchange be offered outside it.

  If this goal cannot be met, Oregon should, at a minimum:

  - Require insurers operating outside the exchange to offer the same tier plans (silver and gold) that insurers operating inside the exchange must offer. Further, Oregon would foster parity by requiring insurers, whether operating in the exchange or in the

outside market, to offer plans in all four tier levels — bronze, silver, gold and platinum.

- Require all plans sold outside the exchange to meet the additional standards for "qualified plans" required of exchange plans.

- Oregon should spread the cost of exchange administrative and broker fees among all individual and small group plans sold in the state.

Ensure that risk-pooling and risk-adjustment rules are effective and adequate

Oregon can take steps to ensure that the mechanisms established by the Affordable Care Act to guard against adverse selection — risk-pooling and risk-adjustment rules — work effectively. It can do this by requiring a monitoring system that ensures that carriers provide accurate information about the health status of enrollees and are pooling risk appropriately. Policymakers can also enact rules to prevent insurers from using subsidiaries to avoid risk-pooling requirements.

Last, Oregon can go beyond the federally-required risk-adjustment tools and employ additional risk-adjustment strategies that promise to effectively compensate for differences among insurance pools.

Conclusion

The newly-created Oregon Health Insurance Exchange, set to launch in 2014, is at risk of succumbing to adverse selection, a potentially fatal development for an insurance exchange. This danger exists despite provisions of the federal Affordable Care Act and Oregon's exchange legislation to protect the state's new marketplace from adverse selection. Indeed, some federal and state rules make the exchange more vulnerable to adverse selection by making health plans within the exchange relatively more expensive and potentially less appealing to the healthiest Oregonians.

To help Oregon's exchange achieve its promise of making health care more available and affordable for individuals and small businesses, Oregon policymakers must inoculate Oregon's exchange from the risk posed by adverse selection.

Endnotes:

[1] Senate Bill SB-99, 76th Legislative Assembly, 2011 Regular Session.

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

[3] Janet Bauer, *The Active Purchaser Imperative: Unless Oregon's health insurance exchange bargains for low prices, it risks collapsing due to effects of adverse selection*, Oregon Center for Public Policy, September 8, 2011.

[4] The Affordable Care Act defines essential benefits as services including "at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care." Affordable Care Act Section 1302(d).The law directs the Department of Health and Human Services to specify the benefits required. Catastrophic plans — which need not conform to the precious-metal tiers and have high deductibles — must also provide essential benefits, except that they can provide as few as three primary care visits in a plan year. Affordable Care Act Section 1302(e).

[5] Under the Affordable Care Act, insurers must treat all individual enrollees in their plans — both inside and outside an exchange — as a single risk pool, and all small-group enrollees as another risk pool. If the state elects to merge its individual and small group markets, an insurer must treat all its enrollees inside and outside an exchange as a single risk pool. Affordable Care Act Section 1312(c).

[6] Affordable Care Act Section 1301(a)(1)(c)(iii).

[7] Insurers will set their own rates and will comply with the "single risk pool" requirement using their own data. Their self-interest in this process may make compliance a challenge, necessitating strong state and federal oversight. See Sarah Lueck, *States Should Structure Insurance Exchanges to Minimize Adverse Selection*, Center on Budget and Policy Priorities, August 17, 2010, p. 9. Additionally, some analysts express concern that insurers may set up affiliates to offer plans exclusively in the outside market, thereby avoiding the single risk pool requirement. See Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, The Commonwealth Fund, July 2010, p. 8. See also Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, September 2010, p. 12.

[8] Affordable Care Act Section 1312(c) and 1301(b)(1)(B).

[9] Individuals with household income between 100 percent and 400 percent of the poverty level will be eligible for a premium assistance tax credit on a sliding scale. Affordable Care Act Section 1401(a).

[10] Starting in the 2010 tax year, small businesses of less than 25 full-time employees and average annual wages of not more than $50,000 are eligible for tax credit assistance on a sliding scale for purchase of health coverage for workers. In 2014, when exchanges are operating, small businesses will be eligible for the tax credits for coverage purchased through an exchange only. Affordable Care Act Section 1421.

[11] Affordable Care Act Section 1343.

[12] An effective risk-adjustment system must take into account health status information. Insurers have reported the health status of enrollees inaccurately, as being sicker than they actually are. See January Angeles and Edwin Park, *"Upcoding" Problem Exacerbates Overpayments to Medicare Advantage Plans: Administrative Action and House Health Reform Bill Seek to Address Problem*, Center on Budget and Policy Priorities, revised September 14, 2009. Additionally, states may have difficulty collecting the range of data to adjust for risk, and insurers may have difficulty in assessing the risk of short-term enrollees, who may be common in the individual market. See Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, p. 15.

[13] Congressional Budget Office, *Designing a Premium Support System for Medicare*, December 2006, p. 27, available at http://www.cbo.gov/ftpdocs/76xx/doc7697/12-08-Medicare.pdf.

[14] Affordable Care Act Section 1343.

[15] Catastrophic plans, permitted to be sold only to those under 30 years of age, are exempt from the requirement to conform to tier levels. Affordable Care Act, Section 1302(d).

[16] Affordable Care Act, Section 1302(d).

[17] Affordable Care Act Section 1301(a)(C)(ii).

[18] Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, p. 8.

[19] Affordable Care Act Section 1311(c)(1).

[20] Affordable Care Act Section 1311(d)(5)(A).

[21] SB 91 Section 4.

[22] Affordable Care Act Section 1303(e).

[23] SB 91 Section 3.

[24] Absent countervailing state legislation, gold-tier plans within the exchange are likely to be more affordable, and therefore more attractive, than such plans outside because insurers within the exchange will be required to pool risk among all individuals they serve (which will include people in exchange silver plans who will tend to be healthier), but insurers offering plans exclusively outside the exchange will not be similarly required to pool risk.

[25] SB 99 Section 17.

[26] Proposed amendments to SB 99: SB 99-1 Section 10(5), available at http://www.ocpp.org/media/uploads/pdf/2011/2011RegularSessionSB0099-1.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).