

MINNESOTA HEALTH INSURANCE EXCHANGE WORK GROUP REPORT

Adverse Selection

July 26, 2012

Work Group Focus

The Work Group will discuss issues related to adverse selection, options for addressing those issues, and describe advantages and disadvantages of various options. The Exchange Task Force will use this information to inform their recommendations to the Commissioner of Commerce.

Issues for Discussion

The Work Group has been tasked with providing the Advisory Task Force with information about the following issues:

The Adverse Selection Work Group will minimally address the following questions:

- What should the market rules be inside and outside the Exchange?
- What should the participation rules be for insurers and health benefit plans inside and outside the Exchange?
- What should the participation rules and options for consumers and employers/employees be inside the Exchange?
- Should the definition of small group be defined as 50 or 100 from 2014 to 2016?
- Should Minnesota use federal risk adjustment methodology or propose a state option?
- What options should Minnesota consider for reinsurance?
- Should the individual and small group market risk pools be merged?
- What options should Minnesota consider to encourage market competition and value?

In addition to these issues, the Task Force may refer additional issues to this Work Group for additional assistance and input.

Meeting Update

The Work Group met most recently on June 14 and discussed the following:

- Potential rules for individual and employer participation in the Exchange
- Update on Plan Certification subgroup discussion topics

Upcoming Meeting Topics

August and September 2012 (Three meetings are scheduled)

- Finish discussion topics related to individual and employer participation
- Discuss other options to promote market competition and value
- Review Plan Certification Subgroup recommendations for certification criteria

Recommendation on Movement Between Metal Levels of Coverage

- During a special enrollment period (with the exception of the last category [9] of special enrollment periods listed in the Exchange final rules – see text below), consumers can change metal levels without limitation.
- During open enrollment periods, consumers may move up one metal level of coverage if they choose from one open enrollment period to the next and can move down any number of levels from one open enrollment period to the next.

Rationale for Recommendations

- To the extent the Exchange does not put some limits on the degree to which consumers can shift the level of coverage they have during open enrollment periods, carriers will anticipate risk selection and incorporate that into setting of premiums.
- This will have the effect of making platinum products more expensive and, conversely, making bronze products less expensive than what they would otherwise be. This makes more comprehensive insurance less affordable to those who need it and less comprehensive coverage even more attractive from a pricing standpoint for those who would qualify for silver level coverage with cost sharing subsidies.
- This recommendation is intended to balance the needs of individual consumers with the needs of the marketplace to have meaningful choices about coverage levels at varying premium levels.
- The recommendation is different for special enrollment periods because the events that trigger special enrollment periods are generally not associated with changes in health status.

Recommendation on Risk Adjustment (previously presented, but not voted on)

Work Group members discussed the advantages and disadvantages of pursuing state-based risk adjustment given HHS final rules and new information about the federal risk adjustment methodology and have the following recommendation:

- Work Group members generally agree the potential benefits of pursuing state-based risk adjustment without authority to use the state's all-payer claims database will likely not outweigh the effort associated with developing that methodology. The disadvantage of not pursuing any state-based approach is that we lose the opportunity for risk adjustment to work

as well as it can given Minnesota's unique characteristics, especially in the first year or two of Exchange operation when adverse selection may begin to materialize.

Work Group members also highlighted two related potential issues for further discussion: 1) The potential for sharing data about risk distribution among carriers on a faster timeframe than what the federal risk adjustment process will produce; and 2) whether it might be possible to take a more systemic approach for required carrier data validation that will involve verifying diagnostic codes on medical records, with a goal of minimizing burden on providers and enhancing consistency of data validation processes.

Supplementary Information on Events that create Special Enrollment Periods

(Excerpted from the Exchange final rules, see <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>, § 155.420 Special enrollment periods, page 18463):

- (1) A qualified individual or dependent loses minimum essential coverage;
- (2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- (3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- (4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- (5) An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- (6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- (7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- (8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(9) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

(e) *Loss of minimum essential coverage.* Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801–6(a)(3)(i) through (iii). Loss of coverage does not include termination or loss due to—

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(2) Situations allowing for a rescission as specified in 45 CFR 147.128.

Update on Plan Certification Subgroup Activities

- The Plan Certification Subgroup has met four times to date and discussed minimum federal criteria across all QHP certification topics and more specific issues related to network adequacy, essential community providers, and service areas.
- The Plan Certification Subgroup’s next discussion topics will relate to potential use of the Tribal Addendum as a component of QHP certification, potential for streamlining offerings to consumers, and issues related to enrollment, recertification and decertification.
- Additional future discussion topics include establishment of a timeline for accreditation and strategies for addressing issues associated with churn between public and private coverage.
- Discussions on quality standards will occur after the Measurement and Reporting Work Group has developed recommendations on the Quality Rating System. Any potential future recommendations on quality standards should relate to measures chosen for inclusion in the Quality Rating System.
- The Plan Certification Subgroup will also discuss issues related to how dental coverage should be offered and displayed on the Exchange as well as certification criteria related to dental plans.
- The Plan Certification Subgroup recommendations will first be reviewed by the Adverse Selection Work Group and then presented to the Exchange Advisory Task Force at the Task Force’s September meeting.