

MINNESOTA HEALTH INSURANCE EXCHANGE WORK GROUP REPORT

Adverse Selection

August 29, 2012

Work Group Focus

The workgroup 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 Workgroup 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 twice recently (August 16 and August 21) and discussed the following:

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

Upcoming Meeting Topics

September 2012

- Finish discussion topics related to individual and employer participation
- Review Plan Certification Subgroup recommendations for certification criteria

Recommendations

1) 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.

Dissent

- While the majority of the workgroup supported this recommendation, there were two members who voted against it because of their concerns about putting limits on consumers' ability to obtain more comprehensive coverage and one member who abstained from voting.

2) Recommendations on payments toward deductibles and out of pocket cost limits for consumers transitioning between public and private coverage

- Amounts paid toward deductibles for a QHP prior to a transition to public coverage should be honored by a carrier if the enrollee transitions off of public coverage again and enrolls in a QHP

through the same carrier in the individual market in a single benefit year. There were 9 votes in favor and 2 against, with 0 abstentions.

- Amounts paid toward out-of-pocket cost limits for a QHP prior to a transition to public coverage should be honored by a carrier if the enrollee transitions off of public coverage again and obtains coverage through the same carrier in the individual market. There were 9 votes in favor and 2 votes against, with 0 abstentions.

Rationale for Recommendations:

- It is anticipated there will be a significant amount of transition between public and private coverage. These transitions will generally involve those who are eligible for advanced premium tax credits and is therefore almost entirely related to those accessing coverage through the Exchange.
- Workgroup members want to ensure that consumers are able to access both coverage and medical care and recognize that consumers moving between public and private coverage are likely to face financial difficulties.
- It only seems fair that a person who made payments toward a deductible and out-of-pocket cost limits to a carrier during an earlier part of the year should get credit for those payments rather than having to begin those payments again in a later part of the year.
- This recommendation is related only to consumers transitioning between public and private coverage and does not have any bearing on special enrollment periods. This recommendation also does not apply to situations in which a consumer may choose a different carrier after a transition from public coverage to a QHP.

Dissent:

- This is a significant departure from current market practice. When a consumer begins a new policy with a carrier today, it is a new contract between the carrier and the consumer.
- This would be a new requirement for carriers and will be administratively complex, particularly related to tracking of cost sharing for a previously covered consumer.

3) Recommendation on Participation Rules for Small Employers

Small employers should have to ensure a minimum percentage (75%) of their employees participate in a small employer plan in order to foster healthier risk mix in the covered small group population. This is the standard required in current state law and Work Group members agreed this standard should be maintained. Small employers should receive “credit” toward the 75% threshold for any employees covered by group coverage or a public program.

Rationale for Recommendation:

- A minimum threshold for participation is needed to ensure the group of employees covered by a small employer health plan has a more balanced risk mix. In absence of such a requirement, healthier employees are likely to seek less expensive coverage in the individual market.
- While a higher participation threshold was suggested, it was pointed out that very small employers (for example, with 5 or 6 employees) would have difficulty in meeting a higher threshold and it isn't practical to increase the threshold among small employers.

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

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.

Workgroup 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 seven times between May and August 2012 to consider proposed QHP certification standards.
- The Subgroup is currently reviewing a draft document outlining its recommendations.
- The Subgroup recommendations will be posted for public comment at the end of this week. Adverse Selection Workgroup and Advisory Task Force members will receive any comments received about the recommendations through the public comment process.
- Advisory Task Force members will discuss the recommendations at the September 27 Advisory Task Force meeting and will need to vote on recommended standards for 2014 QHP certification at that meeting.
- The Plan Certification Subgroup is now turning its attention to dental plan certification and related issues.