

## **Adverse Selection Work Group**

Advantages and Disadvantages Associated with Options for Five Key Issues  
Summary of November 30, 2011 and December 2, 2011 Meetings

### **Issue #1: Should the individual and small group market risk pools be merged?**

Advantages of merging markets:

- A larger risk pool could create more stable premiums by spreading risk of catastrophic and MCHA claims over larger population.
- May encourage new insurers to enter the market if they can merge the risk pools - could create more market competition. Keeping the markets separate may make it more difficult for new insurers with smaller risk pools to enter the market.
- Rating rules (age, geography, family composition, tobacco use) for the individual and small group markets will be the same starting in 2014.
- Dr. Gruber and Ms. Gorman stated that the risk of the two markets will be very similar starting in 2014 as the individual market grows and risk mix changes with addition of MCHA, uninsured, and some public program and small group enrollees – no significant premium impact of merging the markets.
- Defined contribution/employee choice for small group market – particularly employee choice of individual market products – could naturally merge markets over time. Proposed federal regulations state that markets must be merged to allow employees of small businesses using the Exchange to purchase individual market products.
- If markets are not merged, small groups may adversely select a market, given the defined contribution option.
- May be easier to implement risk adjustment with a merged market – particularly with defined contribution/employee choice for small group market.
- Could reduce administrative costs for insurers and Exchange over time.

Disadvantages of merging markets:

- There is already going to be disruption from changing market rules in 2014; merging markets could create additional uncertainty for premium rating.
- If you keep the markets separate, it may be easier to identify issues when market rules are changing and develop solutions to those issues – it may be hard to identify issues with too much change at one time.
- Once markets are merged, it would be difficult to separate them in the future if there are negative consequences – this decision can always be made in the future.
- If the markets are merged, it could eliminate risk-based advantages of small group coverage - would there be any advantage to being a group anymore?
- Might require insurers to offer small group and individual market coverage that do not want to do so – may discourage some insurers from offering coverage in the state.
- Depending on transitions for the individual market, small groups may experience premium increases, which may discourage participation by small groups.
- Merging the markets will have a negative impact on the individual market since the value of the federal reinsurance program for individual coverage would be diluted if it were spread across the combined individual and small group markets.
- There may be initial additional costs and administrative challenges to merging markets for insurers.

**Issue #2: Should the definition of small group be increased from a maximum of 50 to a maximum of 100 in 2014 before this change is required in 2016?**

Advantages of moving to size 100 in 2014 vs 2016:

- A larger risk pool could create more stable premiums by spreading risk of catastrophic and MCHA claims over larger population.
- The change is required in 2016, why not implement now so that all market rule transitions/disruptions occur at the same time – don't drag out the premium impact from market rule changes.
- Could help the 51-100 market get more stable premium rates.

Disadvantages of moving to size 100 in 2014 vs 2016:

- Would add an additional level of change and uncertainty to the market already experiencing change and disruption.
- The 51-100 market is partially experience rated, so healthier groups in 51-100 employer group sizes may see premium increases from modified community rating and opt to self-insure or drop coverage. If healthy groups leave the market, premiums will go up in the small group market. (If the 51-100 market is not included in the Exchange prior to 2016, mechanisms would need to be instituted to prevent small groups from self insuring to prevent adverse selection and unaffordable rates for those in the Exchange)
- Modeling work shows there would be no significant impact on either market's premium by merging the two markets - there may not be a clear advantage to doing so prior to 2016.

**Issue #3: Should Minnesota defer to a federal risk adjustment model or propose a state risk adjustment model?**

Advantages of state risk adjustment model:

- The federal model would collect claims data starting in 2014 and would need to rely on a retrospective method initially. Minnesota could immediately adopt a prospective risk adjustment model in 2014 (provided that Minnesota's all payer claims database is authorized for this purpose) that creates stronger incentives for care management than a retrospective model.
- A state-specific model would create a more accurate risk-based "level playing field" for insurers offering Exchange products because it could be tailored to Minnesota-specific issues.
- A state-specific model could incorporate the risk experience of Medicaid enrollees into a more accurate methodology as Medicaid enrollees may move between Medicaid coverage and subsidized individual market coverage.
- A state-based risk adjustment model could build on the federal methodology and be changed to address unique Minnesota-specific factors, such as geography.
- A state-based methodology would be more flexible to make changes/adapt to the market over time.
- A state-based risk adjustment model could help move money more quickly and proactively among insurers to more promptly address risk distribution issues.

- A state-based process for risk-adjustment could garner more confidence from insurers than a federal process, resulting in more stable premiums.

Disadvantages of state risk adjustment model:

- Cost of doing risk adjustment at a state level. Start-up cost can be federally funded, but not ongoing cost starting in 2015.
- Resources/effort needed to develop and operate state risk adjustment model.

**Issue #4: Should the market rules for health plan certification be consistent inside and outside the exchange?**

Advantages of consistent market rules:

- We have a history in Minnesota (MEIP) and other states that has shown that different market rules could lead to adverse selection and a premium death spiral either inside or outside the exchange.
- An unlevel playing field inside vs outside the exchange could lead to adverse selection by consumers and employers and gaming of the system by insurers, particularly in the small group market.
- Risk adjustment may be difficult inside and outside the exchange if the market rules are different in areas such as network adequacy.
- Different rules inside vs outside the exchange would be confusing to consumers and employers.

Disadvantages of consistent market rules:

- If certification rules are too stringent, rules could limit innovation, product development, and participation in the market.

**Issue #5: What should the participation rules for insurers and health benefit plans be inside and outside the exchange?** *We heard a variety of comments that could generally be categorized as advantages or disadvantages for whether insurers and health benefit plans should be the same or different inside and outside the exchange.*

Advantages of different insurers and health benefit plans inside vs outside exchange:

- Consumers using the Exchange (many of whom have not purchased insurance before) may become overwhelmed by too many choices, especially if the choices are not meaningfully different from each other.
- Limiting choices or having the exchange act as a purchaser could facilitate competition by insurers to offer more affordable and valuable choices to exchange consumers.
- Limiting choices could help ensure that Exchange participants (especially those receiving subsidies) have access to more comprehensive coverage and thus, reduce uncompensated care and cost-shifting.
- Could ensure that innovation and creativity are not limited in the market – particularly outside the exchange.
- Administrative costs for insurers may be different inside and outside the exchange and these differences could drive competition on efficiency.

Disadvantages of different insurers and health benefit plans inside vs outside exchange:

- Differences inside vs outside the exchange in terms of insurer participation and health benefit plan offerings could incent insurers to game the system and result in adverse selection, particularly for small groups and for healthier, younger, and higher income populations.
- Could encourage innovation and creativity outside vs inside exchange. Having the same insurers and same benefit plans inside and outside the exchange would ensure that consumers inside and outside the exchange both benefit from market innovation, creativity, and competition.
- Limiting plans inside the exchange could be viewed as discriminatory. Consumers are different – some want to see all the choices and others do not.
- Limiting choices to more comprehensive coverage could make coverage unaffordable for consumers and employers not receiving subsidies, particularly for small employers providing defined financial contributions for employees to purchase individual market coverage through the exchange.
- There are a variety of ways to incent competition other than limiting choice to higher value insurers and health benefit plans. A greater variety and number of choices could facilitate competition between insurers and various incentives could be considered to incent value by insurers and providers.
- May limit portability and potential for long-term care management relationships if insurers and health benefit plans are limited and vary from year to year.

*Note: For issues 1-5, comments from the work group will be added to existing materials sent to the work group for the presentation to the Exchange Task Force on December 7<sup>th</sup>.*

#### **Issue #6: What should the participation requirements be for consumers and small employers and employees?**

*Note: As discussed at the December 2<sup>nd</sup> meeting, this issue will not be brought to the Task Force at its December 7<sup>th</sup> meeting given the depth of this issue. The purpose of this part of the meeting summary is to capture the initial thoughts of Adverse Selection Workgroup members on this topic. We will come back and discuss this further at our next meeting in January.*

- Should employee participation rules apply for small employer participation in the exchange? (i.e. Should at least 75% of employees participate for an employer to participate in the exchange).
- How much movement should individuals be able to make when changing coverage between metal levels from year to year?
- Should individuals that drop coverage be required to wait a specific period of time to re-enroll or pay a late enrollment penalty?
- What are the options for people who seek coverage outside of the open enrollment period?
- What should the coverage options be for families. Should family members be able to pick different metal levels of coverage?
- What issues should be considered related to self-funding and adverse selection?
- What issues should be considered related to association plans and adverse selection?

#### **Background on Defined Contribution Discussed at the December 2<sup>nd</sup> Meeting:**

*Sources for this background information include the following: Final Report: Health Insurance Exchange Study (Mathematica Policy Research, 2008); Consideration of Early Creation and*

*Operation of a Health Benefit Exchange (Health Economics Program, 2010); and October 31, 2011 Comments on Proposed Rules Submitted to HHS from the Minnesota Departments of Commerce, Human Services, and Health.*

In 2014, an exchange must provide employers the ability to either choose to provide one plan to all employees or to provide employee choice of plans. Employee choice can occur in a number of ways. For example, employers can decide which plans to offer, allow choice of all plans in a metal level, and allow choice of all plans offered in all metal levels. An employer offering employee choice could provide a defined financial contribution by selecting a benchmark or standard plan and paying the same percentage of the premium for each employee at each age rate or establishing a contribution for each employee at each age rate that requires each employee to pay the same dollar amount for that benchmark plan. If the employee chooses a different plan that is more or less expensive, the employee pays the difference in the premium level.

Defined contribution arrangements in 2014 would allow for employee purchase of portable individual market plans with pretax dollars. Under various federal laws including HIPAA and ERISA, employers are currently limited in their ability to provide a defined contribution towards individual coverage in markets like Minnesota that do not currently have guarantee issue and modified community rating. The reason for this is that an employer's contribution towards coverage, regardless of whether it is a group or individual health plan, is considered a group health plan under these federal laws and group health plans are prohibited from restricting access to or varying premiums based on health status. The ACA provisions requiring individual guarantee issue and modified community rating for individual health plans allow employees of small employers to choose and utilize tax-preferred employer defined contributions to purchase individual market coverage. Under the ACA, individuals enrolled in a group health plan or eligible for an affordable group health plan are not eligible for the individual premium tax credits. So employees receiving a defined contribution for the purchase of individual market coverage would not be eligible for individual premium tax credits.

Defined contribution towards employee purchase of portable individual market plans would allow individuals and families to choose and keep the individual health plan they like if they change jobs, lose their job, or become self employed. If an individual loses their job or becomes self employed and thus does not have an employer contribution, they would potentially be eligible for a premium tax credit and could apply it to the cost of their existing health plan. It also encourages long term relationships with insurers and associated health care providers and that provides incentives for care coordination and health improvement. Premiums could also be aggregated from more than one small employer to help part-time workers afford coverage and simplify health care coverage for families with more than one worker by aggregating contributions from both employers towards the purchase of one family policy.