

Adverse Selection Meeting Summary June 14, 2012

I. Ms. Todd-Malmlov welcomed work group members and gave an overview of the agenda, which included continued discussion on potential rules for individual and employer participation in the Exchange; an update on plan certification subgroup activities; and a preview of future discussion topics for the Adverse Selection Work Group.

II. Ms. Burns reviewed the draft meeting summary from the May 10, 2012 Adverse Selection Work Group meeting to remind members of what the work group had previously discussed and the structured options work group members had suggested. Work group members had proposed to consider the appropriateness of limits or penalties on the amount of movement between metal levels of coverage from one open enrollment period to another as well as during different types of special enrollment periods (those that are more typical “qualifying events”, such as marriage or birth/adoption of a child) and those that are unique to the ACA, such as when a person loses minimum essential coverage.

Issue: Should limits be placed on the extent to which consumers can shift metal level coverage from one open enrollment period to the next or during special enrollment periods?

- Consumers will make different choices about the level of coverage they need based on their own understanding of their needs of medical services. Consumers have a rational interest in purchasing more comprehensive coverage when they know they need more medical care. These interests need to be balanced with the need for a well functioning insurance marketplace.
- Plan designs across the four metal levels will be different with respect to total amount of cost sharing (as opposed to differences only in how the cost sharing is structured). All metal levels will have limits on out-of-pocket costs.
- As a principle (and with the exception of special enrollment periods), consumers need to stay in the same metal level coverage and qualified health plan for a benefit year.¹
 - 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.
- What is the purpose of a limit on degree of movement between metal levels? Is it to incent people to buy more comprehensive coverage to begin with or to create a barrier to people having adequate insurance when they need it?
 - Bronze level insurance is still adequate in nature.

¹ It was also noted that American Indians have the ability to change QHPs as often as monthly if they choose.

- This is about balancing the needs of individual consumers with the needs of the marketplace to have meaningful choices about coverage levels at varying premium levels.
- Work Group members discussed what constitutes a special enrollment period. Those circumstances include the following (taken 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.
- The Work Group voted to support the following recommendation:
 - During a special enrollment period (with the exception of the last category [9] of special enrollment periods listed in the Exchange final rules), 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.

- 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 on the recommendation.
- Work Group members voted on a separate proposal to impose a financial penalty on consumers who wanted to move more than one metal level from one open enrollment period to the next. There was no support for this recommendation.
 - Those who supported imposing a limit on the amount of movement between metal tiers were concerned a penalty would likely be insufficient to prevent adverse selection, while those who did not support limiting movement between metal tiers were concerned the penalty would also limit consumers' ability to obtain more comprehensive coverage.
- Work group members then proceeded to discuss how much plans can change year over year and still meet guaranteed renewability provisions, especially related to changes in formularies and whether you can add new or substitute generic prescription drugs.

Issue: How should the Exchange address accumulation of deductibles, cost-sharing, and out of pocket maximums?

This issue is particularly relevant to consumers that churn in and out of public coverage over the course of a benefit year and could also be relevant to consumers who change carriers due to a special enrollment period during a coverage year. Should we consider options that would adjust the amount of cost sharing required when a consumer transitions out of a public program and into a commercial QHP part-way through a coverage year or moves between carriers and/or QHPs due to another type of special enrollment period mid-way through the year?

- This is complicated to sort through, in part because cost sharing across plans will be structured differently and some QHPs may not have deductibles.
- This is further complicated because the services for which consumers would be required to pay some level of cost sharing will also vary between plans.
- While there are strategies that can be considered to address cost-sharing obligations for consumers who make these types of transitions, there is no way to bring complete equity around cost sharing to consumers who move between public and private coverage or between commercial carriers during a benefit year (which is generally only allowable for certain defined circumstances as noted above).
- Options include:
 - Pro-rating deductibles
 - Apply amount paid in cost-sharing to the first carrier to a new plan with a second carrier
 - Other options proposed by Work Group members

Issue: Can consumers be incented to purchase more comprehensive coverage upfront?

- Work group members have discussed this issue previously at a high level and have different opinions about whether the Exchange should be attempting to incent consumers to purchase more comprehensive coverage. No further discussion will occur on this issue.

Issue: What options could be considered for an individual who enrolls in an individual product and whose coverage is terminated due to non-payment of premiums?

- Members had a preliminary discussion about this issue and Exchange staff will follow up to provide background information and to clarify some questions related to this issue.
 - If a consumer has not paid premiums for some period in the last 12 months, can the Exchange require the consumer to pay premiums in advance?
 - Does loss of essential coverage due to non-payment of premium trigger a special enrollment event? (Answer: no, it does not. This is specifically prohibited in the special enrollment provisions of the Exchange final rules – see excerpted text above.)
 - Is it possible to institute some type of waiting period for those who didn't pay premiums in the prior year? (Answer: this is likely not an option, but Exchange staff will confirm.)

III. Plan Certification Subgroup Update

- The Plan Certification Subgroup held its first meeting on May 30 and reviewed federal Exchange requirements for insurers and qualified health plans. The subgroup is charged with developing an understanding about what the first year of requirements for QHPs will be based on existing provisions in state laws and considering potential additional certification criteria for implementation in 2015 and beyond.

IV. Adverse Selection Workgroup Future Discussion Topics

- The Adverse Selection Workgroup has three key topics to undertake before the September Task Force meeting:
 - 1) finish up options for individual and employer participation
 - 2) discuss broader strategies for incenting value and competition
 - 3) review recommendations for certification criteria from the Plan Certification Subgroup
- Exchange staff will work with members to set and confirm future meeting dates. It is possible we will need to have two or three longer meetings over the next few months to complete work on key discussion topics.

V. The meeting was adjourned.