Washington State Health Benefit Exchange Project

First Draft for Comments and Discussion

Issue Brief #7: Managing Health Insurance Expenditure Risks for Washington's Exchange
November 24, 2010

Summary

The success of Washington's Health Benefit Exchange ("Exchange") will depend in part on its ability to provide Washingtonians with health insurance that is equitably-priced among population groups. Equitable health insurance, in turn, depends on the proper management of health care expenditure risk. Without effective risk management, insurers need to focus some of their efforts on attracting less risky members and setting prices based on relative member risk, rather than on service quality and efficiency.[1] Without effective risk management, an Exchange is unlikely to survive. (*see sidebar*)

With risk management in mind, the ACA[2] included provisions to help the Exchange manage expenditure risks and provide an equitable market for health insurers. Among these are two tools over which Washington and its Exchange can exercise discretion in their use:

- **Merging markets**. The ability to merge risk pools of the Individual and Small Group health insurance markets.
- **Risk leveling methods**. Risk leveling methods provided through the ACA (reinsurance, risk corridors, and risk adjustment) will likely help even out the risk playing field for insurers participating in the Exchange.

Employers began backing away

Cappy McGarr the founding chairman of the Texas state-run exchange *Insurance Purchasing Alliance,* wrote about its failure:

"Initially, the alliance worked exactly as planned. Sixty-three percent of the businesses that participated were able to offer their employees health coverage for the first time. … And we didn't charge higher rates to firms with older or less healthy workers. …

Nevertheless, six years after the program got off the ground, it folded. Many factors contributed to our failure. … Most important, though, our exchange failed because it never attained a large enough market share to exert significant clout in the Texas insurance market. Private insurance companies, which could offer small-business policies both inside and outside the exchange, cherry-picked relentlessly, signing up all the small businesses with generally healthy employees and offloading the bad risks – companies with older or sicker employees – onto the exchange. … as a result, our exchange was overwhelmed with people who had high health care costs, and too few healthy people to share the risk. The premiums we offered rose significantly. Insurance on the exchange was no longer a bargain, and employers began backing away.

Texas … Florida … North Carolina … and California. All these state exchanges failed for the same reason."

The New York Times; October 6, 2009

[1] Hall, M et al., "HealthMarts, HIPCs, MEWAs, and AHPs: A guide for the perplexed", *Health Affairs* 20, no. 1 (2001): 142-53.
[2] Patient Protection and Affordable Care Act, enacted March 23, 2010.

This issue brief addresses the use of these two tools.

Summary **continued**

Merging markets is a complex technical topic that requires careful consideration of:

- **Goals**. The goals that Washington and its Exchange want to achieve by merging markets.
- **Impact on enrollment and premiums**. The impact of such a merger on enrollment and relative premium levels for (a) individual and small group plans in the Exchange, (b) Individual and Small Group plans outside the exchange, (c) Association plans, and (d) a federal Basic Health program if the State adopts one.
- **Insurer acceptance**. How a merged market would affect willingness of insurers to participate in the Exchange and, generally, in the Washington health insurance market.
- **Small employer definition**. How the choice of defining a "small employer" to be 1-50 employees or 1-100 employees might be affected by such a merger, and conversely.
- **Small employer impact**. The reaction of small employers to a merged market, and how it would affect their decisions to self-insure, move to "defined-contribution" coverage (whereby an employer would simply give each employee a certain sum to help with purchasing health insurance), or drop health insurance coverage altogether.
- **Practicality**. The relative difficulty of a market merger.
- **Grandfathered plans**. The impact on grandfathered plans.
- **Timing**. The timing of a market merger (either before or after Exchange implementation).

Key considerations related to the risk leveling methods are:

- **Effectiveness**. How the Exchange can implement them so that they are effective, fair, and robust to market changes.
- **Integration**. How to integrate the methods, so that they work together toward established goals.
- **Practicality**. Whether they can be implemented cost-effectively and with minimal disruption.

A third powerful tool always at the State's disposal for risk management is an ability to regulate the health insurance market inside and outside the Exchange. A key related consideration is how association plans will respond to the opportunity of an Exchange in 2014. Their response might depend on how many low-income members now enroll through the association, whether the plan has "grandfather" status and how long the association anticipates the plan will retain that status.

Background

PPACA has many provisions to help the Exchange manage expenditure risks and provide equitable health insurance. Among these are requirements for insurers to guarantee the issue and renewability of coverage to everyone (regardless of health status), follow community rating rules that are independent of health status, provide the same plans with the same premiums inside and outside of the Exchange, and avoid marketing practices that are biased toward healthier consumers.

In particular, PPACA provides two tools to manage health care expenditure risk, tools over which Washington and the Exchange can exercise discretion in their use: an ability to merge the risk pools of the Individual and Small Group health insurance markets, and risk leveling methods.

Expenditure risk

Although the concept of expenditure risk often causes confusion, it is simple:

A person's expenditure risk is simply the likelihood that the person will have high health care expenditures. If a person is sicker than average, or is likely to be sicker than average (eg, because of advanced age), he or she has a higher expenditure risk than average. Similarly, a group of people that is sicker than average, or is likely to be sicker than average, has a higher expenditure risk than average.

Without effective risk management, insurers prefer individuals and groups with low expenditure risk, because they are likely to be less expensive.

A. Merging markets

PPACA provides that a State can, at any time, elect to merge its Individual and Small Group insurance markets. [3] Currently the Washington Individual and Small Group markets are separate community-rated pools: An insurer determines the amount of its Individual plan premiums based solely on members covered under Individual insurance plans, and similarly, Small Group premiums are determined based solely on members covered under Small Group plans. Under a merged market, premium amounts for Individual and Small Group coverage would be based upon a combined Individual and Small Group risk pool.

By creating a larger population over which health care expenditure risks are spread, merging the markets would have several potentially salutary effects. It could reduce premium volatility, reduce insurer earnings volatility, reduce administrative costs, and reduce the incentive for insurers to guard against adverse selection by segregating risk.

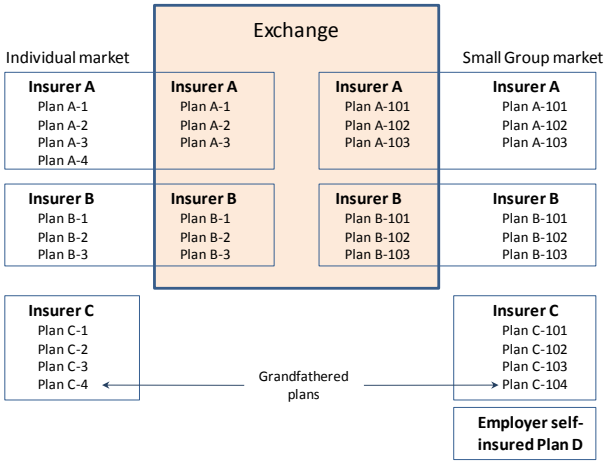
[3] PPACA § 1312(c)(3)

Background continued

A. Merging markets continued

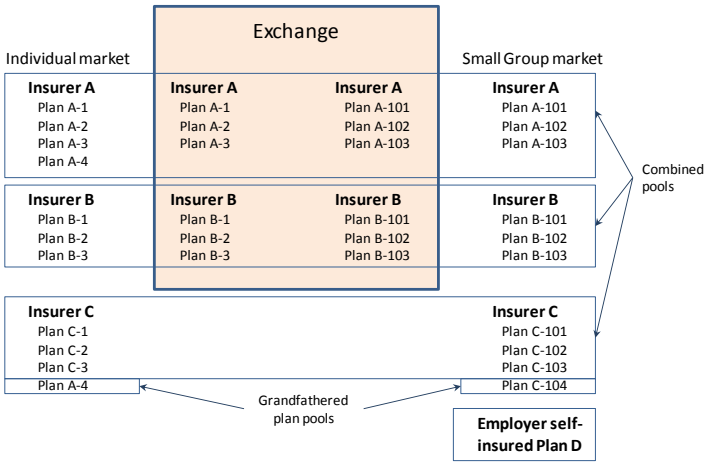
The charts below illustrate how markets could be merged.

Before merger of Individual and Small Group markets



Before merger of the Individual and Small Group markets (the current situation in Washington), each insurer pools its Individual market separately from its Small Group market. For example, as you see in the top chart, Insurer A combines all its Individual market plans into one risk pool (indicated by the blue box) and similarly for its Small Group plans.

After merger of Individual and Small Group markets



After merger of the markets, each insurer pools its Individual and Small Group plans together into one larger pool – with one exception: Grandfathered plans can be exempt from the merger. And, of course, self-insured plans are also exempt.

In 2006, for its "Health Connector" exchange, Massachusetts merged the Individual and Small Group markets. Other states – including New York, Vermont, and Rhode Island – are seriously considering such a merger. However, each State's situation is unique.

Background continued

B. Risk leveling methods

PPACA provides three methods to help even out the health care expenditure risk playing field, two of which are temporary: [4]

- *Reinsurance:* For plan years commencing in the 3-year period starting January 1, 2014, PPACA provides for each State to set up a reinsurance program to reimburse insurers for their excess costs due to covering high-risk people in the Individual market. [5] All State fully-insured and self-funded plans will contribute to the program's costs. Further, to carry out the new program, each State can eliminate or modify any existing State high-risk pool, such as the *Washington State Health Insurance Pool*.
- *Risk corridors:* For calendar years 2014-2016, PPACA provides that, for qualified health plans offered in the Individual and Small Group markets, if a plan's "allowable costs" exceed 103 percent of its premium income (less administrative expenses), then the program pays an amount to the plan to partially offset its losses. Conversely, if a plan's "allowable costs" are less than 97 percent of its premium income (again less administrative expenses), the insurer must pay a portion of its profit to the program. The risk corridors program will be administered by the Department of Health and Human Services. The program is funded by an assessment on the same qualified health plans that participate in the program. [6]
- *Risk adjustment:* For plans in the Individual and Small Group markets, if the expenditure risk of an insurer's members for a year is less than the average expenditure risk of all members in all Washington Individual and Small Group plans (other than grandfathered plans) for that year, the State will assess each such insurer with a charge to recognize its disproportionate share of low-risk members. Conversely, if the expenditure risk is greater than average, the State will pay each such insurer an amount to partially offset its disproportionate share of high risk members. The risk adjustment program is funded by an assessment on all individual and small group plans. [7]

The two temporary methods are included in the law because in the first few years of the Exchange, insurers may experience significant irregularities in the allocation of expenditure risk. For example, until 2017 when the individual mandate fully phases in, higher-risk people may be overrepresented in the Exchange.

[4] PPACA provides two other risk-leveling programs that expire on January 1, 2014: a national high-risk pool, and a national reinsurance program for early retirees.
[5] PPACA § 1341, as modified by § 10104
[6] PPACA § 1342
[7] PPACA § 1343

Background **continued**

B. Risk leveling methods *continued*

There is ample evidence that risk leveling methods work. For years, the Centers for Medicare and Medicaid Services (CMS) has successfully employed a risk adjustment method for Medicare Advantage plans and for prescription drug plans. In addition, the Massachusetts Health Connector reallocates premiums among Commonwealth Care insurers using a risk-leveling method.

C. Regulation

In Washington, State regulation beyond the aegis of PPACA may be required as an additional risk management tool to address perceived inequities in the structure of the state's health insurance markets. For example, State regulation may be required to prevent interactions between Small Group and association markets that could lead to adverse effects for either market. However, assessing such adverse effects requires careful modeling and study.

Key Considerations

In determining how to manage health insurance expenditure risks for Washington's Exchange, following are key considerations:

A. Merging markets

Following are considerations related to merging the markets:

- **Goals**. Before deliberating whether to merge or not merge markets, Washington and its Exchange should firmly establish the goals to be achieved by merging markets. Such goals might include: reducing premium volatility, reducing the incentive for small employers to change from Small Group coverage to Individual Coverage, or vice versa, reducing insurer administrative expenses, etc.
- **Impact on enrollment and premiums**. Merging the markets will impact enrollment and relative premium levels for (a) plans in the Exchange, (b) Individual and Small Group plans outside the exchange, (c) Association plans, and (d) a federal Basic Health program if the State adopts one. Before making a decision to merge markets, Washington and the Exchange may want to study these effects.
- **Insurer acceptance**. National insurers may view a merged market as an added burden and, as a consequence, may be less willing to participate in the Exchange or even in the Washington health insurance market outside the Exchange.

Key Considerations continued

- **Small employer definition**. For the first three years of Exchange operation, Washington has the option to continue defining "small employer" (ie, those employers that can participate in the Exchange) as employers with 1-50 employees. Alternatively, as of January 1, 2014, it can change the definition to employers with 1-100 employees. Because larger small employers might be affected differently by a merged market (their employees may have different risk characteristics, and they may be more inclined to self-insure), Washington and its Exchange should consider studying how the definitional choice interacts with merging the markets.
- **Small employer impact**. Small employers might view a merged market as disadvantageous, and so be more inclined to self-insure, move to "defined contribution" coverage, drop health insurance coverage.
- **Practicality**. In Washington State, the Individual and Small Group markets have similar regulatory rules. They are similarly community rated, and have similar rules for provisions such as guaranteed issue and renewability.[8] Thus, one potential obstacle to merging markets is absent. However, there may be other significant practical obstacles, such as the costs involved in revising State and insurer administrative systems. Such potential obstacles need to be carefully considered.
- **Grandfathered plans**. Employers and individuals who do not change their current insurance coverage (so-called "grandfathered plans") are exempt from many provisions of PPACA, including the provision to merge markets. However, as the number of grandfathered plans dwindles over time, their separate risk pools will shrink and could become unsustainable. Therefore, if Washington and its Exchange decide to merge markets, the state could review the legal constraints of requiring grandfathered plans to participate in the merger.
- **Timing**. The markets can be merged at any time. They do not have to be merged as of January 1, 2014 when the Exchange starts. Thus, the decision to merge markets can be delayed until the dynamics of Washington's health insurance markets with an Exchange can be studied.

B. Risk leveling methods

- **Effectiveness**. For the risk leveling methods to work, they have to be perceived as – and in fact be – fair. To accomplish this, they must be presented transparently and applied equitably to all insurers. (Even so, fairness may be elusive. Most risk adjustment models overpredict expenditure risk for healthier people and underpredict for sicker people.) In addition, so that the methods remain effective, their impact needs to be continually monitored as market conditions change, and recalibrated accordingly.
- **Integration**. During 2014-2016, three risk-leveling methods will be available. Care should be taken to integrate the methods, so that they work in concert toward established goals.

[8] Between the markets there is one significant difference: For the Individual market, there is a high-risk pool, the "Washington State Health Insurance Pool". The Small Group market does not have such a pool.

Key Considerations **continued**

B. Risk leveling methods *continued*

- **Practicality**. To implement the methods cost-effectively and with minimal disruption, many practical issues must be addressed, such as dealing with uneven data quality, high member turnover, and the dramatic change in diagnosis codes that will occur in 2013 (from ICD-9 to ICD-10).

Another related consideration is what to do with the existing high risk pool, the Washington State Health Insurance Pool (WSHIP). PPACA requires the State to eliminate or modify WSHIP to the extent necessary to carry out the risk-leveling methods. Accordingly, Washington may decide to discontinue WSHIP. These considerations are complicated by the fact that regulations and guidance governing the methods will not be available until mid or late 2011.

C. Regulation

To further manage expenditure risk, the State might need to consider whether to establish additional regulatory actions in 2014 as it develops an exchange:

- Require participating insurers to offer qualified health plans in all levels of an exchange.
- Require insurers to offer the same plans inside and outside of the exchange.
- Interpret individuals and small employer members of an association as enrollees in the individual or small group risk pool, or alternatively, as enrollees of a merged individual-small group risk pool.
- Merge association plan risk pools with the Small Group risk pool.
- Require insurers that participate in the Exchange to sell only qualified plans. That is, they cannot sell non-qualified plans outside of the Exchange.
- Require insurers not participating in the Exchange to comply with requirements for plans participating in the Exchange.
- Prohibit insurers participating in the Exchange from establishing separate companies to sell plans only outside the Exchange
- Prohibit producers from collecting higher commissions for plans outside the Exchange.

Of course, the potential impact of any regulatory change must be carefully studied.

Key Considerations **continued**

D. General

Even with judicious use of the tools described in this brief, biased selection and bumps in the playing field will be possible. To help ensure a fair and robust health insurance market, Washington and its Exchange should consider establishing a program, incorporating carefully-developed metrics, to continually monitor the allocation of health insurance risks within the State, and patterns of enrollment and disenrollment. Of course, such monitoring will require data from insurers, and entail additional administrative expense.

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