

ACA Implementation—Monitoring and Tracking

Stabilizing Premiums Under the Affordable Care Act: State Efforts to Reduce Adverse Selection

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Introduction

The Patient Protection and Affordable Care Act (ACA) makes an array of changes to private health insurance market rules that will lead to greater sharing of health care costs between those who have high health care needs and those who are healthier at a particular point in time. It also sets up entirely new marketplaces—exchanges—through which individuals and small businesses can purchase private health insurance, while largely retaining a marketplace for individual and small group coverage outside the exchanges. As a consequence of this significantly reformed market, insurers, regulators, and policymakers have raised concerns about short-term “rate shock”—an increase in health insurance premiums as a result of enhanced consumer protections and the more equal sharing of risk compared with today’s market. There are also concerns about longer-term instability due to adverse selection, or the phenomenon by which particular insurance plans or insurance markets attract an enrollment with higher than average health care risks.

The ACA includes a number of strategies intended to protect against and mitigate the effects of both “rate shock” and adverse selection. For example, the federal law requires that all citizens and legal residents purchase health insurance in 2014 or pay a fine, provides for significant premium tax credits to make coverage more affordable to individuals regardless of their health risk, makes available catastrophic health insurance plans for young adults or those otherwise unable to afford coverage, requires individual and small-group plans to meet certain standards whether or not they are offered through an exchange, generally requires insurers to treat all their enrollees as part of a single risk pool inside or outside the exchange, and establishes

risk adjustment and reinsurance programs to reduce the incentives to health plans to deliberately select or attract lower-risk enrollees and/or deter higher-risk enrollees. These strategies will help reduce adverse selection but they are unlikely to eliminate it. In addition to strategies set forth in the federal law, states have the flexibility to implement additional approaches aimed at further decreasing the likelihood and impact of rate shock and adverse selection on consumers and health plans.

This paper explores several strategies states could implement beyond federal requirements, using policy decisions in 11 states—Alabama, Colorado, Illinois, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia—to illustrate the array of choices being made. While rate shock and adverse selection are potential concerns in both the small group and individual insurance markets, we focus exclusively on strategies in the individual market, the market most susceptible to adverse selection. We explore mechanisms intended to reduce adverse selection against the individual market in the early transition years of the reforms—those intended to address the rate shock concerns, as well as those designed to ensure stability in the individual market and the individual exchanges in the long-term. These strategies and the states adopting them are summarized in table 1.

Our findings indicate that study states had mixed approaches to mitigating rate shock and adverse selection, with some taking steps beyond the required federal measures but with other policy options left unexplored. Minimizing the impact of adverse selection—both against the overall insurance market and the exchanges—will require strong monitoring and oversight.

Background

Adverse selection can occur for a variety of reasons, including plans having characteristics that tend to attract enrollees with higher needs (e.g., broader choice of providers, effective chronic care management programs), insurance market rules making particular markets more accessible to high-cost people, or insurers and their representatives exhibiting different types of marketing and enrollment behavior. Depending on the ways in which

rates are set in affected markets, adverse selection can lead to higher premiums for plans selected against and, in the extreme case, can destabilize plans or markets to the point of unsustainability. As a result, insurers have strong incentives to avoid adverse selection and considerable attention has been paid to developing public policies that can mitigate the likelihood that it will occur under health insurance reform.

Table 1. Short-Term and Long-Term Adverse Selection Mitigation Strategies

Adverse Selection Mitigation Strategy	Explanation of Strategy	States that Adopted the Strategy
Strategies to Reduce Short-Term “Rate Shock”		
Supplemental or Alternative Reinsurance Program	States have the option of using state funds to increase premium protection provided by reinsurance or to create their own alternative reinsurance program	Maryland Oregon
Supplemental Risk Corridor	Program that redistributes funds from exchange-based plans with lower than expected costs to those with higher than expected costs. States can supplement this program	None
Alternative Risk Adjustment Strategies	States are allowed to submit their own risk adjustment mechanism	None for 2014
Geographic Rating Areas	States have flexibility to determine rating areas to align with available cost and utilization patterns and reduce premium spikes for certain geographic areas, or states can default to federally determined areas	State Determination: Minnesota New York Oregon Rhode Island Federal Default: Alabama New Mexico Virginia
High-Risk Pool Transition	Created to provide coverage for people with pre-existing conditions, but are now no longer needed due to market reforms. States can implement policies to transition the sick people out of the HRP to minimize market disruption	Closed to New Enrollment: Colorado Minnesota Oregon Shutdown Date Unclear: Alabama Illinois New Mexico Later Shutdown Date: Maryland
Early Renewal Regulation	Prevent or constrain insurers from renewing plans early, delaying compliance with ACA market rules	New York Illinois Oregon Rhode Island
Age Rating	States have flexibility to establish their own age curves, which determine the distribution of rates across age bands	Minnesota
Strategies to Stabilize Individual Market and the Individual Market Exchange		
Insurer Lockout Periods	Precluding insurers who choose not to participate in the first year of the exchanges from participating in the second or third year of the exchange	Maryland New Mexico New York Oregon
Limits on Sale of Catastrophic Products	Restricting the sale of catastrophic plans to limit selection effects and attract catastrophic plan enrollees to exchange plans	Maryland New York Oregon Rhode Island

Adverse Selection Mitigation Strategy	Explanation of Strategy	States that Adopted the Strategy
Regulation of Non-Traditional Products	Some non-traditional insurance entities or products may be exempted from market reforms in the ACA. States have the ability to regulate these products as part of the small or individual group and ensure there is a level playing field	New York Oregon Rhode Island
Broker Compensation	Standardizing broker compensation inside and outside of the exchange markets to prevent brokers from steering customers away from one market and towards the other	Colorado Maryland New York Oregon
Network Adequacy	Narrow network plans have low up-front costs and fewer providers, which can attract healthy individuals who have fewer provider needs. States can set similar network adequacy standards inside and outside of the exchange.	Colorado Michigan Illinois Minnesota New Mexico New York Rhode Island
Service Area Alignment	Regulating insurers' service areas to ensure they are not cherry-picking healthier service areas	Colorado Maryland Michigan Oregon Rhode Island
Plan Standardization	Mitigating the potential for variations in plan benefit design within coverage levels, as well as plans outside and inside the exchange, reducing opportunity for benefit designs that may disproportionately attract healthy individuals	Maryland Michigan New York Oregon
Requirements to Offer at Specified Metal Levels	Preventing insurers from avoiding higher risk individuals by requiring them to offer plans at a range of coverage levels	Maryland New York Oregon

Before the ACA, insurance companies selling coverage in individual markets attempted to avoid the enrollment of higher-risk individuals using an array of strategies, most prominently medical underwriting, or using an individual's prior medical use and health status to determine premiums or access to coverage. Individuals could be charged higher premiums based on their determined risk as defined by factors such as their health status, prior use of medical services, gender, age, industry of employment, and participation in hazardous behaviors such as smoking. In almost all states' individual markets, carriers could also deny coverage outright based on such an assessment, and, in many states, insurers could also use underwriting information to offer plans that exclude benefits for particular conditions or body systems. Combined, these approaches allowed insurers significant leverage in avoiding high-cost individuals or at least avoiding significant shares of costs associated with their care.

The process of underwriting and the strategies that relied on it assuaged insurance company fears that a consumer who signed up for one of their plans was doing so because of personal knowledge of future medical needs without being charged a premium commensurate with the estimated costs of their anticipated care. However, these practices led to many consumers in less than perfect health being unable to access health insurance, either because they were denied coverage outright or they were offered coverage that was unaffordable or of limited value to them. The ACA eliminates underwriting in the individual market beginning in 2014, requires plans to cover essential health benefits and comply with actuarial value standards, and mandates guaranteed issue of all products in those markets. Additionally, modified community rating will be implemented in these markets at the same time, meaning that premiums for identical coverage can vary across enrollees only by age (with the oldest adult not being charged more than three times as much as the youngest

adult), tobacco use (with tobacco users not being charged more than one and a half times non-tobacco users), and geographic rating area; rating based on health status or prior use of medical services and other factors will no longer be permitted.

These reforms, along with the requirement that most individuals obtain health insurance coverage or pay a penalty, will significantly broaden the sharing of risk in individual insurance markets, making coverage significantly more accessible to those with health problems. Without the ability to pre-determine the risk of plan applicants and charge them accordingly or exclude them entirely, two central concerns arise: rate shock and long-term market instability due to adverse selection.

First, requiring insurers to enroll all applicants and restricting premium differences across individuals with different characteristics may increase the average cost of enrollees relative to the prior system, leading to significant increases in premiums for those previously enrolled, particularly those used to advantageous rates, such as healthy young adults. This rate shock fear is largely a transitional concern, particularly because many anticipate that those with the greatest health care needs will be those quickest to newly enroll in coverage once the reforms are in place. In the long run, the population expected to enroll in the new exchanges will have characteristics similar to those in the larger population covered by employer-sponsored insurance, and federal premium and cost-sharing subsidies, along with the availability of catastrophic plans, will ameliorate the financial jolt of the new modified community rating rules for the vast majority of young adults.¹ For higher-risk individuals, such as older adults or those with a health problem, the reforms could significantly lower their rates, particularly when factoring in premium tax credits. Even so, the implications of the changes for first-year decisions by healthy adults currently enrolled in the nation's individual insurance plans remain a concern, particularly since the new plans will tend to provide significantly expanded benefits compared with many current plans, creating further adjustment concerns between this year and next year while current enrollees absorb the differences in value of the products.²

The second concern is that the individual market, in general, and the individual exchange, in particular, may continue to attract a disproportionate share of unhealthy enrollees in the long-run due to broader based sharing of risk. There are a number of ways that a state's health insurance exchange may be selected against and cause long-term problems. One way is if benefit designs or cost-sharing structures differ between exchange and non-exchange plans. While there are federal standards that exchange and non-exchange

plans must both meet, federal law does not require that insurers offer the same plans inside and outside the exchanges, and even somewhat subtle disparities could work to attract healthier individuals to the insurance plans offered outside the exchange.³

Another difference that could have similar effects relates to provider networks. If network adequacy requirements are more robust inside the exchanges than they are outside them, it is possible that older or sicker consumers will specifically seek plans with the broader provider options in the exchanges. Thus, older or sicker individuals may be more likely to seek coverage in the exchanges, while younger, healthier individuals who are less concerned about specific providers may be attracted to plans off the exchanges. While federal law requires exchange plans to meet network adequacy standards, these same standards are not required of plans sold outside the exchanges unless states choose to impose such requirements. Another concern is whether strategies used by insurers and their agents or brokers could encourage healthier consumers to purchase coverage outside of the exchanges while those with health problems are encouraged to buy inside them, thus driving up exchange premiums relative to non-exchange premiums. While the majority of expected exchange enrollees would be protected from the effects of such selection against the exchange due to the federal premium subsidies, not all consumers will be eligible for them, and selection of this type could have significant implications for federal costs.

The ACA includes a number of strategies intended to mitigate adverse selection. Significant strategies include offering premium and cost-sharing subsidies exclusively in the exchange market (thereby drawing a population with varied health care risks into exchange plans), limiting open enrollment periods so that individuals cannot enroll in coverage at the moment they need medical care, requiring all individual plans to cover a set of 10 categories of essential health benefits (including prescription drugs and mental health care), and an individual requirement to obtain coverage. In addition, the law explicitly provides for two temporary strategies—reinsurance and risk corridors—and one permanent strategy, risk adjustment, to address the adverse selection concerns. Together, they are commonly referred to as the “3 Rs.” The first two are intended to ease the effects of rate shock in the first three years of implementation of the largest reforms, and the latter is intended to increase market stability in the long-term.

Some, however, remain nervous about the extent to which the combined strategies can effectively abate the ramifications of adverse selection. Consequently,

a number of states have taken it upon themselves to implement additional policies to further address these concerns. In this paper, we describe the approaches taken in 11 study states. We collected information from state government contacts in each state, asking about the states' plans to implement any of an array of strategies delineated in a National Association of Insurance Commissioners (NAIC) white paper;⁴ however, some proposed strategies have not been implemented in the 11 study states. We also asked states to provide us with information on any other strategies that they may be implementing in efforts to reduce adverse selection but that were not explicitly included in the white paper. We provide a brief explanation of the rationale for

each possible strategy and describe related efforts in applicable states in our group of 11.

We recognize that an essential strategy to mitigate adverse selection in individual markets is an aggressive and broad-based outreach and education campaign about the exchanges, subsidies, and market reforms coming into play in 2014. This, combined with a simple, highly-accessible enrollment system, can go a long way toward attracting a large population across both healthy and less healthy populations. State efforts at developing and implementing outreach and enrollment strategies are not discussed in this paper, however, as they are described at length in a separate analysis.⁵

Policy Options Designed to Reduce Short-Term Rate Shock in the Individual Market

Supplemental or Alternative Reinsurance Program

The ACA provides for a temporary reinsurance program to operate from 2014 through 2016 in all states. The program will impose assessments on insured and self-insured group health plans, distributing the funds to non-grandfathered individual health insurance plans that insure high-risk people. The objective is to stabilize costs in the individual insurance market in the transition period following implementation of insurance market reforms that will significantly improve access to insurance for people with significant health expenses. The federal approach sets an attachment point at \$60,000, the level of individual incurred medical expenses above which reinsurance funds will be made available, a coinsurance rate (80%), the share of medical expenses for which the insurer will be reimbursed above the attachment point, and a cap (\$250,000), above which no reinsurance payments will be made. The federal assessment on group plans is \$5.25 per enrollee per month in 2014. In aggregate, \$10 billion will be collected in 2014 from insurers and third party administrators running self-insured plans to fund the program; the program funds will fall to \$6 billion in 2015 and \$4 billion in 2016.

States have the option of supplementing this reinsurance program with state funds to increase the premium protection provided by the reinsurance for individual plans. Instead, they could create an alternate reinsurance program. The supplementary approach can be done by increasing the cap, lowering the co-insurance rate, or lowering the attachment

point. An alternative approach would replace the federal option. In any case, the reinsurance program is intended to be revenue neutral, with collections equaling payouts.

Only two of our study states have taken any action related to participation in their reinsurance program: Maryland and Oregon. Maryland has provided legal authority for their Health Benefit Exchange to adopt new reinsurance benefit parameters beyond those federally defined; however, they will not do so for 2014. Any specific potential policy approaches in this realm for 2015 and beyond have yet to be identified. Oregon has, however, already defined a state-based reinsurance program that will wrap around the federal program, thus allowing the state's individual insurers to take advantage of both programs.

The Oregon program will be implemented beginning in 2014, with the Oregon Health Authority serving as the state's reinsurance entity; the Authority has contracted with the Oregon Medical Insurance Pool to administer the program.⁶ Under the Oregon approach in 2014, individual insurers will be reimbursed for 90 percent of their costs for enrollees incurring annual claims of \$30,000 through \$60,000, 10 percent of annual claims above \$60,000 through \$250,000 (this will be in addition to the 80 percent reimbursed by the federal program), and 90 percent of annual claims by enrollees between \$250,000 and \$300,000. Thus, combining the Oregon and federal program means that individual insurers in Oregon will be reimbursed for 90 percent of their members' annual claims of \$30,000 to \$300,000 for the 2014 plan year. Program

benefit levels will be phased down over three years. Combined, the state estimates that the two reinsurance programs will lower average individual insurance premiums in the state by about 15 percent (11 percent from the federal program and 3.9 percent from the state program). Oregon will fund its program with an assessment of \$4 per member per month on individual, small group, large group, and self-insured policies, the same approach that the state has used for financing its pre-ACA high-risk pool (the high-risk pool will be closed as of 2014). The total federal and state assessment for reinsurance, \$9.25 per member per month, is below the current average assessment for the high-risk pool, which was most recently \$11.44 per member per month.

Reinsurance is a mechanism for spreading health care risk in the individual market to the broader population of the privately insured—in this case, on a temporary basis. As such, it will cushion consumers accustomed to the prior individual insurance market dominated by healthier than average enrollees from the financial effects of implementing modified community rating and guaranteed issue. At this time, Oregon is the only study state among the 11 that has taken steps to provide additional sharing of risk across the full private insurance market. Maryland has the authority to take similar action, and other states could establish additional reinsurance mechanisms in the future if the average cost of enrollees in the individual market is substantially higher than anticipated; however, none of the other study states indicated at this point that they would. State funds could also be used to extend a reinsurance program beyond 2016, when the federal program is set to end, if that was deemed valuable.

Supplemental Risk Corridor Program and Alternative Risk Adjustment Strategies

The federal temporary risk corridor program will redistribute funds from exchange-based qualified health plans with lower than expected costs to those with higher than expected costs. This program is intended to increase stability in the exchange market during the transition to the new reforms. The program compares actual QHP medical costs to the plan's projected medical costs. If the actual costs are less than 97 percent of the expected, a share of the savings goes to HHS; if the actual costs are more than 103 percent of the expected, a percentage of the excess costs is paid to the QHP by HHS.⁷ The program is not necessarily revenue neutral, so if more money is paid out to plans with higher than expected costs than is collected from

plans with lower than expected loss, those net costs are absorbed by the federal treasury. States could choose to supplement the federal approach, but none of the study states have chosen to do so.

The federal government will also operate a risk adjustment program that covers plans in the individual market both inside and outside the exchanges (a separate adjustment will cover fully insured small group plans). Risk adjustment will redistribute funds from plans attracting disproportionately healthy enrollees to those enrolling individuals with disproportionately worse health. Because the mechanism can redistribute premium funds between the exchange and non-exchange markets as well as within them, it is expected to create long-term stability for both parts of the market. However, it also may serve a function in mitigating short-term rate shock to the extent that new enrollees in the exchange market may be disproportionately high-cost. Federal law allows states to submit their own risk adjustment mechanism for approval, if they choose. While a number of our study states continue to consider the merits of developing and implementing an alternative mechanism to the federal approach, none will do so for 2014.

Geographic Rating Area Definitions

Rating areas define the geographic regions within which a plan's enrollees with the same characteristics—in the case of the ACA, these are age and smoking status—will be charged the same premium. In other words, enrollees residing within a particular geographic rating area will have their health care risks pooled together for purposes of setting premiums. Insurers have geographic rating areas that they used before the ACA, and states have considerable flexibility in defining these areas for the individual and small group insurance markets under the ACA. If, however, a state does not establish rating areas as provided for in the law or if The Center for Medicare and Medicaid Services (CMS) determines that state-defined rating areas are inadequate, CMS is required to implement default rating areas. These have been defined to be one rating area per metropolitan statistical area (MSA) and one additional rating area, which will include all non-metropolitan statistical areas in the state. Substantial changes to rating areas used by insurers before 2014 could lead to significant changes in the ways in which risk is shared within a state; such changes have the potential to increase premium differences between the pre- and post-reform periods. As such, states have had the flexibility to determine their rating areas in a way designed to maintain as much stability as possible between the two periods.

Of the 11 study states, Alabama, Virginia, and New Mexico are relying on the federal default approach to define their rating areas. New Mexico, however, has made the additional risk-sharing move of capping the maximum differential between the highest and lowest rated areas at 40 percent. Oregon and Rhode Island are using the same geographic rating areas the states used before the ACA—Oregon has seven county-based areas, and Rhode Island itself is a single rating area. Maryland allows insurers to set their own rating areas.

Colorado previously defined its rating areas to include its seven MSAs plus two more for its non-MSA areas. The state will continue to use the seven MSA-based areas, but made some changes to the non-MSA rating areas. On further analysis conducted as a result of the ACA, the state used cost and utilization data along with information on where individuals residing in specific geographic areas obtain their care and other considerations to determine that using four non-MSA rating areas would more effectively group together areas with similar populations. Michigan and New York both relied on analyses of pre-ACA rating practices and service areas to maximize market stability and minimize disruption in their definition of post-ACA rating areas.

If insurers are allowed to set premium rating areas that separate healthier populations from less healthy populations, the broader sharing of health care risk envisioned under the ACA's reforms can be undermined. As a consequence, four of the study states (Colorado, Illinois, Michigan, and New York) took the opportunity provided by the ACA to analyze state health care data and prior insurer rating practices to determine the most appropriate approach for minimizing selection concerns while simultaneously keeping market disruption as low as possible. Oregon and Rhode Island maintained their pre-ACA rating areas, with Rhode Island having already maximized sharing of risk due to having a single rating area for the entire state. Other states are relying on the federal default approach, which may lead to sufficient risk sharing as well; future experience will instruct on that point. As the only study state with multiple rating areas that explicitly limited premium differences between the areas with the highest and lowest rates, New Mexico took a step toward greater risk sharing as well.

High-Risk Pools

Before the ACA was enacted, 35 states had created high-risk pools to provide a coverage option for people with pre-existing conditions.⁸ These pools are distinct from the Pre-existing Condition Insurance Plan (PCIP) program created and funded under the ACA, which establishes

temporary federal or state-run high-risk pools in all 50 states. The PCIP program will be discontinued in January 2014. The state determines whether and how state-funded high-risk pools will continue operating.

Generally, state high-risk pools have been available to residents who were considered uninsurable and unable to buy coverage in the individual market, either because they were turned down for coverage, charged a higher premium because of their health status, or offered a plan that excluded coverage of their pre-existing condition. These high-risk pools do not enroll a large percentage of each state's population; however, they tend to include some of the oldest, sickest, highest-cost residents. Of our study states, six had established high-risk pools to provide their residents with a coverage option. A seventh state, Alabama, also has a high-risk pool, but it is open to individuals who have lost group coverage or exhausted their COBRA coverage and have not had a gap in coverage for 63 days or more (see table 2).⁹

Table 2. State High-Risk Pools

State	High-Risk Pool	Enrollment (as of December 31, 2011) ^a	Per Member Per Month Expenses
Alabama	Alabama Health Insurance Plan ^b	2,133	\$830
Colorado	CoverColorado	13,859	\$743
Illinois	Illinois Comprehensive Health Insurance Plan	19,998	\$979
Maryland	Maryland High-Risk Pool	20,646	\$815
Minnesota	Minnesota Comprehensive Health Association	26,859	\$893
New Mexico	New Mexico Medical Insurance Pool	8,442	\$1,207
Oregon	Oregon Medical Insurance Pool	12,152	\$1,116

a: This information was obtained from Kaiser Family Foundation State Health Facts. Available at <http://kff.org/other/state-indicator/high-risk-pool-enrollment/>

b: Alabama's high-risk pool is available only to those who were previously enrolled in an employer's health plan or in extended COBRA coverage after their employment ended, without a break in coverage for 63 or more days.

Because of the ACA's insurance reforms and premium subsidies, the high-risk pools will no longer be a necessary coverage option after January, 2014. However, some analysts fear that the sudden influx of these high-cost individuals in the state's individual insurance market,

whether inside or outside the marketplace, will put upward pressure on individual health insurance rates.¹⁰ As a result, some states have considered transition policies for their high-risk pools so that the introduction of high cost individuals into the exchange takes place more gradually.

In spite of adverse selection concerns, a majority of our study states plan to close their high-risk pools to new enrollment by the end of 2013; Colorado, Minnesota and Oregon will shut down their pools by the end of 2014. New Mexico and Alabama have not yet decided on a transition policy for their high-risk pools, while Maryland's pool may not shut its doors until 2020 (see table 3). Illinois has begun winding down its high-risk pool by eliminating broker commissions for new enrollment effective July 1, 2013 and sending notices to enrollees encouraging them to switch to a marketplace plan.¹¹ Some enrollees have been told their plans will not be renewed effective December 31, 2013.¹² For example, in Minnesota, the legislature called on the state to establish a "phase-out and eventual appropriate termination of coverage" for the state's high-risk pool, called the Minnesota Comprehensive Health Association (MCHA).¹³ Officials kicked off a public process to develop and publish a transition plan that emphasized "minimal disruption" for enrollees and the individual insurance market.

Table 3. State Transition Plans for High-Risk Pools

State	Closed to New Enrollment	Shutdown	Notice to Enrollees
Alabama	January 1, 2014	Unknown	Unknown
Colorado	December 31, 2013	March 31, 2014	Yes
Illinois	January 1, 2014 ^a	Unclear	Yes
Maryland ^b	December 31, 2013	Between January 1, 2014 and January 1, 2020	Yes
Minnesota	December 31, 2013	December 31, 2014	Yes
New Mexico	Unknown	Not yet decided	Yes
Oregon	January, 2014	January, 2014 ^c	Yes

a: Illinois has not yet determined whether a high-risk pool will be maintained for HIPAA-eligible individuals. HIPAA pool enrollees may be able to renew their coverage.

b: Maryland estimates that the elimination of subsidies will move 7,000 of the 20,646 people enrolled in their high-risk pools into the health insurance marketplace.

c: Budget and cash reserves will be maintained for the claims run-out period, which can extend for over one year after closure.

In addition, all the high-risk pools either have provided or will provide notice to enrollees about the closing of the program and the availability of new coverage options, including Medicaid and premium tax credits through the health insurance marketplaces. For example, Colorado's high-risk pool, CoverColorado, has sent notices to members to terminate their coverage on December 31, 2013, although it is not required until March 31, 2014. Enrollees have been warned that they may have to pay two deductibles if they remain in CoverColorado coverage beyond the end of this year and then will have to switch to a new plan later in 2014.¹⁴ While there is no set end date established for New Mexico's high-risk pool, administrators expect that enrollees will transition to the health insurance marketplace. The high-risk pool will provide customer assistance for all members moving to a new plan.¹⁵

In spite of adverse selection concerns, states are closing down their high-risk pools for a variety of reasons. First, these pools were designed to serve a population that could not access adequate insurance coverage in the commercial individual market because of their health status. Because health underwriting is prohibited under the ACA, these individuals will now be able to obtain commercial health insurance, most at more favorable rates. They will also be able to gain access to premium tax credits, which they can only do if they drop their high-risk pool coverage and enroll in a plan through the exchanges. Second, states may be confident that the ACA's risk mitigation programs, such as reinsurance, will adequately guard against rate shock effects of these individuals moving into the individual market.

Lastly, because many high-risk pools are subsidized through insurer assessments, some states were interested in other uses of that revenue. For example, Minnesota officials note that their insurers will be required under the ACA to pay an assessment for the federal reinsurance program as well as an assessment for their high-risk pool, but will not be eligible to receive a reinsurance reimbursement for claims filed through the high-risk pool. In other words, the federal reinsurance program only compensates insurers for high claims in the individual commercial market—not for claims through the high-risk pool. Thus, the state has a strong incentive to close down the high-risk pool and eliminate the additional assessment on insurers, which the state estimates adds an additional 2.86 percent to each premium dollar. In deciding to close down its high-risk pool, Colorado is recapturing some of the revenue and using it to partially fund its exchange.¹⁶ Oregon is redirecting its high-risk pool assessments to its supplemental reinsurance program.

Action on Early Renewals

The ACA's most sweeping insurance market reforms, such as guaranteed issue, modified community rating, and minimum standards for essential benefits and consumer cost-sharing, go into effect for plan years starting on or after January 1, 2014. In recent months, however, some insurers have encouraged their current customers in the individual and small group markets to renew their plans early, in December 2013 or sooner. By renewing plans early, insurers can delay complying with the ACA's market rules for almost 12 months. They are also using it as a strategy to retain their youngest, healthiest customers by offering them lower rates than they might obtain in an ACA-compliant plan.

Thus, early renewals can affect the balance of healthy and sick individuals in the risk pool both inside and outside the health insurance marketplaces, which will, in turn, affect premiums for 2015. While insurers may offer the option of early renewal to all their policyholders, such renewals offer the greatest financial benefit to younger, healthier groups and individuals. And because these younger, healthier enrollees will be carved out of the risk pool for the new marketplaces, it will leave those who renew or buy a new plan in 2014 in a sicker risk pool. If the only people who enroll in new plans in 2014 are more expensive to cover than insurers have accounted for in setting their rates, which have been coming in lower than anticipated in a number of states, insurers will try to make up for the higher risk the following year, but market competition could make this difficult in many areas.

As a result, a number of states have taken action to prohibit or limit early renewals.¹⁷ Among our study states, Illinois, New York, and Rhode Island have prohibited the practice, although New York's prohibition applies only to the small group market.¹⁸ Oregon has restricted the practice by requiring all plans renewed between April 1, 2013 and December 31, 2013 to come into compliance with the ACA by April 1, 2014.¹⁹ Colorado and Virginia permit insurers to renew policies early, but Colorado requires them to provide enrollees with notices educating them about other coverage options. Colorado's rules further prohibit such notices from causing adverse selection (see table 4).²⁰

Related to the issue of renewals for existing plans, on November 14, 2013, President Obama announced a possible "fix" to address the concerns of some consumers who have received notices from their insurance companies that their non-grandfathered insurance plans were being cancelled due to the fact that the plans did not meet the standards required under the ACA. Combined with the HealthCare.gov

website's troubled launch, political pressure to expand the transition period between the old and new systems became intense. The President's approach would allow insurers to renew existing policies (nongroup and small group) not meeting the ACA's standards through September of 2014. As a result, some individuals and small groups who might otherwise have purchased new policies in the reformed markets beginning in 2014 will not do so until 2015. Those maintaining these non-compliant policies may be healthier on average than those who do not. Experts from the American Academy of Actuaries and the National Association of Insurance Commissioners have warned that the proposal could worsen adverse selection in the reformed markets during the first year of full implementation. However, state insurance commissioners still have discretion over whether to implement the suggested change, and some insurers may decide not to renew policies that they have already cancelled. As a result of these uncertainties and the fact that carriers were already actively pursuing early renewals in some states prior to the announcement, the net effect of the President's suggested approach on adverse selection can be expected to be relatively modest.

Table 4. State Action on Early Renewals

State	Prohibit or Limit Early Renewals	Notice Requirement	Market Affected
Colorado	No	Yes	Individual and Small Group
Illinois	Yes		Individual and Small Group
New York	Yes		Small Group
Oregon	Yes		Individual and Small Group
Rhode Island	Yes		Individual and Small Group
Virginia	No		Individual and Small Group

Age Rating

The ACA creates new federal rules that limit how much of a premium increase insurance companies can impose on individuals and small businesses based on factors such as health status, age, tobacco use, and gender. These rules go into effect starting January 1, 2014 and will preempt most existing state laws on premiums. In particular, the ACA prohibits insurers from charging an older person more than three times the premium of a younger person. The law further requires that the US Department of Health and Human Services (HHS) establish acceptable age bands for rating purposes.²¹ Federal rules thus establish age bands as follows:

- Children: A single age band for children ages 0 through 20.
- Adults: One-year age bands for adults ages 21 through 63.
- Older adults: A single age band for adults ages 64 and older.²²

The rules further stipulate that these age bands set a national standard to which all states, in both individual and small group markets, must adhere. However, states are allowed to establish their own uniform *age curves*, which set the relative distribution of rates across all the age bands. To guard against insurers manipulating the age curve to attract younger, healthier consumers, federal rules require that a state's age curve apply to all insurers, although states can set a different age curve for the individual and small group markets. If the state does not establish its own age curve, then a federal default age curve will be used (see table 5).²³

In the case of our study states, all but two—Minnesota and New York—are using the federal default age curve. New York, which has pure community rating, prohibits age rating and thus does not use an age curve. Minnesota chose to establish a state-based age curve because of concerns that the federal 0.635 age rating factor for children would artificially depress premiums for that age bracket and discourage insurers from selling plans that appeal to young families. Minnesota's age curve thus sets the age rating factor for children up to age 20 at 0.890.²⁵ In all 11 states, the use of a standardized age curve will help guard against manipulation by insurers to attract younger enrollees and discourage older ones, thus helping to spread risk more broadly across the market.

Table 5. Federal Default Standard Age Curve²⁴

Age	Premium Ratio	Age	Premium Ratio	Age	Premium Ratio
0–20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and Older	3.000

Policy Options Designed to Strengthen the Long-Term Stability of Individual Insurance Markets and Individual Exchanges

Insurer Lockout Periods

Some states have established lockout periods for insurers choosing not to participate in the exchanges during the first year. Given that many believe that early enrollment in exchange plans will be disproportionately made-up of those with high health care needs since those are the individuals most eager to obtain insurance, sitting out exchange participation in 2014 is one possible way in which an insurer could potentially avoid enrolling a high-cost population. This is especially true if individuals with high medical needs enroll in the first post-reform year and become loyal to providers included in the networks of the plans in which they enroll right away. Insurers that know that they will not have access to the exchange enrollment market share for multiple years if they do not participate in the first one may be dissuaded from waiting to offer on the exchange.

Both New York and New Mexico have stated that the next participation opportunity for plans after 2014 will be for the 2016 plan year. Oregon's contracts with exchange plans are in effect for two years and can be extended by mutual consent. Thus, the intent is that plans not participating in 2014 could not participate until 2016 at the earliest, but they do not have a statute or rule that would prohibit the exchange from releasing a request for applications for new plans earlier than 2015 (for the 2016 plan year) nor is the state required to open up the exchange for additional plans to participate in 2016.

Maryland law requires most insurers (those with \$10 million or more in business in the state's individual market) to participate in the exchange. If they do not participate in the exchange, the law requires that they exit the outside market as well. As a result, most of the state's insurers automatically participate in the exchange. In addition, there is a state rule in the insurance article that prohibits insurers from exiting a state market from re-entering for five years. However, a July 3, 2013 rule issued by the Maryland Insurance Administration states, carriers that continue to sell grandfathered plans in the non-exchange market may continue to do so, regardless of their level of business. These carriers may not issue new policies to individuals not already enrolled in the grandfathered plans and may not sell other plans in the non-grandfathered market. Carriers

doing so will not be subject to the five-year ban and, as such, may apply to sell coverage in the exchange next year, if they so choose. Given that a number of carriers in the prior individual market had chosen not to participate in the exchange, this approach was considered a compromise so as not to create disruption in the market for consumers wishing to hold onto the plans they already had at the time of ACA enactment. As a result, the state no longer has an effective lockout period for carriers remaining in the grandfathered market.

As noted earlier, lockout periods encourage insurers to participate continuously in the exchange, decreasing the likelihood of the types of instability of plan choices that can result from insurers making different participation decisions each year. In addition, lockout periods may also prevent insurance companies from attempting to "game" the system by entering the market after the first plan year in an effort to avoid enrolling the most eager exchange enrollees—those who may have disproportionately higher rates of high-cost medical needs. By providing a two year lockout period (or, in one case, anticipating a two year lockout period) where insurers not participating in the exchange in year one will not have the opportunity to enter the new markets, New York, New Mexico, and Oregon have gone the farthest with this approach among the 11 states studied.

Limits on the Sale of Catastrophic Products

Under the ACA, catastrophic health insurance plans, which provide coverage that does not meet the actuarial value standards of bronze, silver, gold, or platinum plans, but that include coverage for essential health benefits and have a deductible equal to the allowed out-of-pocket maximum for Health Savings Account plans (\$6,250 for single coverage, \$12,500 for family coverage in 2013) will be available to two groups: those under 30 years of age at the start of the plan year and those without other affordable offers of health insurance coverage. The catastrophic plans must cover approved preventive care services without cost-sharing as well as at least three primary care visits before an enrollee meets the deductible.

Since the catastrophic plans require larger cost-sharing responsibilities than other individual insurance policies under

the ACA and most of those eligible to enroll in them will be young adults, these plans have the potential to attract a lower-risk population of enrollees than the rest of the individual insurance market. Through a number of federal regulatory decisions, catastrophic plans have effectively been separated from the larger individual insurance single-risk pool, and, as such, some concerns remain that their availability will lead to adverse selection in the central individual plans. These concerns stem from CMS' proposed regulations that indicate that plans have leeway to adjust the premiums of catastrophic plans for the demographics of those who enroll.²⁶ Relatedly, the federal risk adjustment mechanism will treat catastrophic policies separately from other individual plans, further suggesting their separation from the remaining risk pool to a significant extent. As a result, some states have decided to place additional restrictions on the sale of catastrophic plans in an effort to limit potential selection effects. In particular, these approaches are designed to attract catastrophic plan enrollees to exchange-based catastrophic coverage, reducing the likelihood that the exchange as a whole will be selected against.

Maryland requires that insurers offering catastrophic coverage outside the exchange to also offer at least one catastrophic plan inside the exchange. Oregon and New York will *only* allow catastrophic coverage to be offered through the exchange. Additionally, New York requires insurers offering coverage in the exchange to offer a standard catastrophic product as well; however, if more than one catastrophic plan is offered in the county, other qualified health plans can choose to opt out, a process that will be managed by the state on a case-by-case basis. While Rhode Island did not impose additional rules on the sales of catastrophic coverage, the only one filed with the Department of Insurance will be sold through the exchange.

As a health plan intended for young adults, catastrophic plans provide a potential opportunity for risk segmentation. If states permit them to be sold exclusively outside the exchange, they could draw healthier risks away from the exchange. Oregon and New York went the furthest of the study states in reducing this potential source of adverse selection against the exchange by requiring insurers to sell catastrophic plans exclusively in the exchange. Without proactive regulation, Rhode Island has had the same practical outcome. Maryland also took steps to reduce selection by requiring that participating carriers selling outside the exchange to also sell these plans inside, but this strategy continues to carry risks of selection against the exchange to the extent that catastrophic plans are marketed more aggressively outside than inside.

Additional Oversight and Regulation of Non-Traditional Products

Certain insurance products, such as association health plans (health plans sold through professional associations), discount medical plans, short-term policies, and coverage through health sharing ministries have often been treated differently, for regulatory purposes, than standard small group or individual health insurance. As a result, they have frequently been exempted from protections provided to consumers of other insurance products, such as limits on premium rating, modified community rating rules, and mandated benefit requirements. While some of these plans are independent and might be self-insured, others have been set up by insurance companies in an effort to offer insurance products not subject to more restrictive state laws.²⁷ Without further incorporation into state regulatory processes, these types of products could become more attractive as vehicles to avoid the broad-based risk sharing policies inherent in the ACA. States have the ability, however, to regulate these products as small group or individual insurance policies if they so choose.

As a result of changes made under the ACA, New York and Oregon will require associations of small groups to be classified as small groups for regulatory purposes, beginning January 1, 2014. Rhode Island established a regulation that delineates standards and consumer protections for Discount Medical Plans.²⁸ The intent of this post-ACA regulation, implemented in June 2011, is to ensure consumer understanding of the role and function of these plans and to protect them from unfair or deceptive marketing, sales, or enrollment practices.

Michigan, in contrast, passed a health care sharing ministries bill in 2013 that explicitly exempted these types of plans from insurance regulation. While the law requires health care sharing ministries to notify consumers that membership does not technically constitute insurance, these ministries effectively offer coverage that acts as a substitute for traditionally regulated insurance. As a result, they create a loophole that allows enrollees in these plans to avoid sharing health care risk with the rest of the individual insurance market. Furthermore, the ACA exempts members of health care sharing ministries from the law's requirement to maintain coverage.

The greater the opportunities for plans to avoid regulations imposed upon the individual and small group insurance markets, the greater the opportunity for risk selection and the more likely the exchange is to attract disproportionately higher cost enrollees. New York and Oregon have taken

explicit steps to bring previously unregulated plans into the regulated market, placing them on equal footing with more traditional insurance plans. The ACA's provision exempting members of health sharing ministries from the individual mandate, combined with Michigan's exemption of these entities from state insurance regulation, works in the opposite direction, maintaining a category of coverage through which particular populations can avoid sharing in the health care risks with the broader population, leaving an opening for adverse selection against the exchange and the non-exchange individual markets.

Broker and Agent Compensation

Insurance brokers and agents (hereinafter referred to as brokers) play a substantial role in marketing and enrolling consumers in insurance plans. Small group purchasers tend to rely most heavily on brokers, but many individual market purchasers do as well.²⁹ Brokers traditionally receive a commission from the insurance company once a policy is sold, with commissions varying for new business and renewals. While navigators will play an important role in connecting individuals to health insurance through the non-group exchange, small employer groups traditionally use brokers and will continue to do so.

Brokers have an incentive to steer consumers to plans that offer them higher commissions or fees.³⁰ A number of exchanges and health purchasing cooperatives that pre-dated the ACA learned the difficult lesson that a failure to collaborate with brokers or provide attractive compensation can lead some brokers to steer customers, particularly healthy customers, away from the exchange.³¹ As a result, some purchasing cooperatives struggled with adverse selection until they made policy changes that emphasized the use of brokers in sales and increased their compensation for selling participating plans.

Many states included in our study have taken action related to broker compensation, in part to guard against the risk that brokers will steer desirable customers away from exchange coverage. Rhode Island, Oregon, New York, Maryland, and Colorado all have policies in place requiring equal broker compensation outside and inside the exchange markets. Rhode Island currently does not have broker participation in the individual market and does not expect that to change in the upcoming plan year; their policy applies to their small group market. Maryland brokers will receive their compensation for exchange-plan sales directly from the insurance company, just as they do for non-exchange sales. While the state's carriers remain responsible for determining compensation levels for their brokers, the Maryland Health Connection (the

state's exchange) advises insurers to "develop equivalent compensation and incentives for sales inside and outside of the Maryland Health Connection."³²

Oregon's model is slightly different from other states. In Oregon, compensation must be the same both inside and outside of the exchange market, but their policy includes a twist: Cover Oregon will be certified as a brokerage agency that will be affiliated with all insurance companies offering plans through Cover Oregon. It will also have a minimum of two trained brokers on staff and it will maintain a stable of affiliated brokers, all of whom have agreed to work with the exchange. Small groups or individuals who come to the exchange directly from the website or call center will be guided to this group of affiliated brokers. Since Cover Oregon is affiliated with all participating carriers, its affiliated brokers are also, by extension, affiliated with all participating insurers.³³ Cover Oregon charges brokers' fees to participating insurers, but those charges are folded into premiums and distributed evenly across individual and small-group purchasers both inside and outside the exchange markets. There is no cost for brokers to become certified to conduct business through the state's exchange, so both independent brokers and brokers affiliated with an insurance company have minimal disincentives to participate in the exchange.³⁴

In many ways, the success of the ACA hinges on the ability to encourage consumer enrollment in health care plans. However, if brokers and other consumer assistants have an incentive to lead particular types of consumers to one market over another, one market (such as the exchange) may be selected against. Rhode Island, Oregon, New York, Maryland, and Colorado have all made efforts to equalize incentives for brokers and agents to sell coverage inside and outside of the exchanges.

Network Adequacy

Network adequacy is critical to an individual's ability to access health care providers under an insurance plan. The ACA requires insurers offering coverage on the exchange to maintain a network that is sufficient in numbers and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay.³⁵ The law also requires the inclusion of a new category of providers called "essential community providers," which provide care to underserved populations.³⁶ The ACA does not impose a network adequacy standard on insurers selling policies outside the exchanges, but many states have their own standards, particularly for Medicaid plans and commercial health maintenance organizations (HMOs).³⁷

The relative narrowness or inclusiveness of a plan's provider network can have an important impact on adverse selection. Narrow network plans tend to have lower up-front costs, but higher costs for patients who seek out-of-network specialty care. Broader networks are often more expensive, but offer greater access to providers, particularly specialists. As a result, healthier individuals are more likely to prefer a narrower network and sicker individuals are more likely to prefer a plan with a broader provider network.

While the ACA does not require states to set similar requirements for network adequacy inside and outside of the exchange, several study states—including Colorado, Michigan, Minnesota, New Mexico, New York, Illinois, and Rhode Island—sought to mitigate adverse selection against the exchange by setting similar network adequacy standards for exchange and non-exchange plans. New Mexico, for example, chose to apply an existing statewide network adequacy standard to qualified health plans in the exchange, and the state's Division of Insurance will enforce both the network adequacy and essential community provider requirements under the ACA.³⁸ In Rhode Island, the Department of Health adopted statewide network adequacy standards for all health insurance issuers offering health plans to individuals residing in or businesses located in Rhode Island; however, the Department's guidance did not preclude the exchange from adopting additional provider network requirements as part of its qualified health plan certification standards.³⁹ Minnesota and New York based their network adequacy standards for exchange plans on existing HMO network adequacy standards.⁴⁰

To minimize potential adverse selection as a result of imbalances in coverage of out-of-network provider services inside and outside the exchange, New York also required insurers offering a plan covering out-of-network provider services outside the exchange, such as a preferred provider organization (PPO), to also offer a plan that covers those services inside the exchange at the silver and platinum levels, in that same county and market.⁴¹ The rule applies only to those carriers that provide out-of-network coverage in their ordinary course of business so as not to discourage carrier participation in the exchange. While Oregon did not set uniform network adequacy standards for insurers inside and outside the exchange,⁴² the state's existing standard is similar to the federal one, and Oregon intends to develop statewide network adequacy requirements to be applied to all coverage (public and commercial).⁴³

Although several study states have put strategies in place to ensure similar network adequacy rules inside and outside the exchange, state approaches to network adequacy

standards in general, as well as approaches to maintaining a level playing field between the exchange and non-exchange markets, are likely to evolve over time. In addition, given the fairly minimal network adequacy standards imposed by the ACA and most states for exchange plans, insurers are likely to continue to have substantial flexibility in network design.⁴⁴

Service Area

Under the ACA, qualified health plans must meet certain minimum criteria regarding covered service areas, including coverage of a minimum geographical area at least the size of a county (unless the exchange determines a smaller area is warranted), and the establishment of service areas in a non-discriminatory manner.⁴⁵ Given well-documented geographic disparities in the cost of care and the health of populations, the manner in which service areas are established is of critical importance in guarding against adverse selection. Regulators must ensure that insurers do not cherry-pick service areas with lower health care costs or healthier populations, so that consumers across a state have adequate access to coverage, and avoid differences in service areas inside and outside the exchange that could translate into differences in premiums in the exchange and non-exchange markets.

To avoid adverse selection against the exchange caused by insurers defining different service areas for exchange and non-exchange plans, at least five study states—Colorado, Maryland, Michigan, Oregon, and Rhode Island—established standards requiring similar service areas to be offered both inside and outside the exchange by the same insurer or plan. In Virginia, exchange plans were evaluated under the same service area standards as required in the state's managed care health insurance plan program. New Mexico required insurers in the exchange to offer at least one statewide plan at the metal level of any other plan submitted at a given metal level. While the state did not impose this requirement on non-exchange plans, regulators felt that the requirement that insurers offer a statewide plan within the exchange would result in those insurers also offering a plan with a statewide network outside of the exchange, once the exchange network was established.

Plan Standardization

The ACA introduces significant new measures to standardize cost-sharing and benefits in health insurance plans, including organizing plans into five coverage levels stratified by the actuarial value of the plans and establishing requirements for the benefit categories (essential health benefits) that plans

must cover. Such standardization reduces adverse selection by restricting insurers' abilities to design plans that might be more attractive to younger, healthier individuals. However, within the coverage levels prescribed by the ACA, there could still be thousands of variations in deductibles, co-payments and coinsurance for various health care items and services. In addition, federal rules allow insurers to substitute items and services within the 10 essential health benefit categories, so long as the substituted item or service is actuarially equivalent to the replacement. This kind of flexibility could be used by insurers to attract or repel certain types of enrollees. Following the lead of Massachusetts's exchange, several state-based exchange states require insurers to further standardize cost-sharing or benefits, although not all of these states require insurers to also sell the same standardized plans outside the exchange.⁴⁶

For example, New York requires a standardized option within the exchange at all metal levels to ensure sufficient consumer choice and access to comprehensive options for those with a need for it, but did not require standardized products to be sold outside the exchange.⁴⁷ New York limited the number of non-standard options insurers could offer within the exchange to reduce consumer confusion. New York also set forth prescriptive rules to ensure that carriers did not limit their non-standard plan offerings to metal tiers with lower actuarial values attractive to relatively younger and healthier purchasers, in an effort to provide meaningful options for those that may be in need of more comprehensive options.

In contrast, Oregon requires insurers to offer standardized plans both inside and outside the exchange; however, insurers are required to offer standardized plans at three coverage levels (bronze, silver, and gold) on the exchange, but only at two coverage levels (bronze and silver) off the exchange, although a carrier can choose to operate in, out, or both in and out of the exchange. Virginia, which does not require additional plan standardization beyond the federal minimum, nonetheless requires insurers that offer coverage inside the exchange to issue the same plans outside the exchange if requested by consumers. Study states that require insurers to offer standardized plans typically standardize both cost-sharing and benefits, as in Oregon and New York. Additional states, such as Maryland and Michigan prohibit insurers from substituting essential health benefits in their plan designs, but do not further standardize cost-sharing within plans to be sold on the exchange. In Maryland, insurers are barred from substituting benefits from the essential health benefits (EHB) benchmark in 2014, with the possibility that the state will reconsider this decision in subsequent years.

Plan standardization is intended to facilitate consumer choices between coverage options and increase transparency of cost-sharing and benefits, which may facilitate consumers' abilities to use their benefits once enrolled. While most of our study states do not require insurers to offer standardized benefits, additional states may choose to apply such requirements if the experience of states with standardized plans is successful.

Requirements to Offer Plans at all or Specified Metal Levels

The ACA specifies that insurers must offer qualified health plans inside the exchange at the silver and gold levels of coverage. States can require insurers to offer additional levels of coverage with higher or lower actuarial values, in either the exchange or non-exchange market. Because lower-risk individuals are expected to prefer plans with lower premiums but higher cost-sharing (such as bronze plans), whereas higher-risk individuals are expected to prefer plans with higher premiums but lower cost-sharing plans (such as platinum plans), the level of coverage offered on the exchange can have an important impact on adverse selection against the exchange.

Only three study states—Maryland, New York, and Oregon—require insurers to offer plans within the exchange at additional coverage levels. Two of these—Maryland and Oregon—also require insurers to offer plans at specified coverage levels outside the exchange. In Maryland, insurers are required to offer plans at the bronze, silver, and gold levels inside the exchange, as well as one plan at each of the silver and gold levels outside the exchange.⁴⁸ Oregon requires insurers to offer a standardized bronze, silver, and gold plan inside the exchange, as well as one standardized bronze and silver plan outside the exchange. New York requires insurers to offer at least one standardized plan on the exchange in each coverage level, including catastrophic, but does not require plans at specific coverage levels to be sold outside the exchange.⁴⁹ New York also places limits on the number of non-standardized plans that insurers can offer at each metal level, thereby preventing insurers from offering a disproportionate number of plans at any given metal level. None of the study states with federally facilitated marketplaces (Alabama, Michigan, and Virginia) require additional coverage levels beyond the ACA minimum to be sold either inside or outside of the exchange in their state.⁵⁰

Conclusion

The health insurance reforms set in motion by the ACA are likely to dramatically change the landscape of today's health insurance market from one in which private insurers have wide latitude to minimize their risk by actively selecting low-risk individuals while shunning or refusing to cover high-risk individuals, to one in which the playing field between insurers and plans is more even, regardless of the risk profile of the individuals they enroll. The transition to this new set of rules, however, has raised concerns about both short-term rate shock as insurers price their policies to account for the expected coverage of higher-risk individuals, as well as longer-term market stability, particularly with respect to the new health insurance exchanges.

In addition to the measures prescribed by the federal ACA, states have had an array of options to further protect against and mitigate the effects of both rate shock and adverse selection. Our survey of a cross-section of 11 states found that, while at least a few states were employing most of these strategies, no single strategy was deployed by all the states, and some strategies went unexplored. Further, policy decisions outside of the scope of this paper—such as robust outreach and enrollment efforts to encourage younger, healthier individuals to obtain coverage, and oversight of insurers marketing plans to healthy young adults outside the exchange—may further affect the short and long-term stability of rates as the reform is implemented.

The presence and importance of rate shock and adverse selection will be measurable as enrollment in the exchange and non-exchange individual markets takes shape for 2014 and beyond. Significant rate shock would manifest

itself as substantial numbers of young, healthy adults previously covered in the individual market leaving it and becoming uninsured, presumably as a result of facing higher premiums from modified community rating and coverage of a broader set of benefits than had been true. However, the implications of such possible market exits could be counter balanced by new young and healthy market entrants taking advantage of the ACA's tax credits and purchasing individual coverage for the first time. Thus, data like the Medical Expenditure Panel Survey, a household component that tracks coverage decisions and socio-demographic and health status information over time, will be instrumental in assessing the extent of rate shock in the individual market as well as whether it has significant effects on the age distribution of coverage in the market.

Measurement of adverse selection against the individual market exchanges will require data on both exchange and non-exchange individual market premiums as well as the distribution of enrollment in exchange versus non-exchange plans by a variety of health status measures. While exchanges will have access to a broad array of such data for their own enrollees, data on the non-exchange market may be considerably more challenging to collect in a uniform matter for comparison purposes. States will be well-served by developing data collection and analytic plans for monitoring and evaluation purposes. If problems of this nature do manifest themselves, identifying the issues early to allow for the efficient implementation of additional policy strategies such as the types of options discussed here will be the most effective approach to ensuring the long-term well-being of the reformed individual insurance markets.

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