



## *Reports and Research*

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## The Numbers Behind “Young Invincibles” and the Affordable Care Act

Dec 17, 2013 | [Larry Levitt](http://kff.org/person/larry-levitt/), [Gary Claxton](http://kff.org/person/gary-claxton/) and [Anthony Damico](http://kff.org/person/anthony-damico/)

As enrollment statistics in the new health insurance marketplaces start to become available, there is a growing focus on whether the enrollment of so-called “young invincibles” will be sufficient to keep insurance markets stable. Enrollment of young adults is important, but not as important as conventional wisdom suggests since premiums are still permitted to vary substantially by age. Because of this, a premium “death spiral” is highly unlikely.

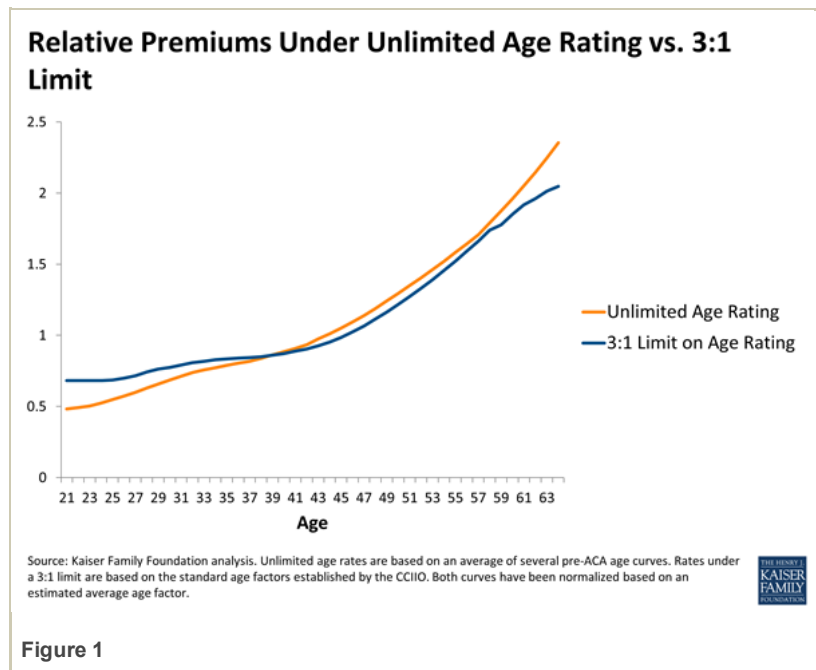
### Why does the age distribution of enrollees matter?

The Affordable Care Act (ACA) requires insurers in the individual market to cover anyone who wishes to enroll and restricts how insurers can vary premiums based on enrollee characteristics. Premiums cannot vary at all based on health status or gender. Premium variations based on age are limited to a ratio of three to one (meaning the premiums for a 64 year-old is three times the premium for a 21 year-old). Previously, premium variations based on age were more typically about five to one.

The limit on age rating means that, on average, older adults will be paying premiums that do not fully cover their expected medical expenses, while younger adults will be paying premiums that more than cover their expenses. For this system to work, young people need to enroll in sufficient numbers to produce a surplus in premium revenues that can be used to cross-subsidize the deficit created by the enrollment of older people. If that does not occur, premium revenues will fall short of expenses and insurers may seek to raise premiums the following year. Figure 1 illustrates how average costs for adults vary by age relative to the allowed premium variation allowed under the ACA.<sup>1</sup> Generally speaking, adults in their late 30s to late 50s will pay premiums that are about the same as what they would pay without any restrictions on age rating. Younger adults pay more than they would without any age rating limits and older adults pay less.

While enrollment in the federal and state-based marketplaces have tended to receive the most attention – and are the only enrollment statistics currently being reported – it is the age distribution across the entire individual market that matters from the perspective of the risk pool. That is because insurers are required to set premiums based on a “single risk pool” that encompasses all plans newly-purchased or renewed after January 1, 2014, both inside and outside the marketplaces. (Policies that are grandfathered or renewed prior to 2014 are not part of this risk pool. And, catastrophic plans, which are available only to people under age 30 and those who cannot otherwise find insurance that costs no more than 8% of their income, may use a different rating approach that reflects the younger age of people expected to enroll in these plans.)

Also, risk pooling occurs state by state, so if one state enrolls a substantial number of young adults, it will not help the insurance market in a state that is less successful.



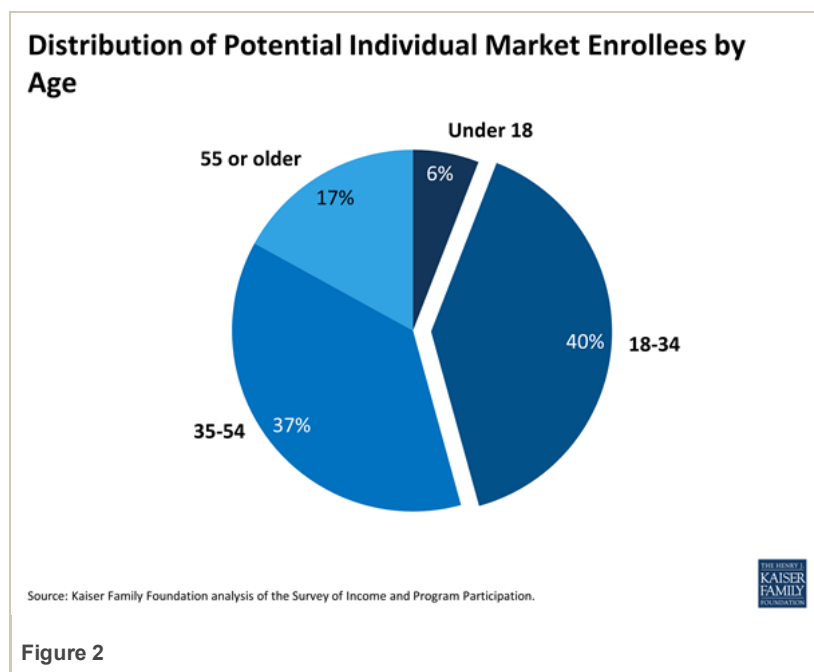
## How many young adults does the market need?

Generally speaking, the goal is to enroll young adults in approximately the same proportion that they represent in the pool of potential individual market enrollees. This potential market includes people who are:

- Currently uninsured or buying their own insurance already.
- Not eligible for Medicaid or affordable employer coverage.
- Residing in the country legally.<sup>2</sup>

Using the basic approach described [here](http://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act/) (<http://www.kff.org/health-reform/issue-brief/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act/>), we analyzed the Survey of Income and Program Participation to estimate the age distribution of potential individual market enrollees. As Figure 2 shows, 40% of the potential market is represented by adults age 18-34.

In setting their premiums for 2014, each insurer had to project who they thought would enroll. Some insurers may have been optimistic, assuming proportionate enrollment of young people. Others may have been pessimistic, and set their premiums somewhat higher across-the-board as a result. Because the ACA includes a risk adjustment system that transfers funds from individual market insurers in a state with younger and healthier enrollees to those with older and sicker enrollees, what really matters for next year is the demographic composition of actual enrollment in total in each state compared to what insurers as a whole projected. In the future, the goal remains to get a proportionate mix of enrollees by age in a given state.



## What happens if enrollment among young adults falls short?

Because young adults will be cross-subsidizing older adults, they need to enroll in sufficient numbers for that cross-subsidy to be sufficient. In other words, if 7 million people enroll in the new health insurance marketplaces – which is what the Congressional Budget Office has projected (<http://www.cbo.gov/publication/44190>) – then 40% of them (or 2.8 million) would need to be young adults (assuming a similar proportion enrolled in ACA-compliant plans outside of the marketplaces as well). If 5 million people enroll, then the target for young adults would be 2 million.

If enrollment among young adults falls short, then the total amount of premiums collected by insurers will be less than the total health care expenses of enrollees plus administrative overhead and profit. And, if insurers believe that those enrollment patterns will continue into 2015, then they may raise premiums higher to compensate for the loss.

However, because premiums are still allowed to vary substantially based on age, the financial consequences of lower enrollment among young adults are not as great as conventional wisdom might suggest.

We simulated the effects of two scenarios:<sup>3</sup>

**Scenario 1: Young adults age 18-34 enroll at a 25% lower rate than other individuals relative to the potential market.** Under this scenario, young adults would represent 33% of individual market enrollees instead of 40% as in the potential market. Taking into account the allowed three-to-one variation in premiums due to age, we find that costs (health care expenses plus overhead and profits) would be about 1.1% higher than premium revenues.

**Scenario 2: Young adults age 18-34 enroll at a 50% lower rate than other individuals relative to the potential market.** Under this scenario, young adults would represent 25% of enrollees, substantially less than their share of the potential market. It is roughly comparable to what Covered California reported (<http://coveredcanews.blogspot.com/2013/12/covered-california-and-california.html>) for October and November (the first two months of open enrollment), with 21% of all enrollees who picked a plan in the 18-34 age range. However, this is likely a worst-case scenario, since the expectation is that older and sicker individuals are more likely to buy first and that younger and healthier people will tend to wait until towards the end of the open enrollment period (which concludes March 31, 2014). In fact, our recent survey (<http://www.kff.org/uninsured/poll-finding/data-note-californias-young-uninsured-a-look-at-19-to-34-year-olds-pre-aca-rollout/>) of people in California who are uninsured found that 58% of young adults said they planned to get coverage in 2014. But, if this more extreme assumption of low enrollment among young adults holds, overall costs in individual market plans would be about 2.4% higher than premium revenues.

Insurers typically set their premiums to achieve a 3-4% profit margin, so a shortfall due to skewed enrollment by age could reduce the profit margin of insurers substantially in 2014. But, even in the worst case, insurers would still be expected to earn profits, and would then likely raise premiums in 2015 to make up the shortfall. However, a one to two percent premium increase would be well below the level that would trigger a “death spiral,” which would occur if insurers needed to increase premiums substantially, in turn further discouraging young and healthy people from enrolling.

From the perspective of keeping insurance premiums stable, how enrollment is distributed by health within each age group is, in fact, more important, since premiums cannot vary at all by health status under the ACA. In other words, the goal is to enroll healthy as well as sick young adults, and also healthy older adults. (Older adults are more likely to be sick than younger people, but that is mostly accounted for by the fact that premiums can vary by age.)

However, questions about health and pre-existing conditions are no longer asked on insurance applications (<http://www.kff.org/health-reform/perspective/how-buying-insurance-will-change-under-obamacare/>), so we will not know for quite a while whether sicker people are enrolling at a higher rate than healthier people. If they do, there are some “shock absorbers” built into the system, including risk corridors (where the federal government shares financially in an insurer’s gains or losses beyond a specified range) and reinsurance (where the federal government covers a portion of the cost for people with high health expenses).

Achieving a balanced risk pool in the individual insurance market will help to make it an attractive market for insurers and keep premiums down over time. Conversely, enrollment of a disproportionate share of older and sicker people will tend to drive premiums up. However, premiums are not as sensitive to the mix of enrollment as fears about a “death spiral” suggest, particularly with respect to age. It is important to attract the “young invincibles,” but maybe with a greater focus on the “invincible” part.

## Footnotes

1. Average costs by age are based on an average of pre-ACA rate tables that reflect no limits on age rating, as well as variations in health costs by age in an analysis ([http://www.healthcostinstitute.org/files/Age-Curve-Study\\_0.pdf](http://www.healthcostinstitute.org/files/Age-Curve-Study_0.pdf)) sponsored by the Society of Actuaries. Relative premiums under a three-to-one limit on age rating are based on the standard age factors for the individual market for 2014. All amounts have been normalized based on our estimate of the distribution of potential enrollees in the individual market by age.

[— Return to text \(http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/#endnote\\_link\\_1\)](http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/#endnote_link_1)

2. Undocumented immigrants are not eligible to purchase insurance in the new health insurance marketplaces. They can buy insurance directly from insurers, but are not expected to do so in large numbers.

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3. For each of the two scenarios, we projected what total costs would be for the assumed age distribution using an estimated variation of costs by age, and then compared that to what premium revenues would be using the standard age factors with three-to-one allowed variation in premiums. We assumed that administrative overhead and profits were a constant percentage of claims across age groups.

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# CALIFORNIA HEALTH CARE ALMANAC



## California's Uninsured: By the Numbers

DECEMBER 2013

# Introduction

California had the greatest number of uninsured residents of any state, 7 million, and the seventh largest percentage of uninsured residents under 65 in the United States. The percentage of Californians who receive coverage through their jobs has declined dramatically, dropping from 63% in 1988 to 54% in 2012. While public insurance has mostly covered this gap, 20% of Californians remain uninsured.

With the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA), the numbers of uninsured residents in California will be reduced, although a significant number will be left behind.\*

*California's Uninsured: By the Numbers* provides a look at California's uninsured population before full implementation of the ACA.

### KEY FINDINGS INCLUDE:

- While one in five Californians overall is uninsured, the rate among those who work is even higher: one in four.
- Employees in businesses of all sizes are more likely to be uninsured in California than in the United States. In businesses with fewer than 10 employees, 40% of workers are likely to have no insurance.
- Nearly one-third of the uninsured in California have annual family incomes of \$50,000 or more.
- Sixty-two percent of uninsured children in California are in families where the head of the household worked full-time during 2012.
- Nearly 60% of California's uninsured population is Latino.

For more information on which groups will be left without insurance after ACA implementation, see [www.chcf.org](http://www.chcf.org).

## California's Uninsured

### Overview

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\*In 2015, an estimated 5.6 million Californians will be uninsured. Of this population, 2.6 million are expected to take up coverage, but 3.1 million are expected to stay uninsured.

# State Comparison of the Uninsured

## 3-Year Average, 2010 to 2012

	TOTAL POPULATION	UNINSURED RESIDENTS	
	IN MILLIONS	IN MILLIONS	SHARE OF TOTAL
<b>United States</b>	<b>266.4</b>	<b>48.1</b>	<b>18.1%</b>
<b>HIGHEST PROPORTION STATES</b>			
Texas	22.9	6.1	26.9%
Nevada	2.3	1.6	25.7%
Florida	15.5	3.8	24.7%
New Mexico	1.7	0.4	24.4%
Montana	0.8	0.2	21.8%
Georgia	8.6	1.9	21.6%
<b>California</b>	<b>33.7</b>	<b>7.0</b>	<b>21.2%</b>

### California's Uninsured

Compared to Other States

California has the seventh-largest percentage and the largest total number of uninsured in the nation. Only three states (Hawaii, Massachusetts, and Vermont) have uninsured rates under 10%.

Note: All numbers reflect the population under age 65.

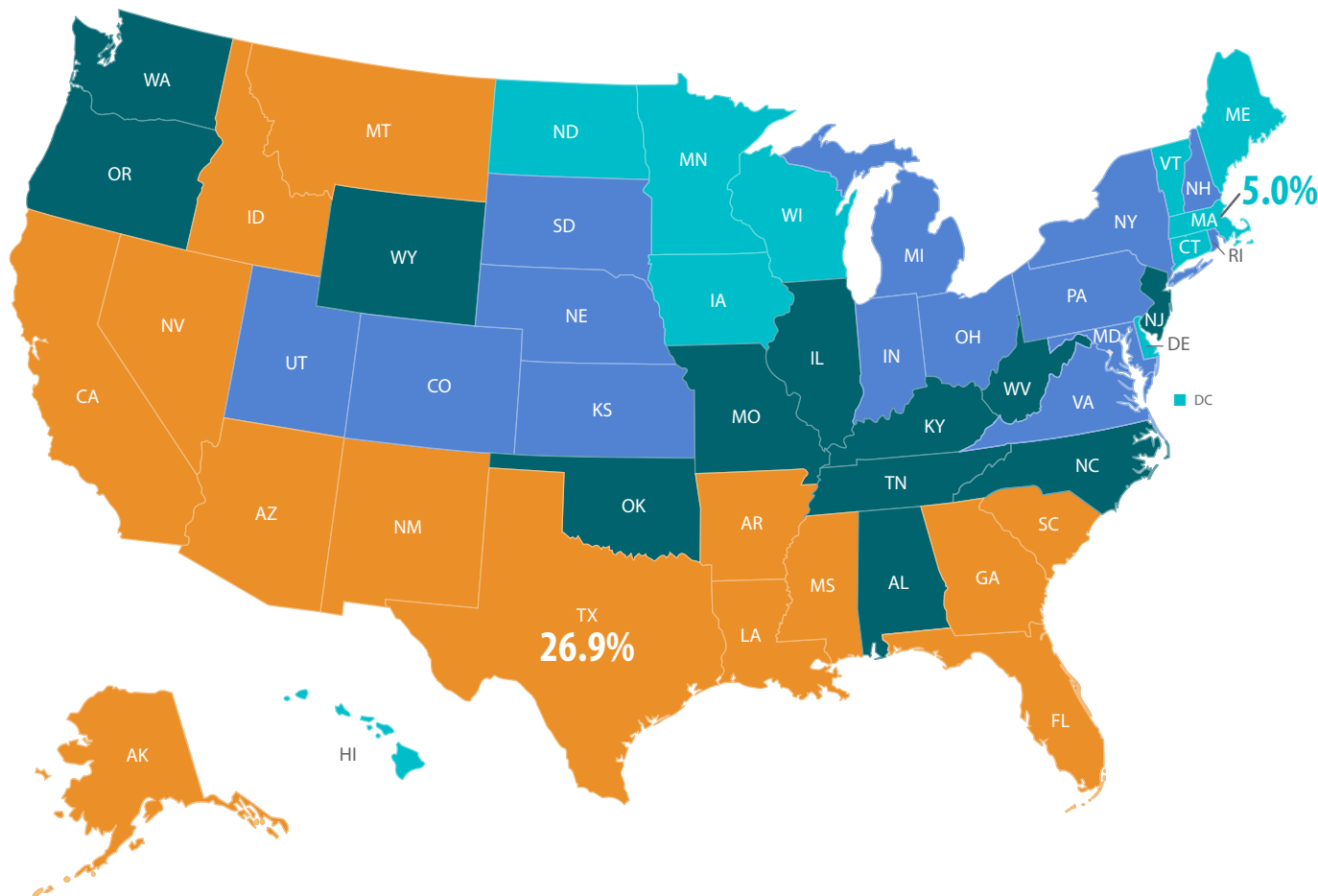
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2011–2013 March Supplements.

# National Comparison of the Uninsured

## 3-Year Average, 2010 to 2012

### PERCENTAGE OF UNINSURED RESIDENTS

■ 0.0% to 12.9%   
 ■ 13.0% to 15.9%   
 ■ 16.0% to 19.9%   
 ■ 20.0% and higher



### California's Uninsured

Comparison to Other States

In 14 states, including California, more than 20% of residents are not insured. Texas has the highest rate of uninsured residents (27%); Massachusetts has the lowest (5%).

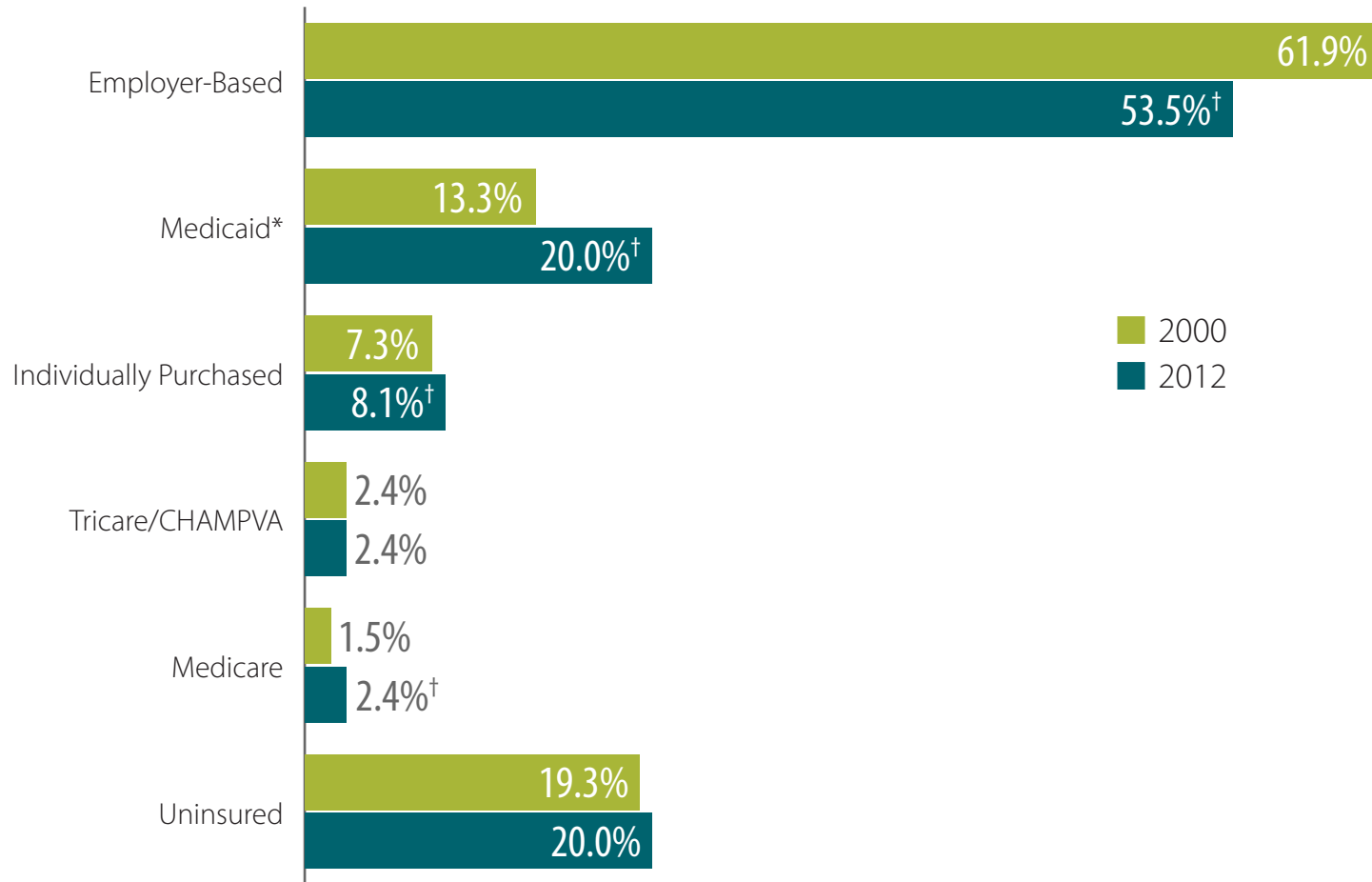
Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2011–2013 March Supplements.



# Health Insurance Sources

California, 2000 and 2012



\*Includes Medi-Cal and Healthy Families.

†Statistically significant from 2000 numbers at  $p \leq 0.05$  level.

Notes: All numbers reflect the population under age 65. Details may not add to totals because individuals may receive coverage from more than one source. TRICARE (formally known as CHAMPUS) is a program administered by the Department of Defense for military retirees and family members of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2001 and 2013 March Supplements.

## California's Uninsured

Coverage Sources and Trends

Over the past 12 years, Medicaid

has partially offset declining

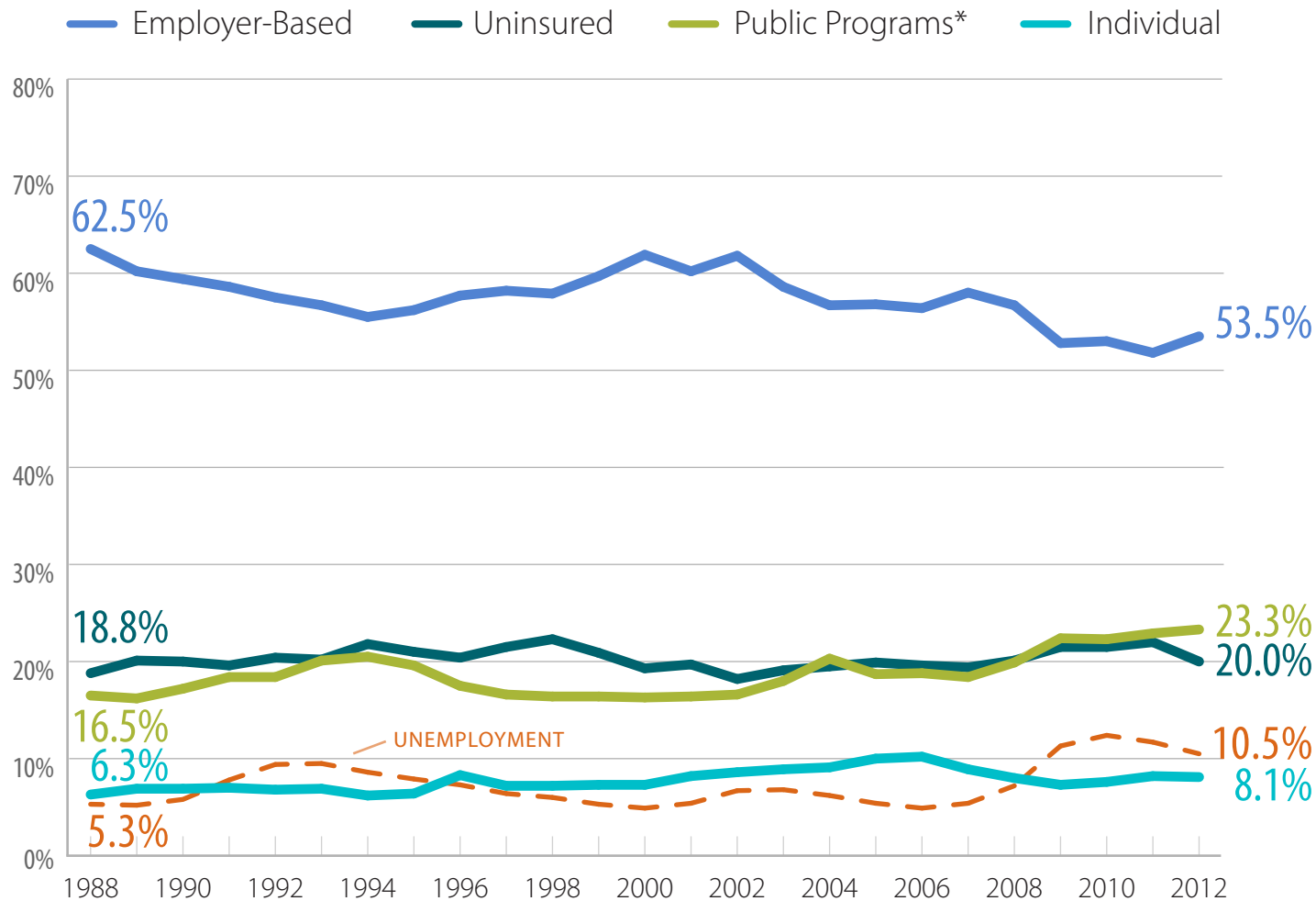
employer-based insurance.

In 2012, one in five Californians

was uninsured.

# Insurance Coverage Source and Unemployment Trends

## California, 1988 to 2012



Although slightly more than half of Californians still receive health insurance through their employers, employer-based coverage has declined substantially since 1988.

\*Includes Medi-Cal, Healthy Families, Medicare, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1987–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Unemployment rates are annual averages without seasonal adjustment.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988–2013 March Supplements.

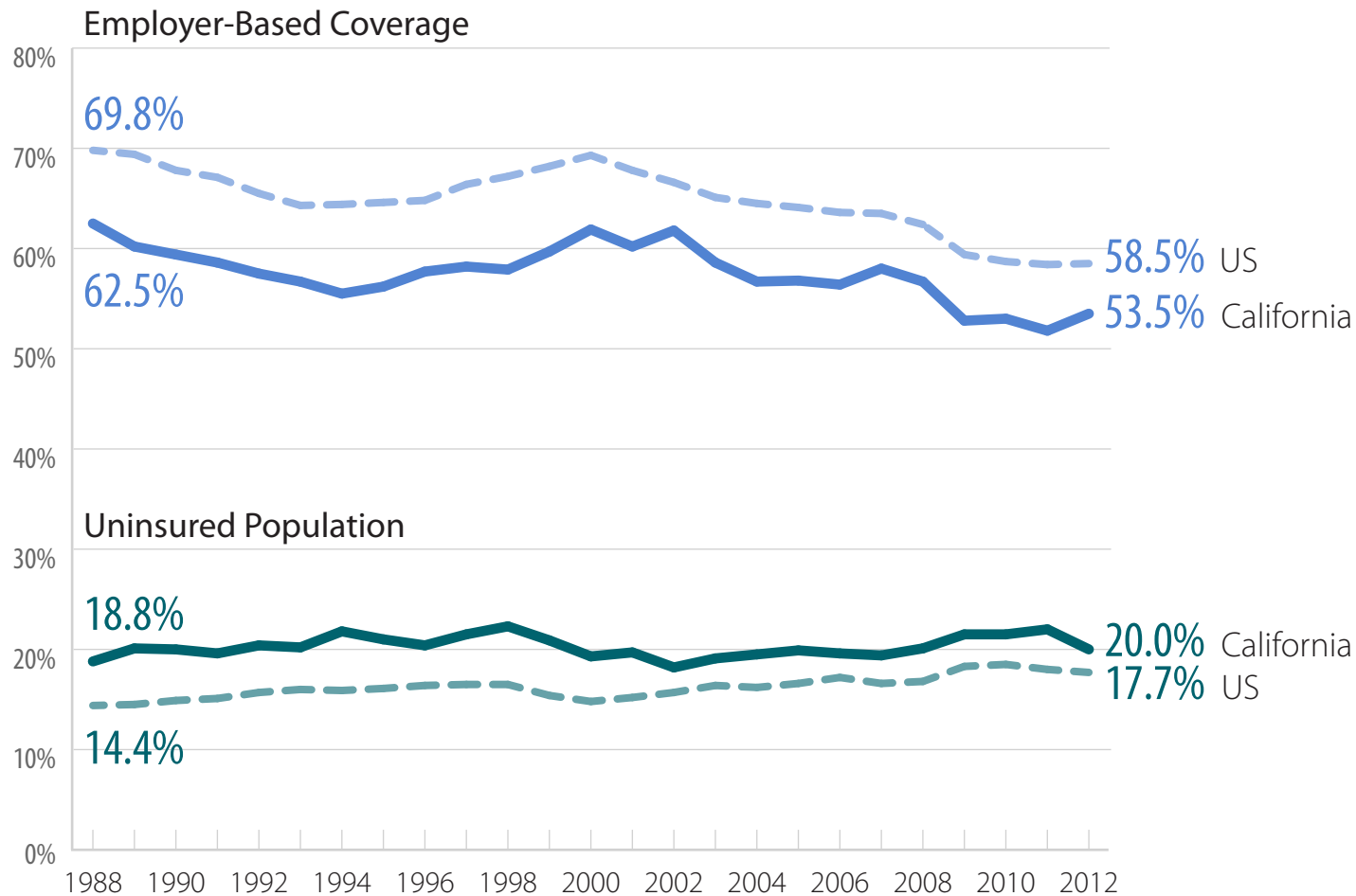
# Employer-Based Coverage and Uninsured Trends

California vs. United States, 1988 to 2012

## California's Uninsured

Coverage Sources and Trends

California has a greater proportion of uninsured residents and lower rates of employer-based coverage than the nation as a whole.



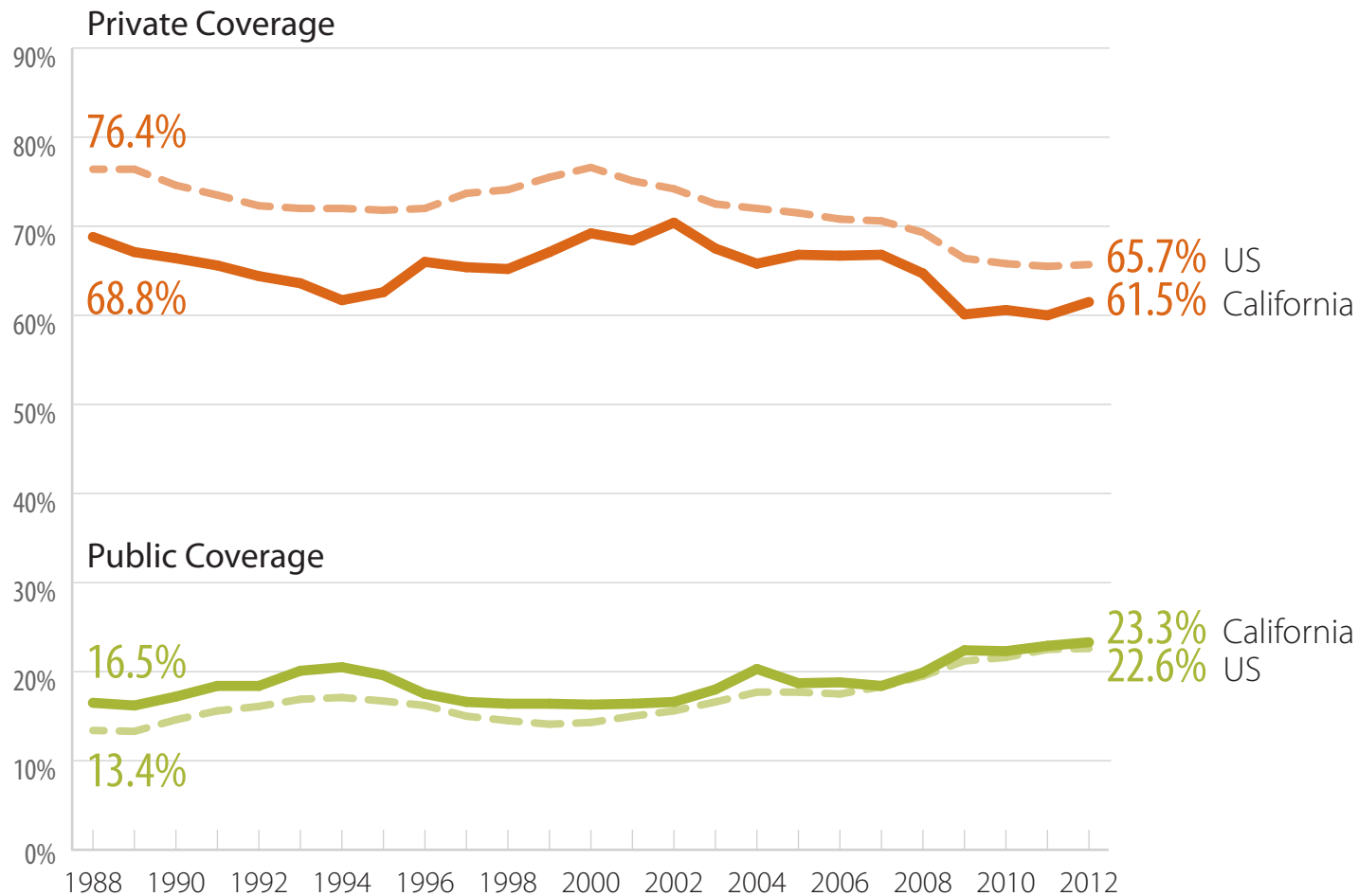
Notes: All numbers reflect the population under age 65. 1987–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Unemployment rates are annual averages without seasonal adjustment.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988–2013 March Supplements.

# Private and Public Coverage Trends

## California vs. United States, 1988 to 2012

While the rate of public coverage for California and the US is comparable, California has lagged the nation in the rate of private coverage.

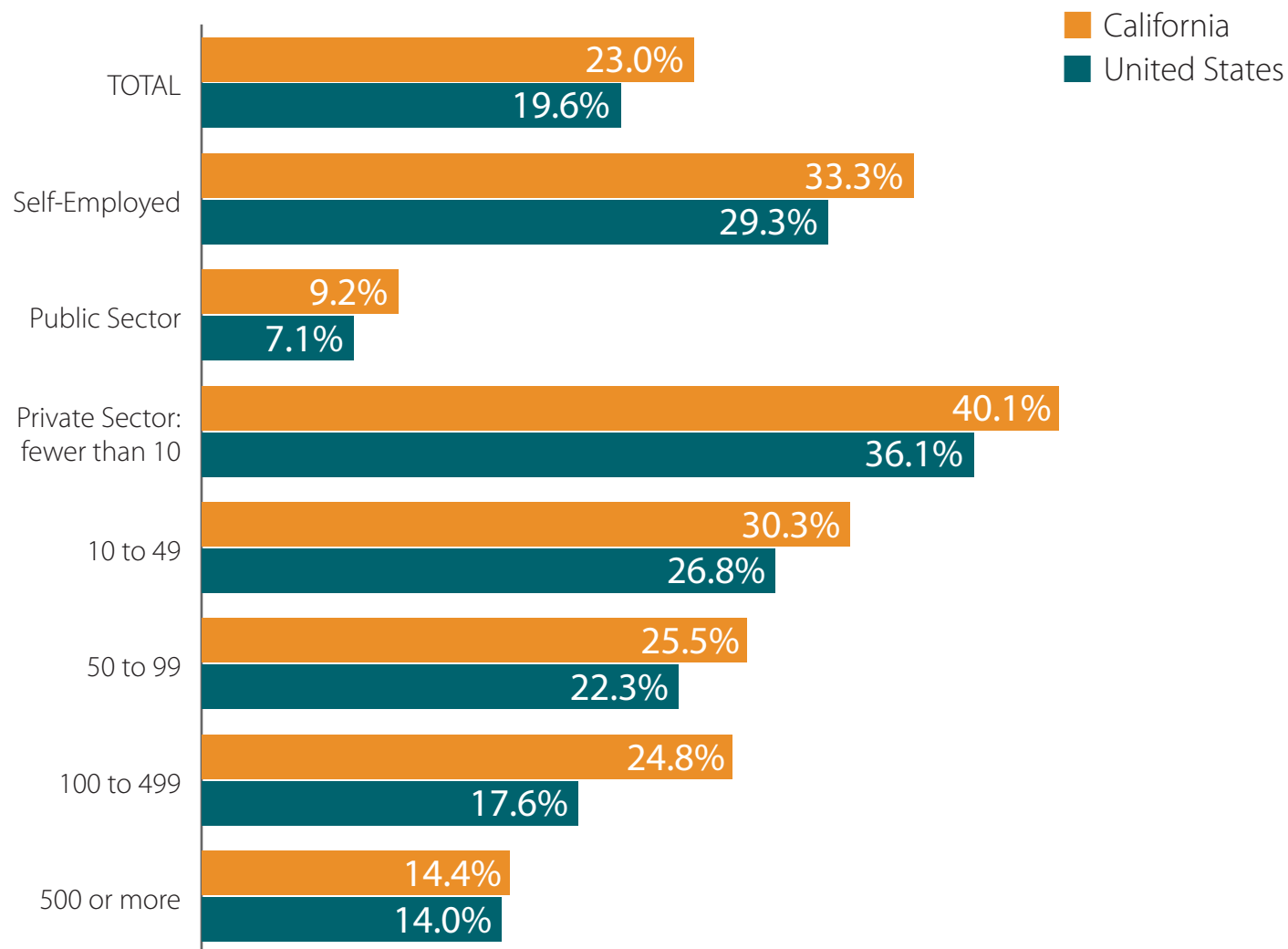


Notes: All numbers reflect the population under age 65. 1987–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988–2013 March Supplements.

# Likelihood of Workers Being Uninsured

## by Employer Size and Type, California vs. United States, 2012



### California's Uninsured

by Employer Size and Type

Compared to workers in other sectors and in larger companies, those who work in businesses with fewer than 10 employees are the most likely to have no insurance (40% in California). One-third of self-employed Californians are likely to go without health insurance.

Notes: All numbers reflect the working population, age 18 to 64. Private sector sorted by number of workers.  
 Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Uninsured Workers vs. Total Workers

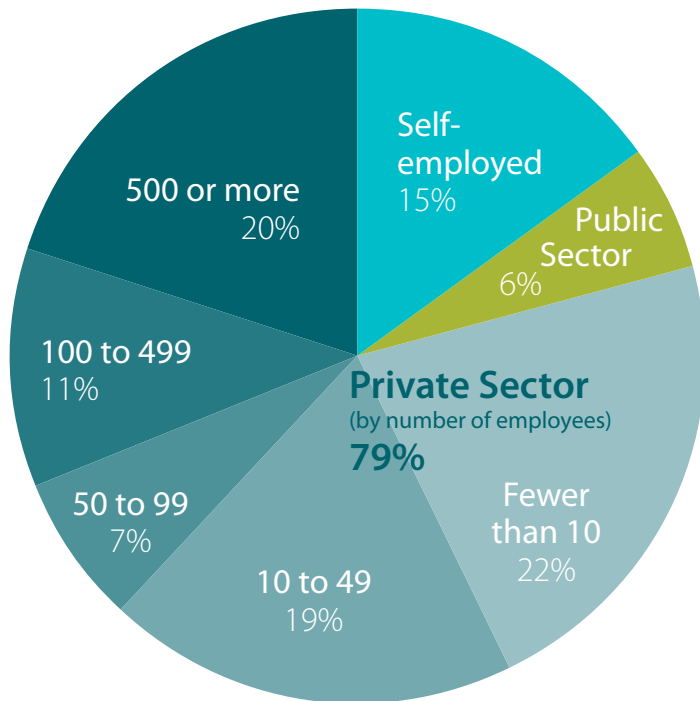
## by Employer Size and Type, California, 2012

### California's Uninsured

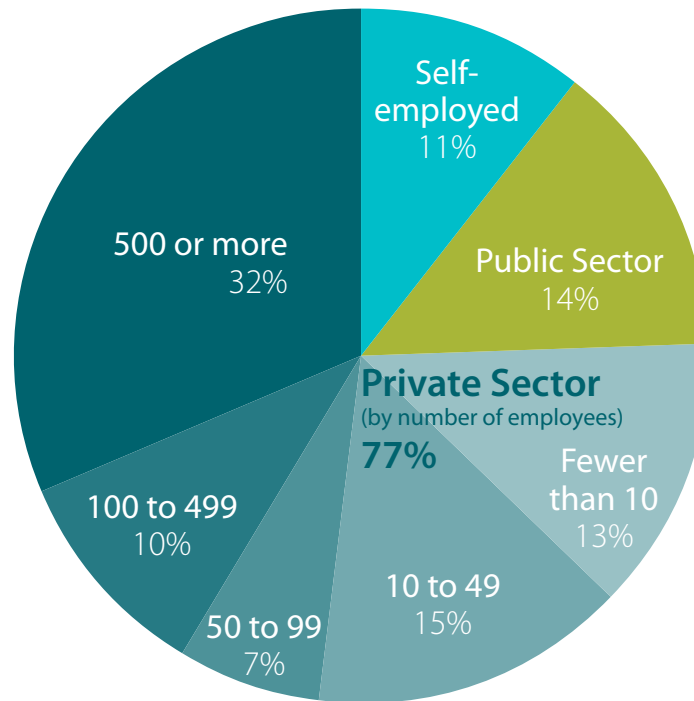
by Employer Size and Type

Slightly more than 30% of California's uninsured workers are employed by companies with 100 or more workers. About one in four workers in California is uninsured.

**Uninsured Workers**  
n=4.1 million



**Total Workers**  
n=17.7 million

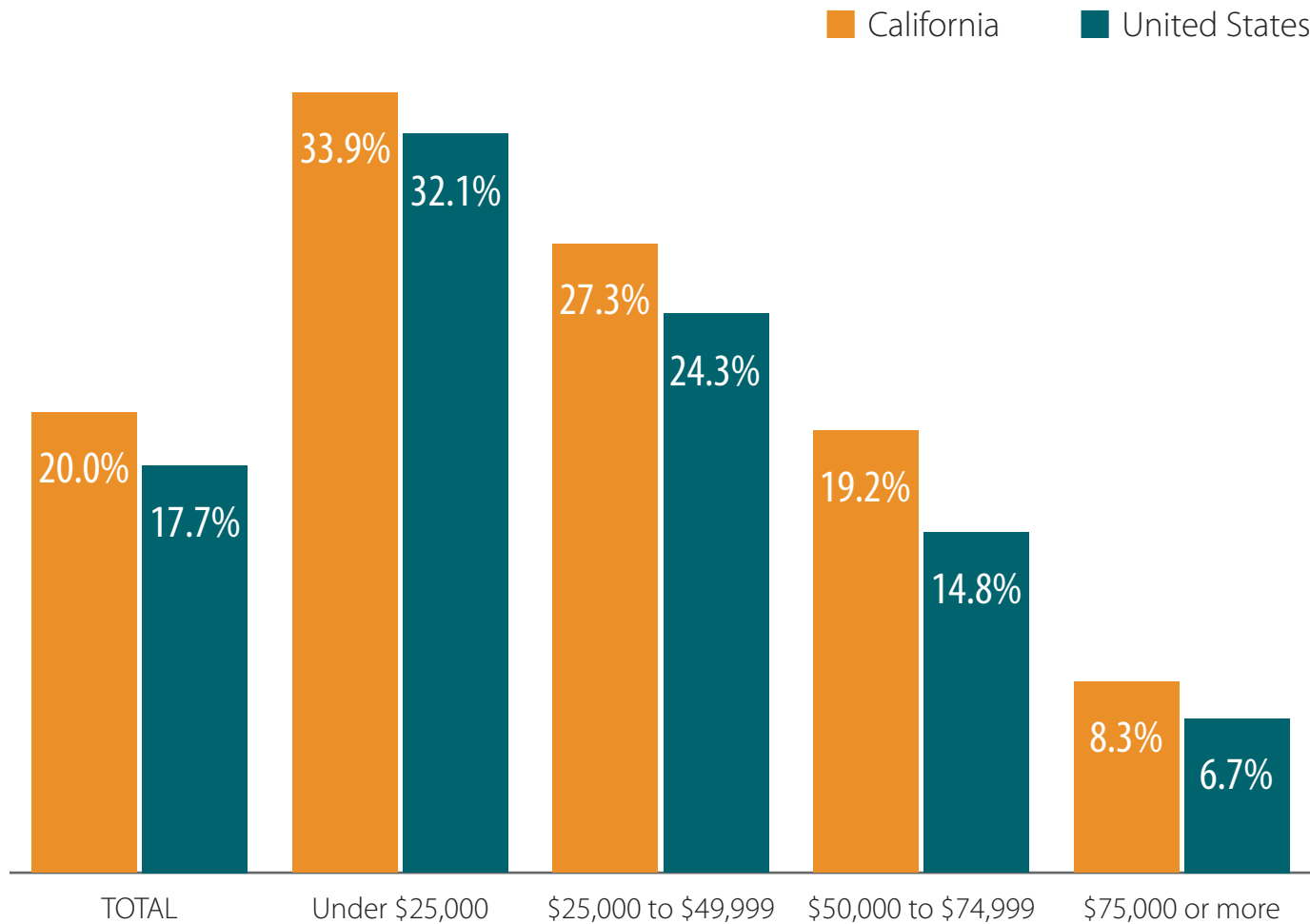


Notes: All numbers reflect the working population, age 18 to 64. Segments may not add to 100% due to rounding.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Likelihood of Being Uninsured, by Family Income

## California vs. United States, 2012



### California's Uninsured

by Family Income

Californians with annual family incomes below \$25,000 are most likely to be uninsured. At all income levels, Californians are more likely to be uninsured than US residents.

Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Family Income of the Uninsured

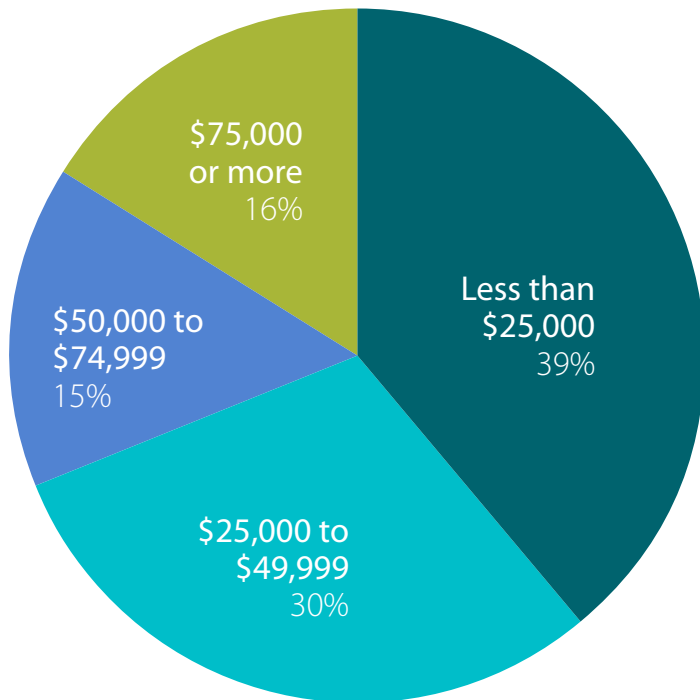
## California vs. United States, 2012

### California's Uninsured

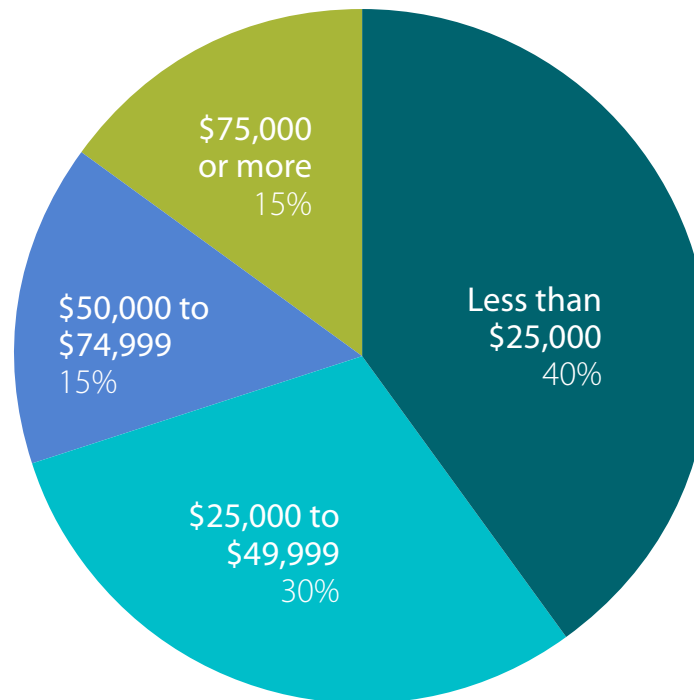
by Family Income

Nearly one-third of the uninsured, in California and in the US, have annual family incomes of \$50,000 or more.

**California**  
n=6.7 million



**United States**  
n=47.3 million



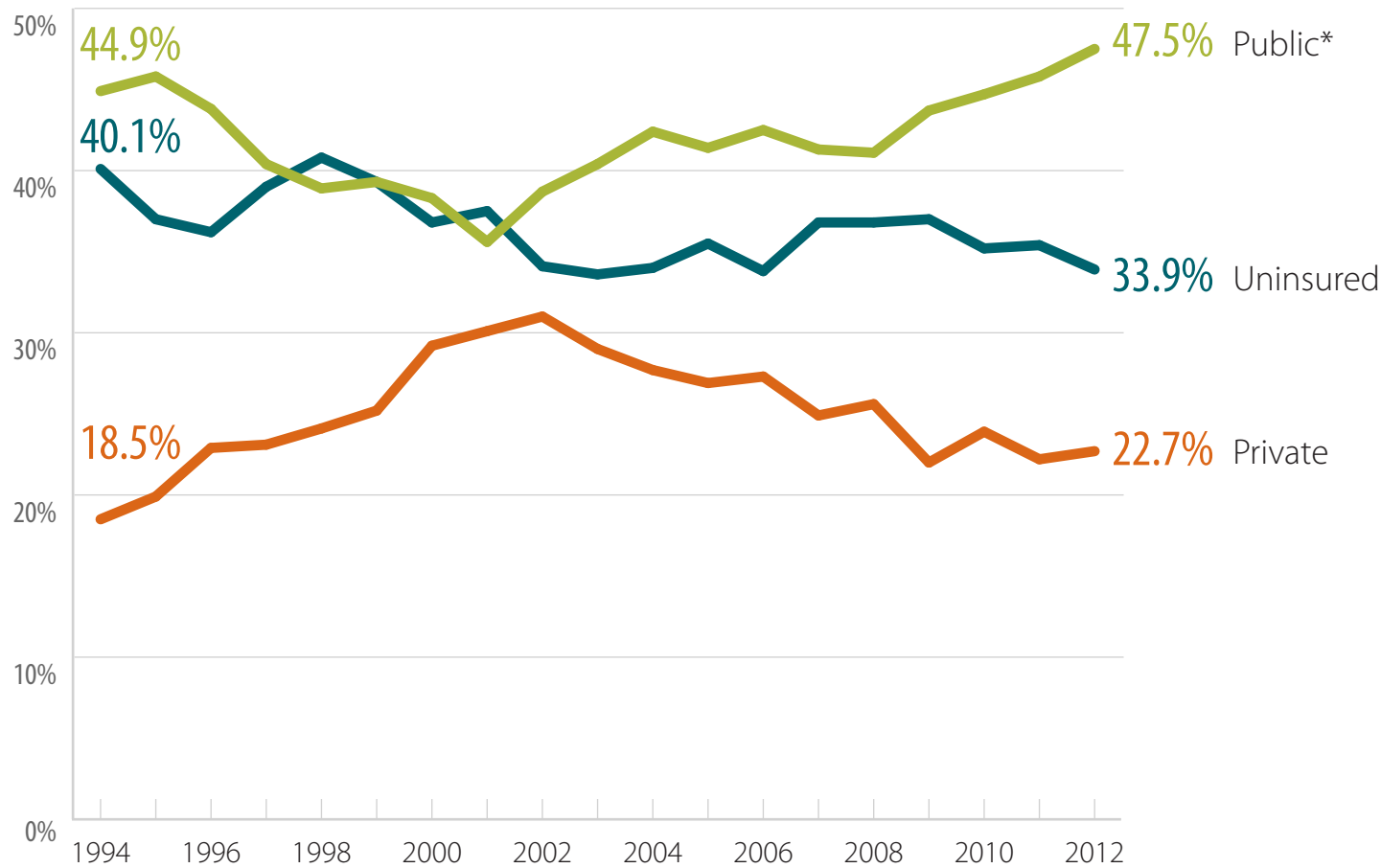
Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.



# Insurance Source Trends, Family Income Below \$25,000

California, 1994 to 2012



## California's Uninsured

by Family Income

Among Californians with family incomes below \$25,000, more were likely to be covered by public programs, and fewer were uninsured in 2012 than in 1994.

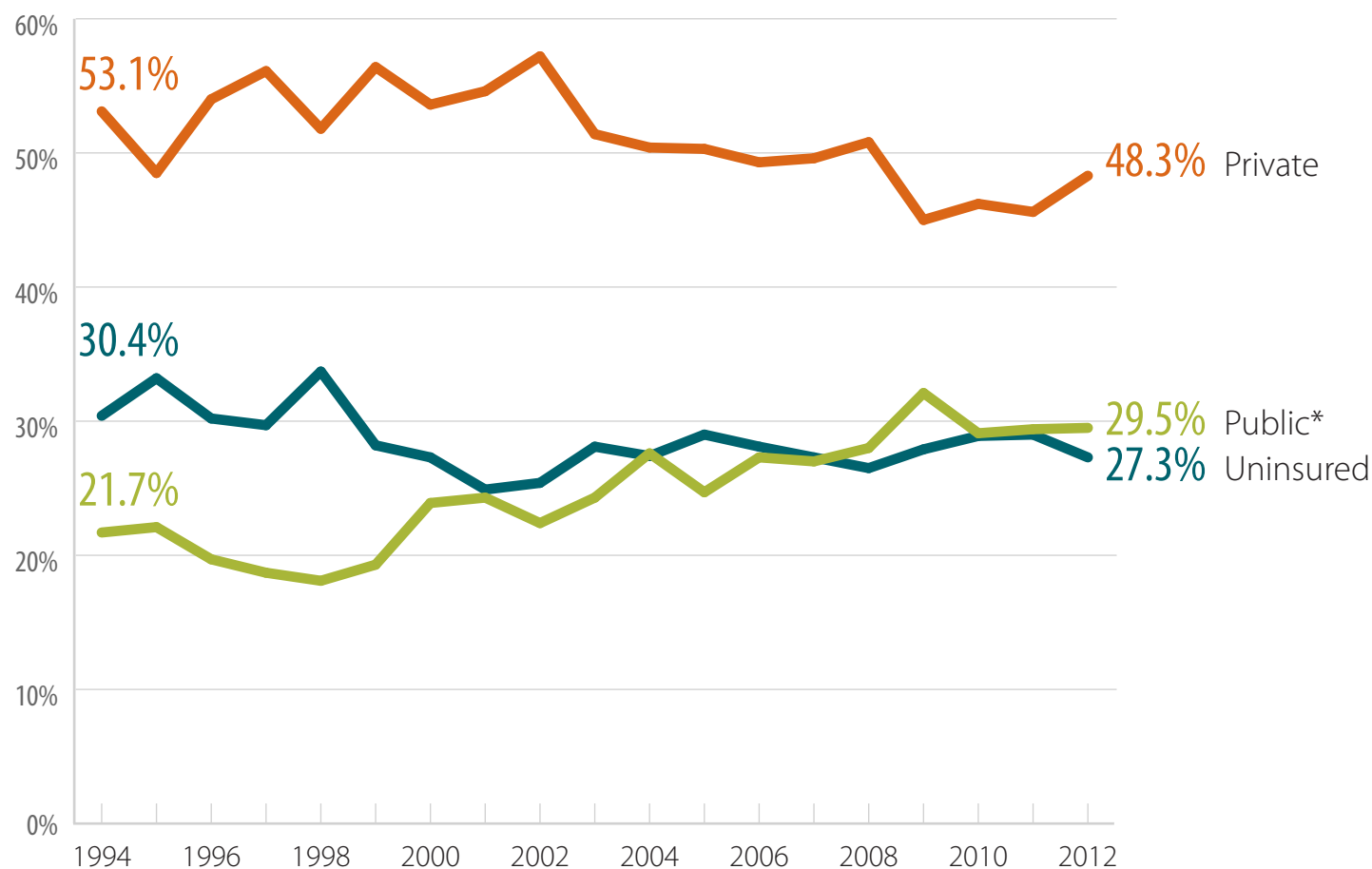
\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

# Insurance Source Trends, Family Income \$25,000 to \$49,999

## California, 1994 to 2012



### California's Uninsured

by Family Income

Among Californians with family incomes between \$25,000 and \$49,999, the percentage likely to be covered by public programs increased between 1994 and 2012.

\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

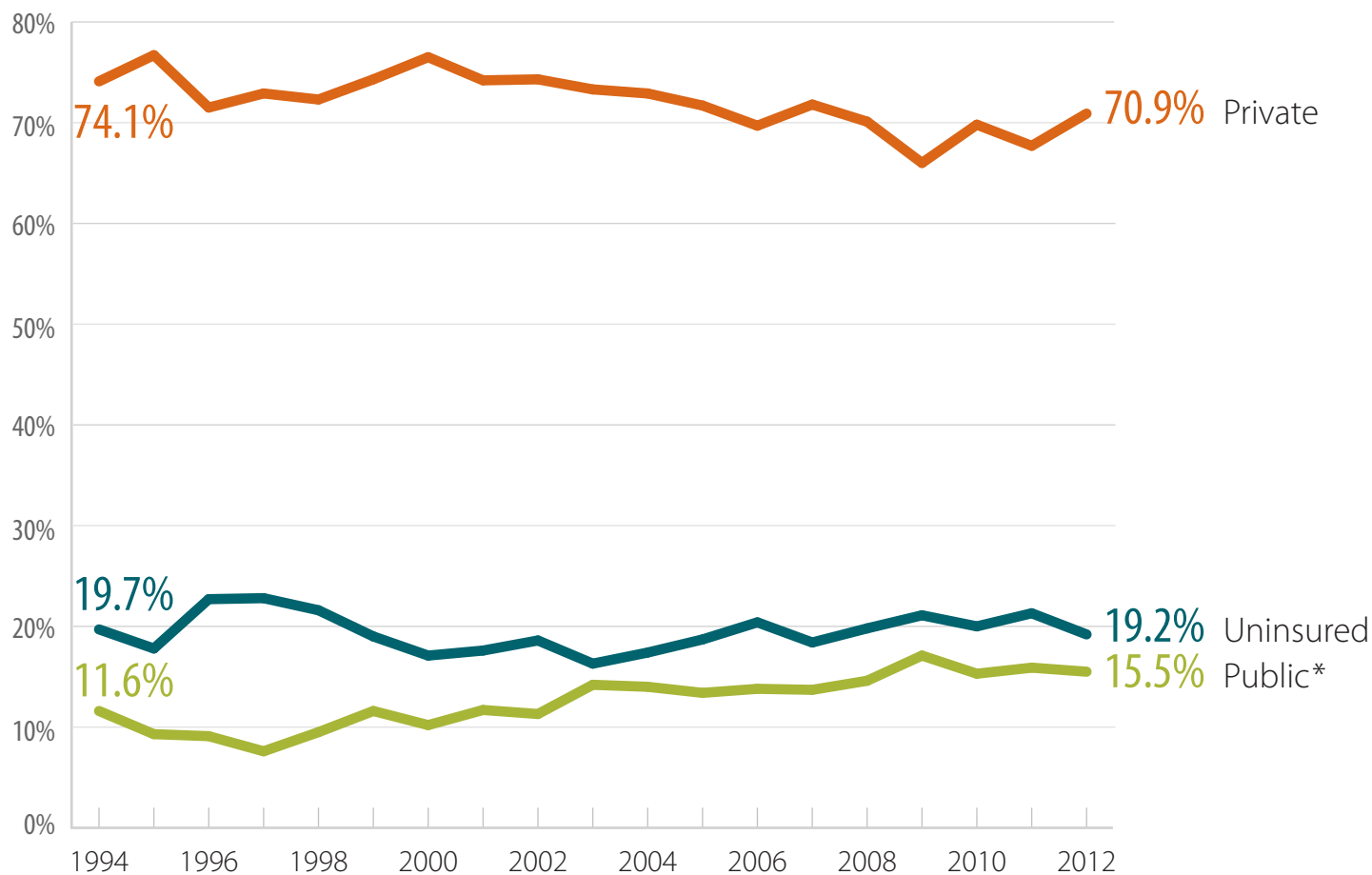
# Insurance Source Trends, Family Income \$50,000 to \$74,999

## California, 1994 to 2012

### California's Uninsured

by Family Income

About 15% of Californians with annual family incomes between \$50,000 to \$74,999 rely on public health insurance. This percentage has increased slightly since 1994.



\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

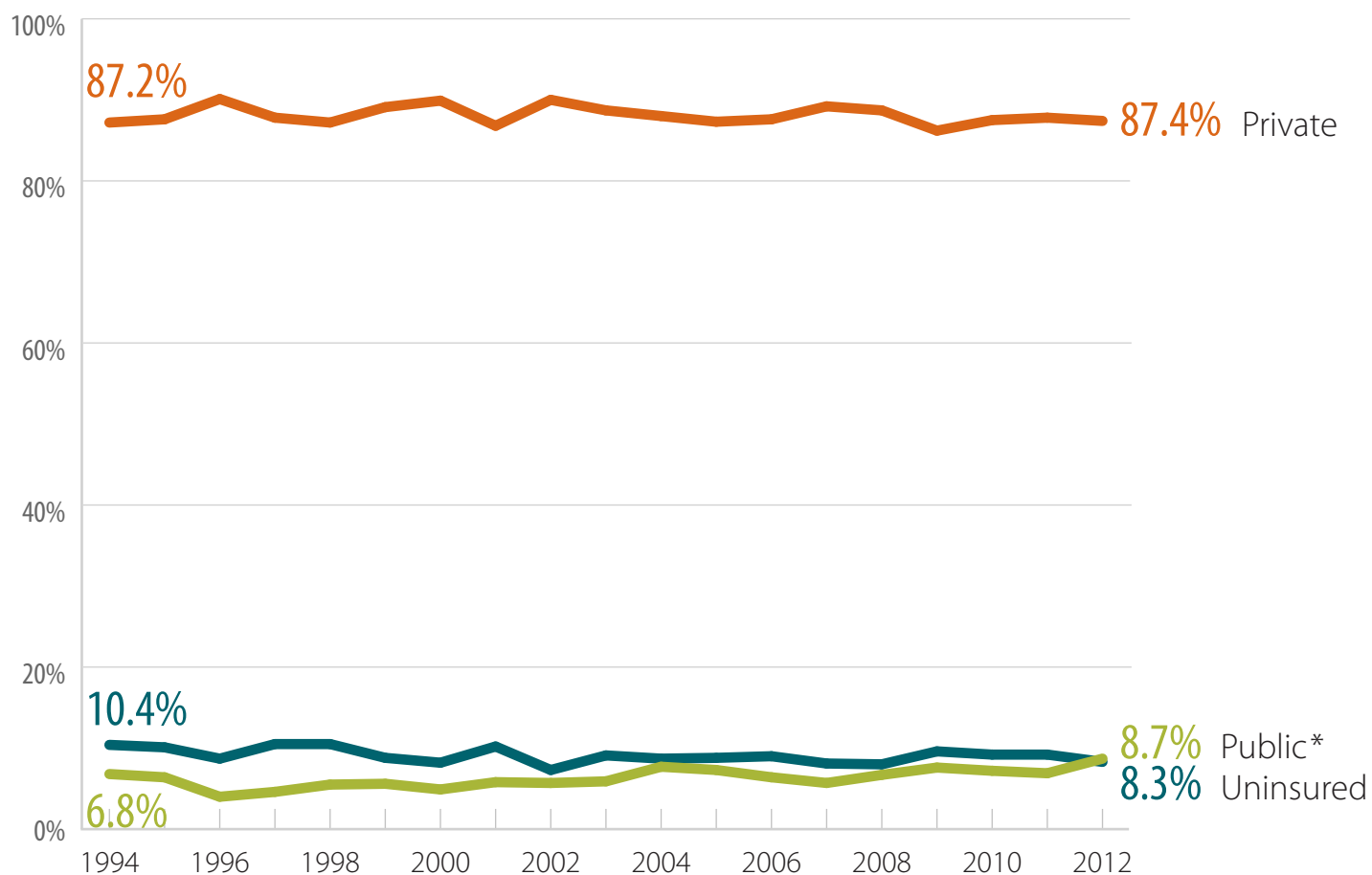
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

# Insurance Source Trends, Family Income \$75,000 and Over California, 1994 to 2012

## California's Uninsured

by Family Income

The vast majority of Californians with family incomes of at least \$75,000 are covered by private health insurance; however, 8% are uninsured.



\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

# Eligibility for Public Health Insurance Programs

## Uninsured California Residents, 2012

### California's Uninsured

by Age Group

Up to 75% of California's uninsured children were eligible for Medi-Cal or Healthy Families in 2012, but only 10% of adults were eligible. Beginning in 2014, under the Affordable Care Act, many more uninsured adults will become eligible for Medi-Cal.

	WITHOUT ADJUSTMENT FOR TIME IN UNITED STATES*		WITH ADJUSTMENT FOR TIME IN UNITED STATES†	
	NUMBER	SHARE OF TOTAL	NUMBER	SHARE OF TOTAL
<b>ADULTS (AGES 19 TO 64)</b>				
<b>Total Uninsured</b>	<b>5,575,177</b>	<b>100%</b>	<b>5,575,177</b>	<b>100%</b>
Eligible for Medi-Cal‡	257,956	5%	566,179	10%
Not Eligible	5,317,221	95%	5,008,998	90%
<b>CHILDREN (AGE 18 AND UNDER)</b>				
<b>Total Uninsured</b>	<b>1,119,639</b>	<b>100%</b>	<b>1,159,639</b>	<b>100%</b>
Eligible for Medi-Cal‡	370,317	33%	455,567	39%
Eligible for Healthy Families‡	378,392	34%	421,415	36%
Not Eligible	370,930	33%	282,657	24%

\*Excludes all noncitizens from eligibility.

†Excludes noncitizens from eligibility if in United States less than five years.

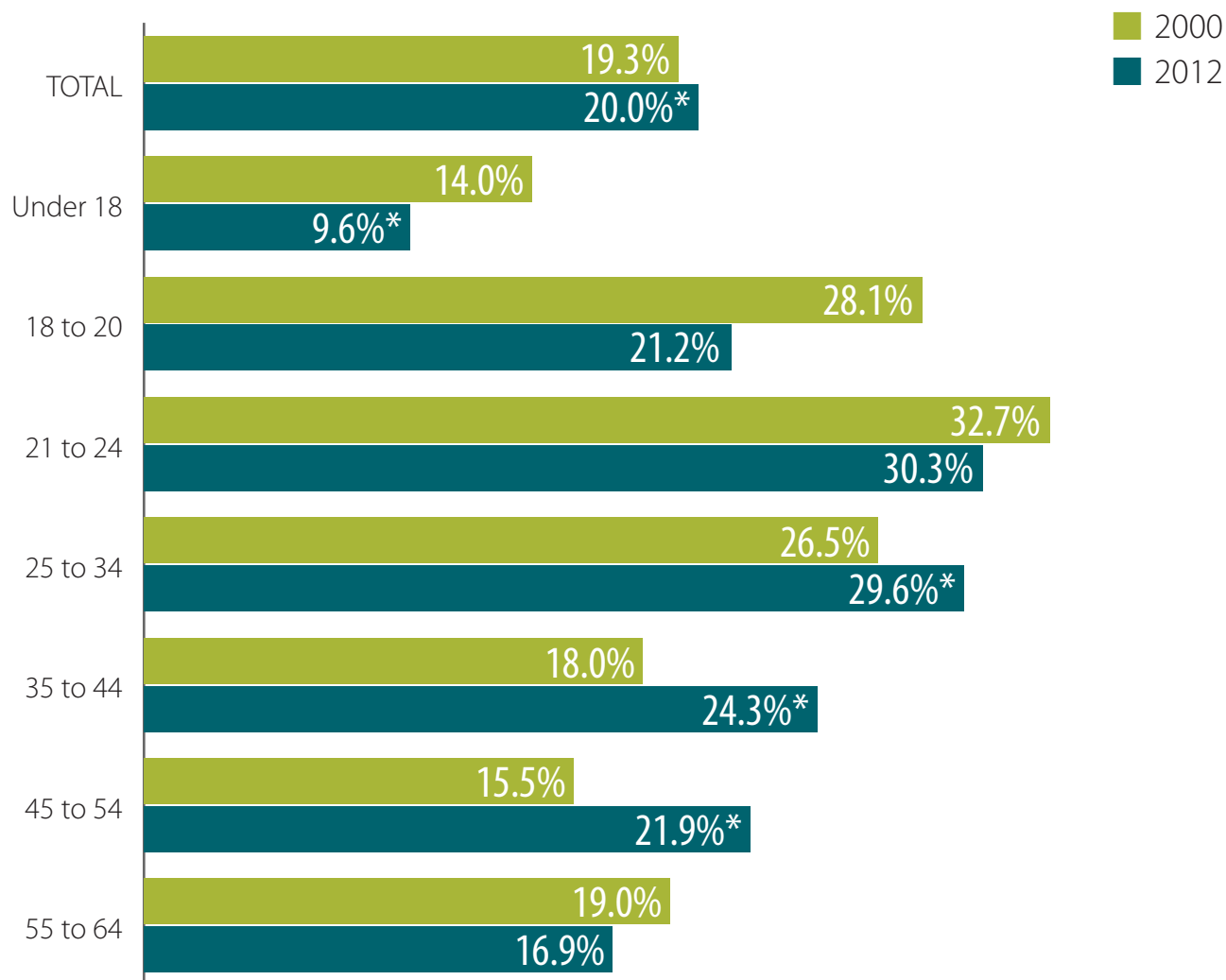
‡CPS collects data on citizenship but not immigration status. The lower number without adjustment underestimates eligible residents because it is restricted to citizens; the higher number with adjustment overestimates eligible residents because it includes all noncitizens who have resided in the US for at least five years (regardless of immigration status).

Notes: The uninsured may be eligible for other public programs. For more information, see *The Crucial Role of Counties in the Health of Californians: An Overview* at [www.chcf.org](http://www.chcf.org). May not add to 100% due to rounding.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Likelihood of Being Uninsured, by Age Group

## California, 2000 and 2012



### California's Uninsured

by Age Group

For adults 25 to 54, the likelihood of being uninsured rose between 2000 and 2012. In contrast, adults under 25 and those 55 to 64 were less likely to be uninsured in 2012 than in 2000.

\*Statistically significant from 2000 numbers at  $p \leq 0.05$  level.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2001 and 2013 March Supplements.

# Age Group of the Uninsured vs. Total Population

## California, 2012

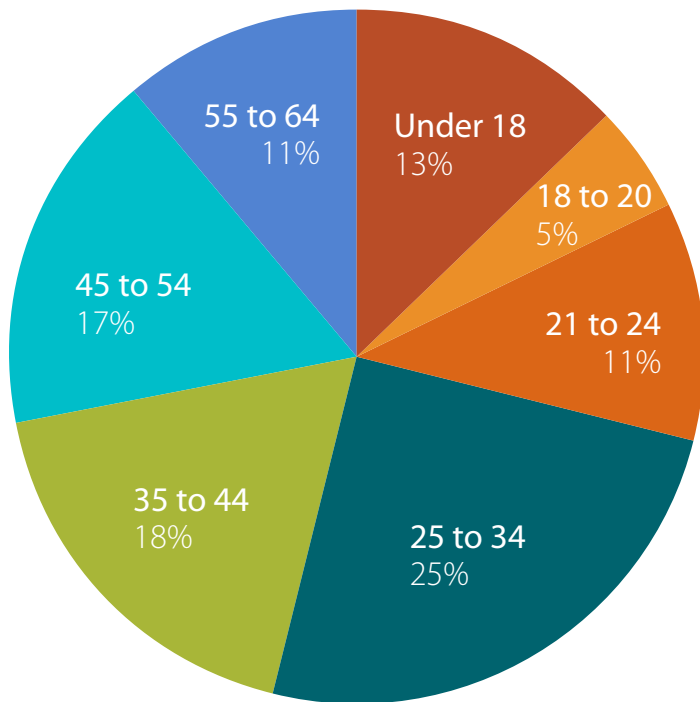
### California's Uninsured

by Age Group

Thirteen percent of California's uninsured are children, but children make up almost one-third of the state's total nonelderly population. One in four of those uninsured is between age 25 and 34.

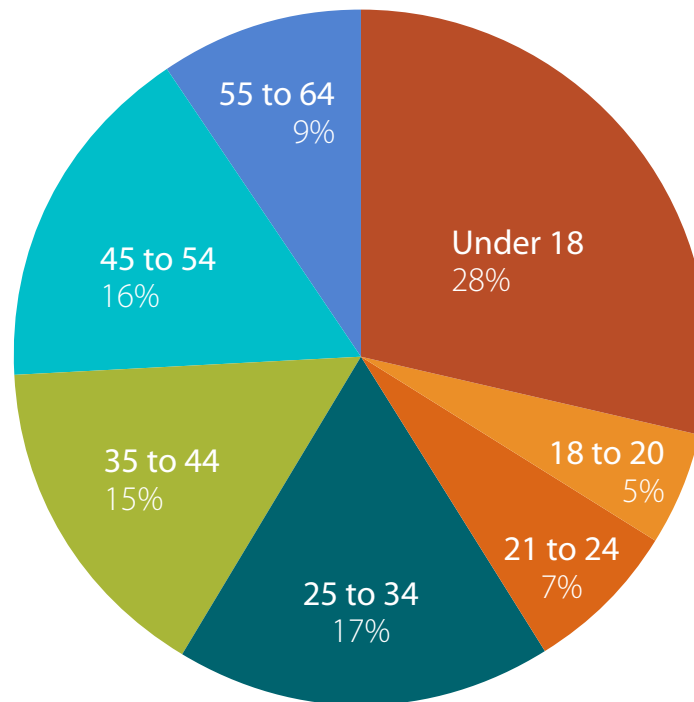
#### Uninsured

n=6.7 million



#### Total Population

n=33.4 million



Note: Segments may not add to 100% due to rounding.

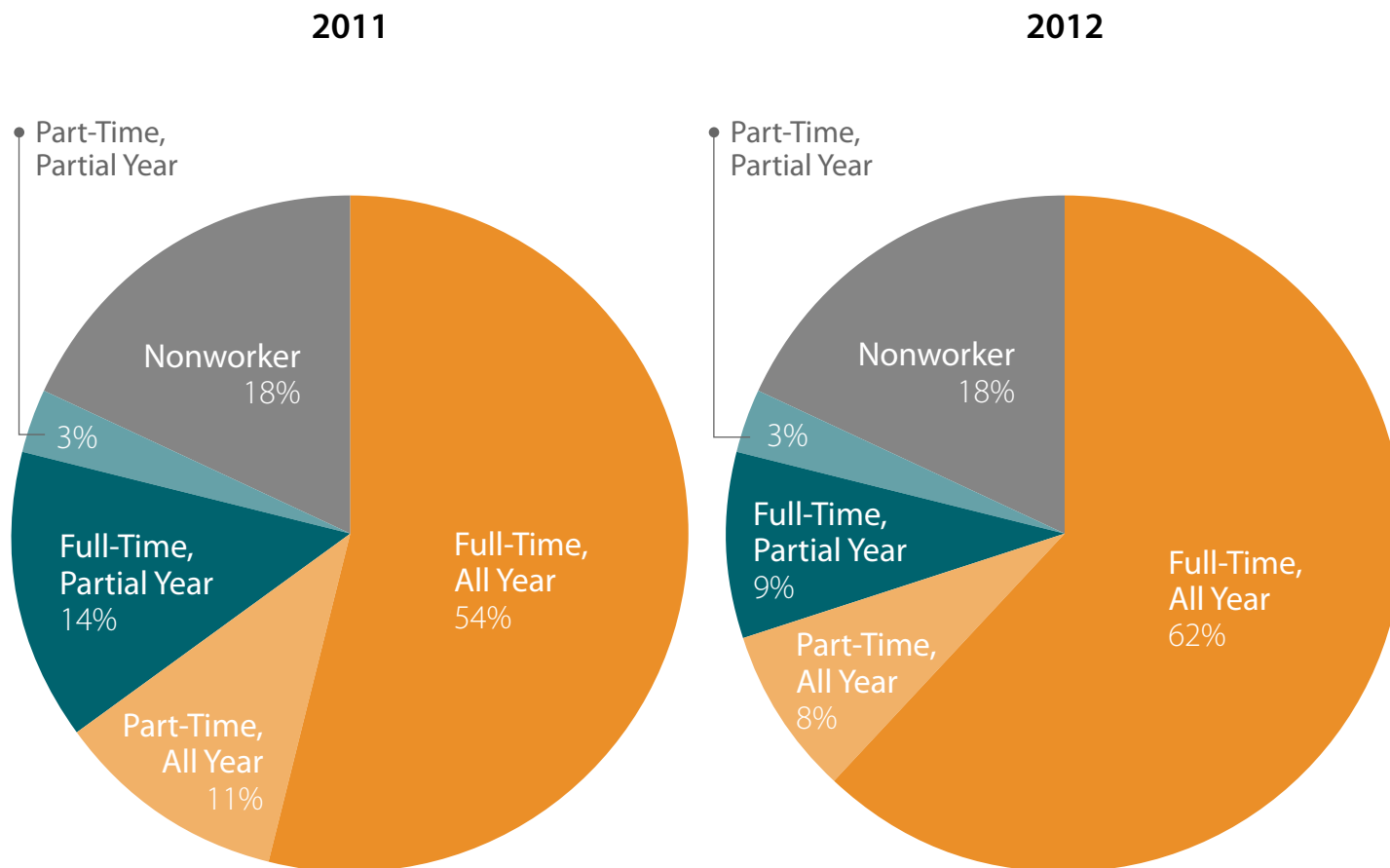
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Uninsured Children, by Work Status of Head of Household California, 2011 and 2012

## California's Uninsured

by Work Status

Sixty-two percent of California's uninsured children live in families where the head of household worked full-time over the calendar year 2012. This percentage is up from 54% in 2011.



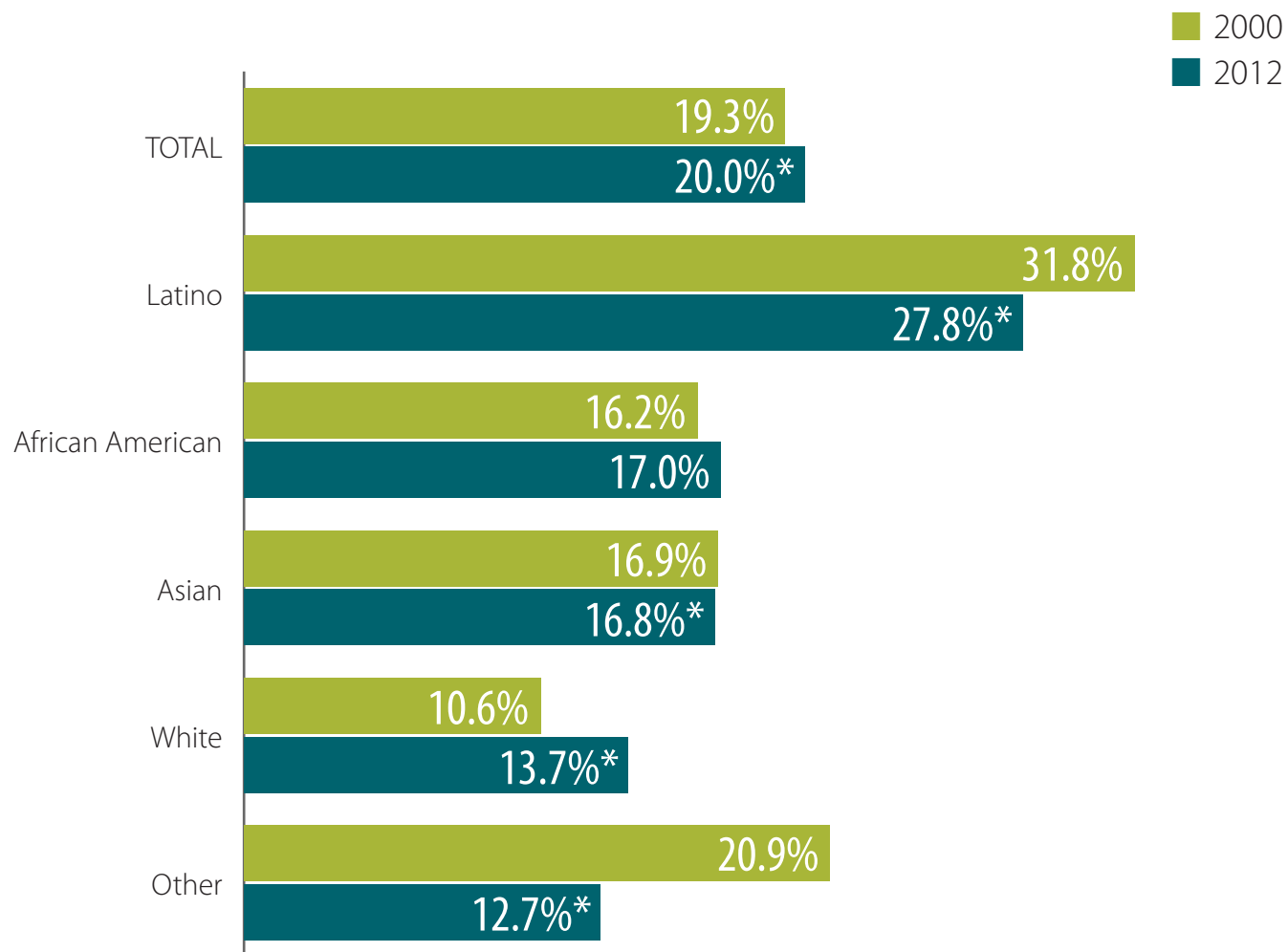
Note: All numbers reflect the population under age 18.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.



# Likelihood of Being Uninsured, by Race/Ethnicity

## California, 2000 and 2012



### California's Uninsured

by Race/Ethnicity

Latinos in California are much more likely to be uninsured than other ethnic groups, and twice as likely as Whites. Nearly three in ten Latinos are uninsured.

\*Statistically significant from 2000 numbers at  $p \leq 0.05$  level.

Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2001 and 2013 March Supplements.

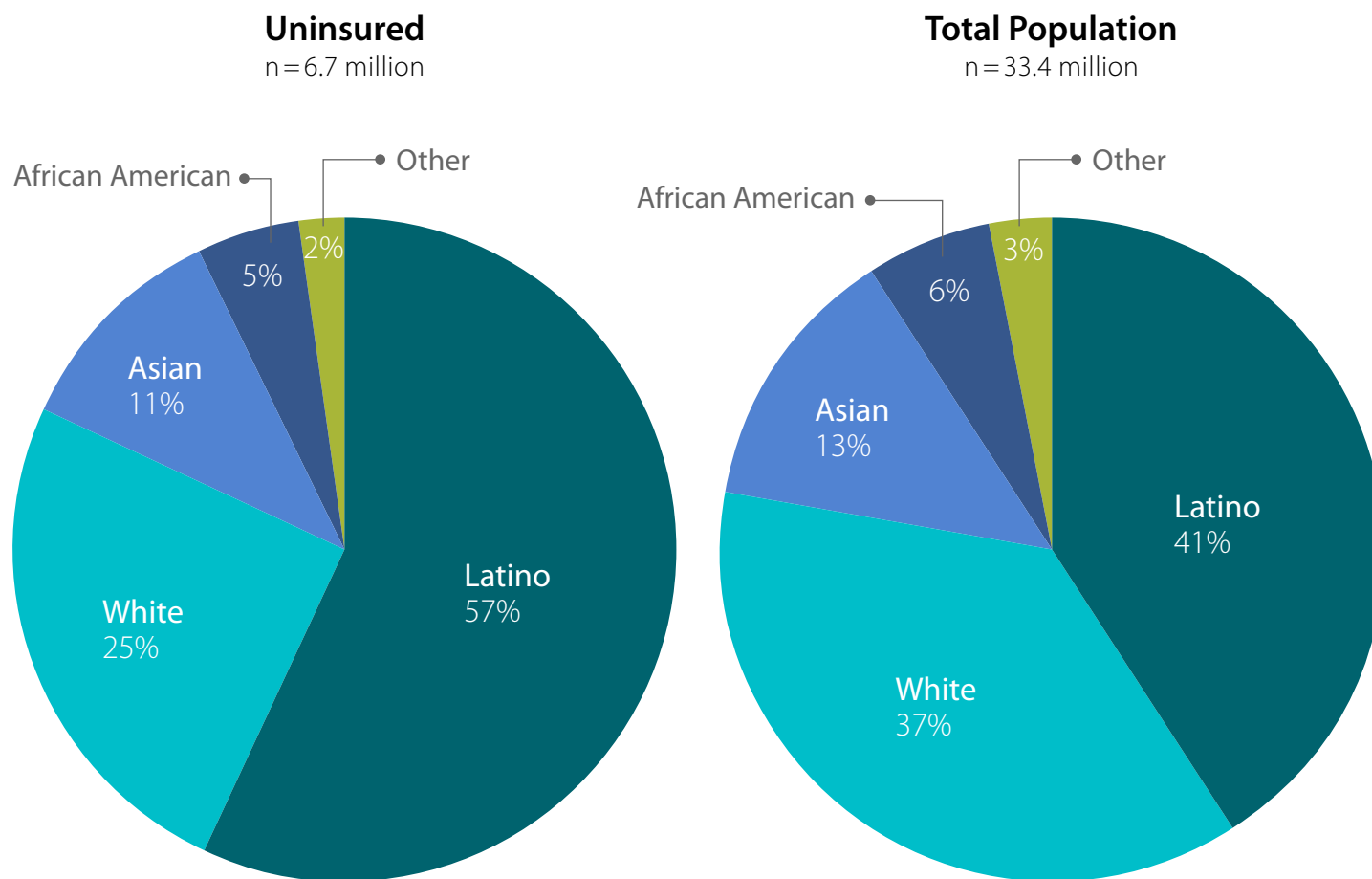
# Race/Ethnicity of the Uninsured vs. Total Population

## California, 2012

### California's Uninsured

by Race/Ethnicity

In California, Latinos represent 41% of the general population, but account for 57% of the uninsured population.



Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Highest Uninsured Noncitizen Rates by State, 2012

	TOTAL POPULATION		PERCENTAGE UNINSURED	
	IN MILLIONS	NONCITIZENS	CITIZENS	NONCITIZENS
<b>United States</b>	<b>266.9</b>	<b>7.7%</b>	<b>15.4%</b>	<b>45.2%</b>
Texas	23.2	11.8%	22.5%	63.6%
Nevada	2.4	10.8%	23.7%	54.5%
<b>California</b>	<b>33.4</b>	<b>14.5%</b>	<b>16.2%</b>	<b>42.9%</b>
New Jersey	7.4	11.8%	12.5%	42.2%
New York	16.4	10.6%	10.5%	33.7%

## California's Uninsured

by Citizenship

While California has the largest population of noncitizens in the nation, it is not the state with the largest percentage of uninsured noncitizens. Sixty-four percent of Texan noncitizens and 55% of noncitizens in Nevada were uninsured. Among noncitizens in California, 43% were uninsured.

Notes: All numbers reflect the population under age 65. Includes only those states with at least 10% noncitizens, among states with at least 75,000 noncitizens.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

## About the Author

Paul Fronstin, Director, Health Education and Research Program  
Employee Benefit Research Institute

## About the Data

Data presented in this report come from the March Supplement to the Current Population Survey (CPS) conducted by the US Census Bureau for the Bureau of Labor Statistics. The monthly CPS is the primary source of data on labor force characteristics of the US civilian, noninstitutionalized population. It is also the official source of data on unemployment rates, poverty, and income in the US. Approximately 98,000 households, representing nearly 203,000 individuals, were interviewed in March 2013 as part of the CPS.

### FOR MORE INFORMATION



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Data tables for the presentation are available at:  
[www.chcf.org](http://www.chcf.org).

# CALIFORNIA HEALTH CARE ALMANAC



## California's Uninsured: By the Numbers

DECEMBER 2013

# Introduction

California had the greatest number of uninsured residents of any state, 7 million, and the seventh largest percentage of uninsured residents under 65 in the United States. The percentage of Californians who receive coverage through their jobs has declined dramatically, dropping from 63% in 1988 to 54% in 2012. While public insurance has mostly covered this gap, 20% of Californians remain uninsured.

With the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA), the numbers of uninsured residents in California will be reduced, although a significant number will be left behind.\*

*California's Uninsured: By the Numbers* provides a look at California's uninsured population before full implementation of the ACA.

### KEY FINDINGS INCLUDE:

- While one in five Californians overall is uninsured, the rate among those who work is even higher: one in four.
- Employees in businesses of all sizes are more likely to be uninsured in California than in the United States. In businesses with fewer than 10 employees, 40% of workers are likely to have no insurance.
- Nearly one-third of the uninsured in California have annual family incomes of \$50,000 or more.
- Sixty-two percent of uninsured children in California are in families where the head of the household worked full-time during 2012.
- Nearly 60% of California's uninsured population is Latino.

For more information on which groups will be left without insurance after ACA implementation, see [www.chcf.org](http://www.chcf.org).

## California's Uninsured

### Overview

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\*In 2015, an estimated 5.6 million Californians will be uninsured. Of this population, 2.6 million are expected to take up coverage, but 3.1 million are expected to stay uninsured.

# State Comparison of the Uninsured

## 3-Year Average, 2010 to 2012

	TOTAL POPULATION	UNINSURED RESIDENTS	
	IN MILLIONS	IN MILLIONS	SHARE OF TOTAL
<b>United States</b>	<b>266.4</b>	<b>48.1</b>	<b>18.1%</b>
HIGHEST PROPORTION STATES			
Texas	22.9	6.1	26.9%
Nevada	2.3	1.6	25.7%
Florida	15.5	3.8	24.7%
New Mexico	1.7	0.4	24.4%
Montana	0.8	0.2	21.8%
Georgia	8.6	1.9	21.6%
<b>California</b>	<b>33.7</b>	<b>7.0</b>	<b>21.2%</b>

### California's Uninsured

Compared to Other States

California has the seventh-largest percentage and the largest total number of uninsured in the nation. Only three states (Hawaii, Massachusetts, and Vermont) have uninsured rates under 10%.

Note: All numbers reflect the population under age 65.

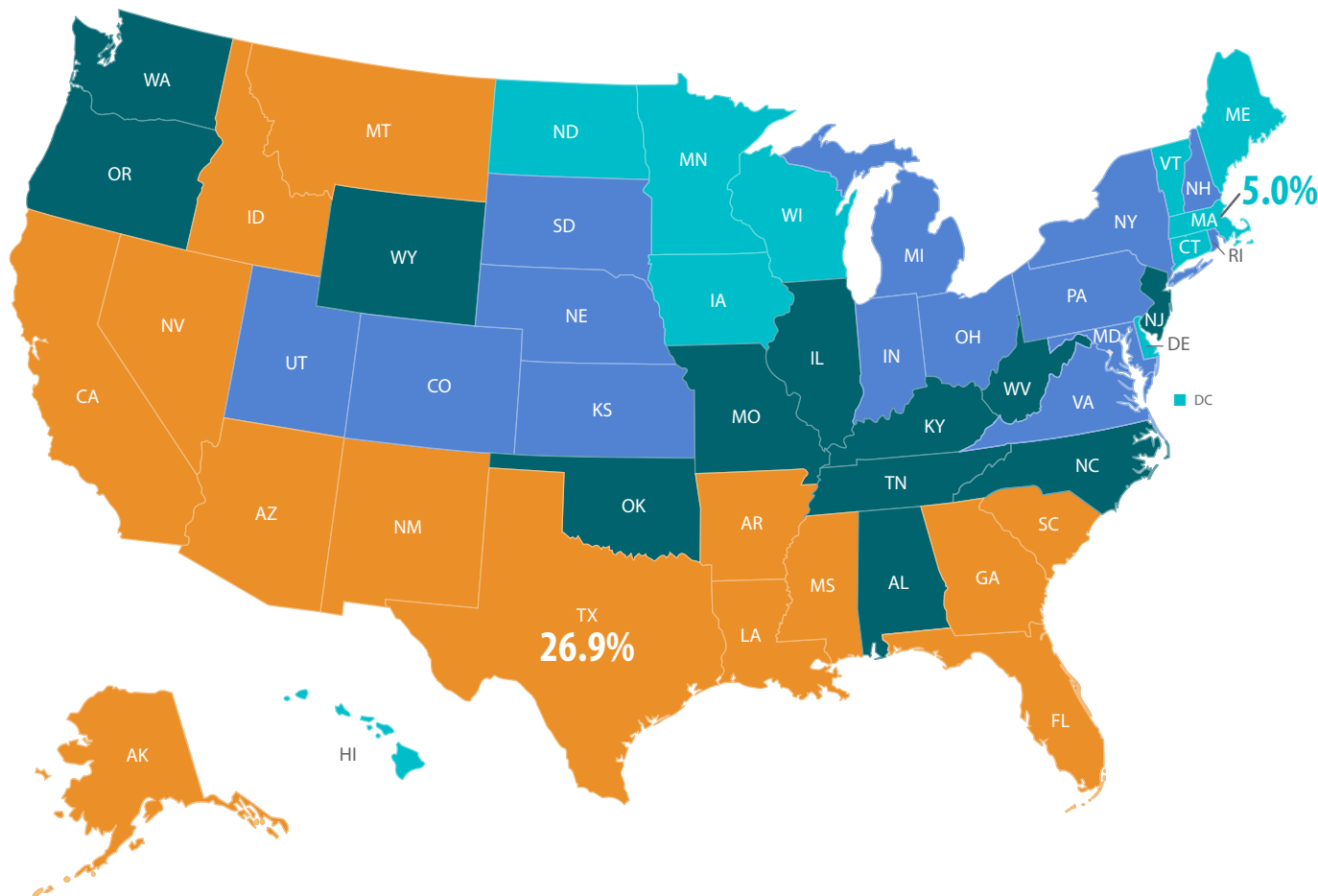
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2011–2013 March Supplements.

# National Comparison of the Uninsured

## 3-Year Average, 2010 to 2012

### PERCENTAGE OF UNINSURED RESIDENTS

■ 0.0% to 12.9%   
 ■ 13.0% to 15.9%   
 ■ 16.0% to 19.9%   
 ■ 20.0% and higher



### California's Uninsured

Comparison to Other States

In 14 states, including California, more than 20% of residents are not insured. Texas has the highest rate of uninsured residents (27%); Massachusetts has the lowest (5%).

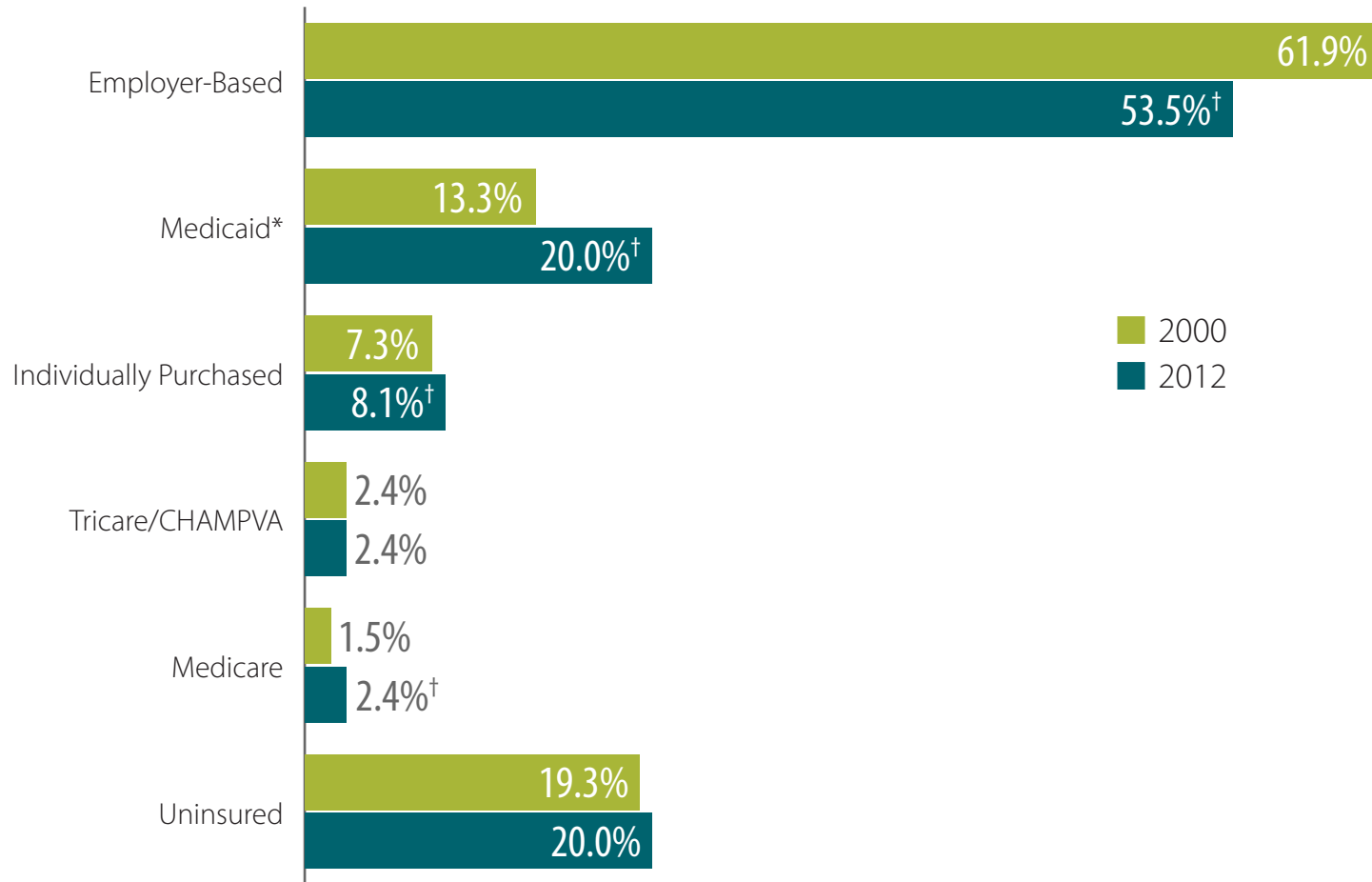
Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2011–2013 March Supplements.



# Health Insurance Sources

California, 2000 and 2012



\*Includes Medi-Cal and Healthy Families.

†Statistically significant from 2000 numbers at  $p \leq 0.05$  level.

Notes: All numbers reflect the population under age 65. Details may not add to totals because individuals may receive coverage from more than one source. TRICARE (formally known as CHAMPUS) is a program administered by the Department of Defense for military retirees and family members of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2001 and 2013 March Supplements.

## California's Uninsured

Coverage Sources and Trends

Over the past 12 years, Medicaid

has partially offset declining

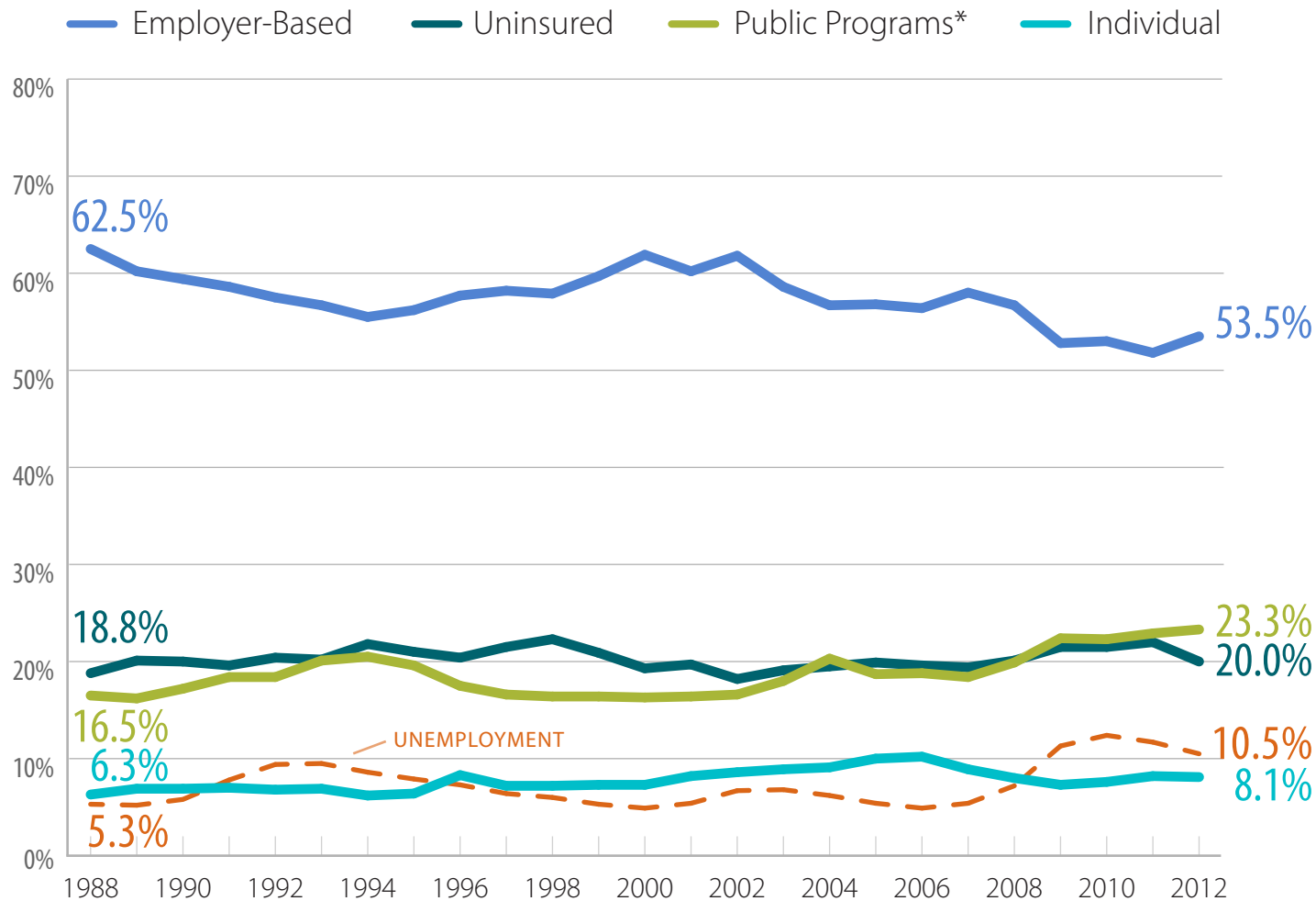
employer-based insurance.

In 2012, one in five Californians

was uninsured.

# Insurance Coverage Source and Unemployment Trends

## California, 1988 to 2012



Although slightly more than half of Californians still receive health insurance through their employers, employer-based coverage has declined substantially since 1988.

\*Includes Medi-Cal, Healthy Families, Medicare, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1987–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Unemployment rates are annual averages without seasonal adjustment.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988–2013 March Supplements.

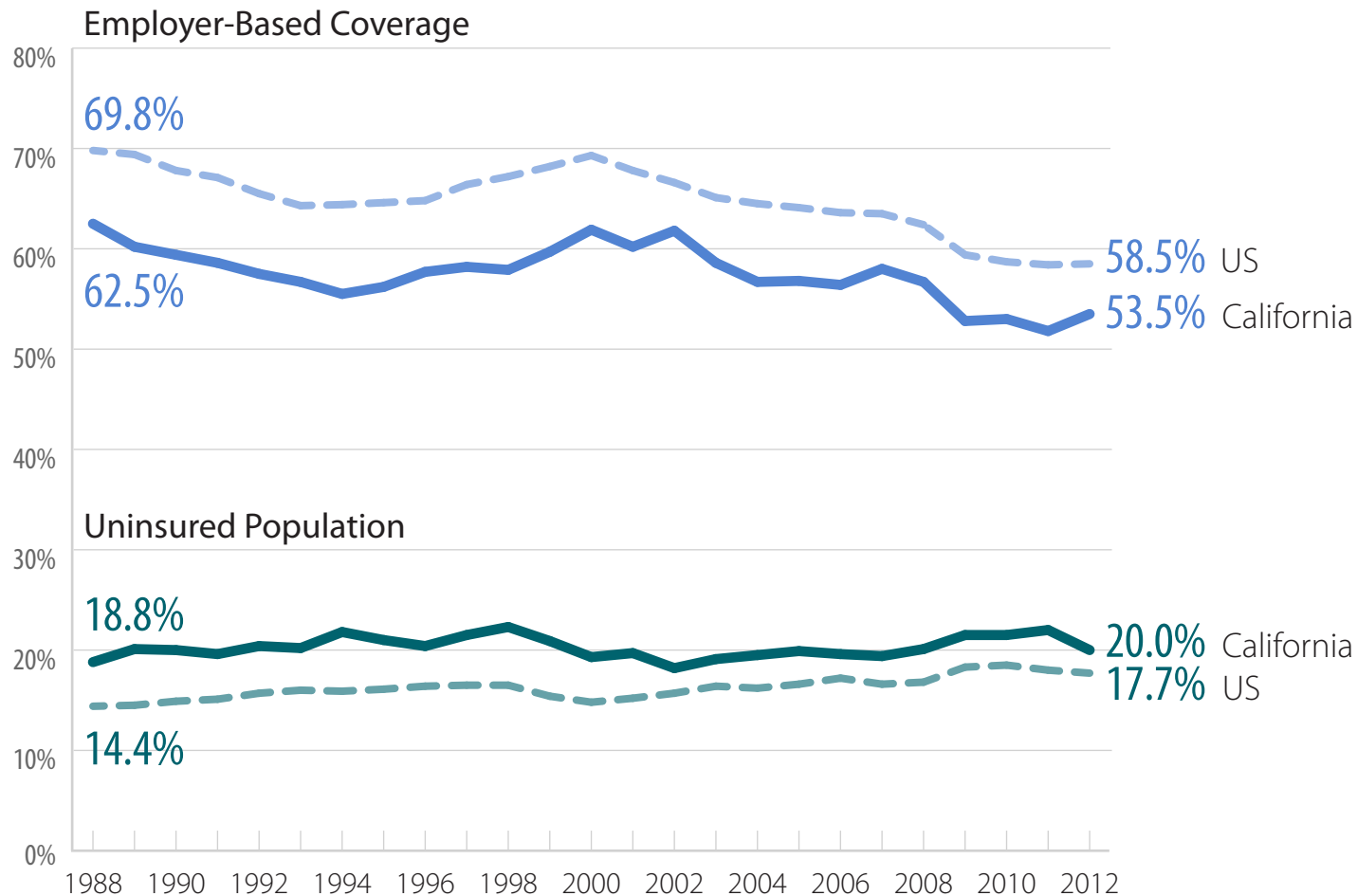
# Employer-Based Coverage and Uninsured Trends

California vs. United States, 1988 to 2012

## California's Uninsured

Coverage Sources and Trends

California has a greater proportion of uninsured residents and lower rates of employer-based coverage than the nation as a whole.



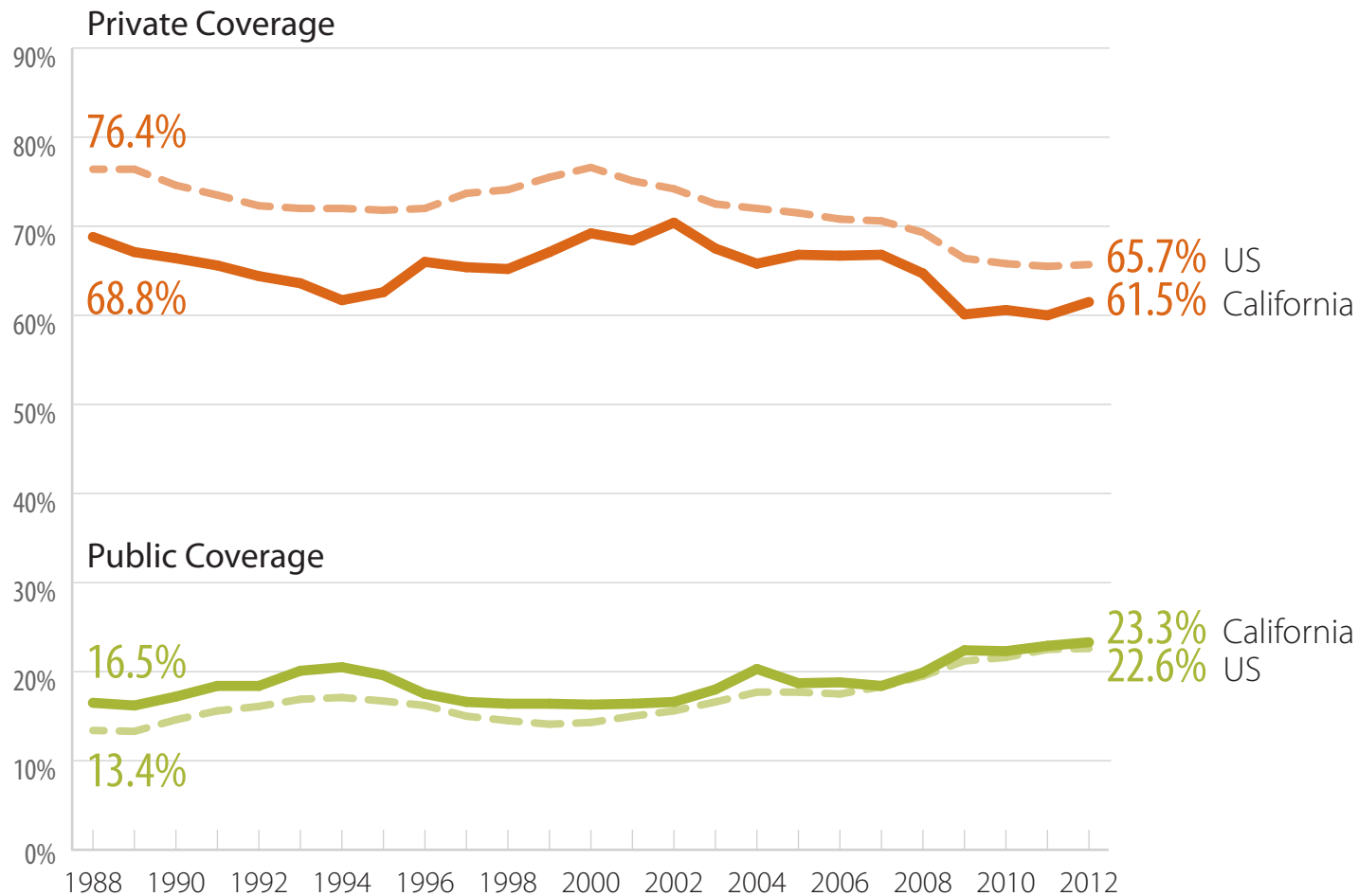
Notes: All numbers reflect the population under age 65. 1987–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Unemployment rates are annual averages without seasonal adjustment.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988–2013 March Supplements.

# Private and Public Coverage Trends

## California vs. United States, 1988 to 2012

While the rate of public coverage for California and the US is comparable, California has lagged the nation in the rate of private coverage.

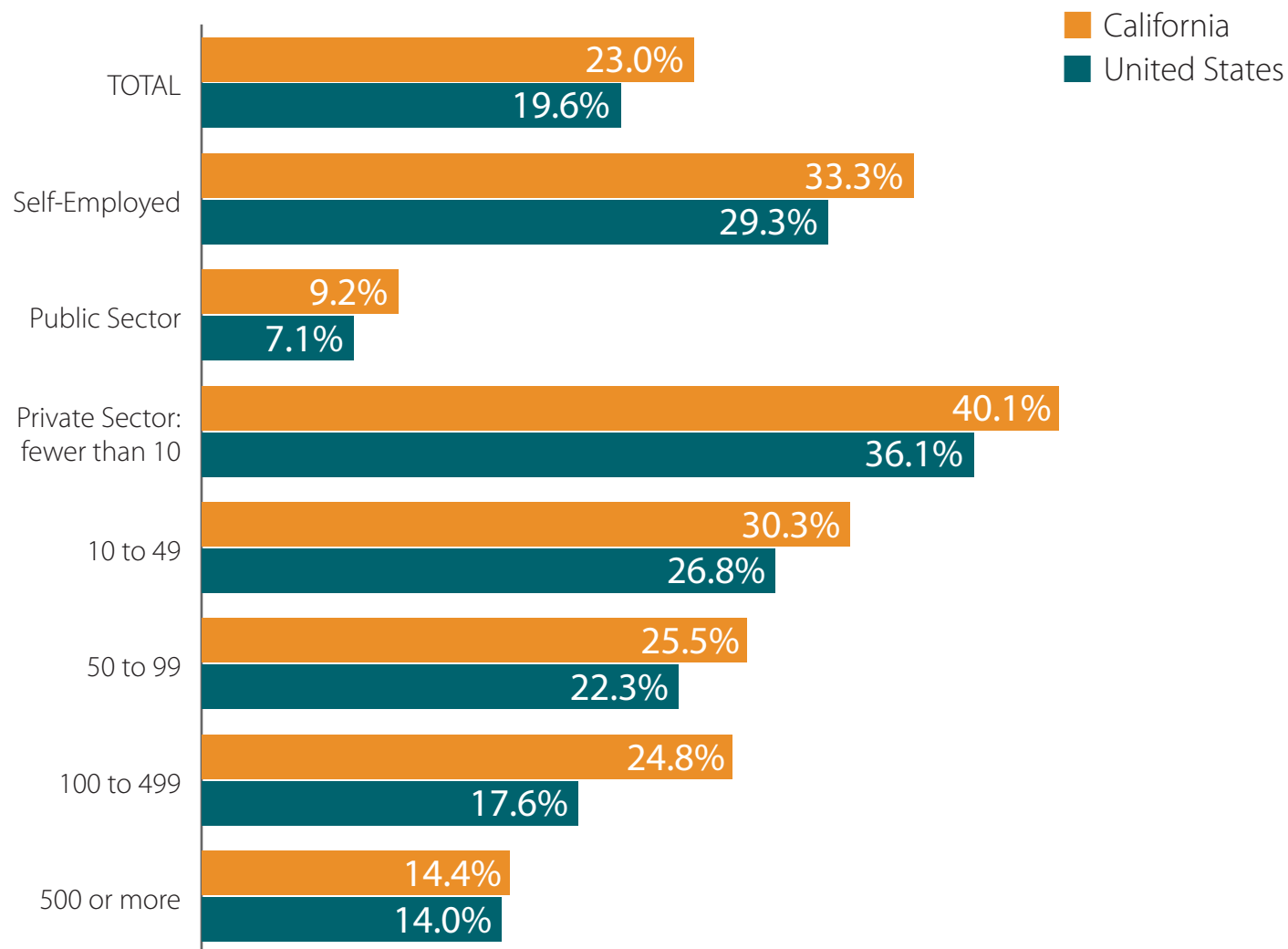


Notes: All numbers reflect the population under age 65. 1987–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1988–2013 March Supplements.

# Likelihood of Workers Being Uninsured

## by Employer Size and Type, California vs. United States, 2012



### California's Uninsured

by Employer Size and Type

Compared to workers in other sectors and in larger companies, those who work in businesses with fewer than 10 employees are the most likely to have no insurance (40% in California). One-third of self-employed Californians are likely to go without health insurance.

Notes: All numbers reflect the working population, age 18 to 64. Private sector sorted by number of workers.  
 Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Uninsured Workers vs. Total Workers

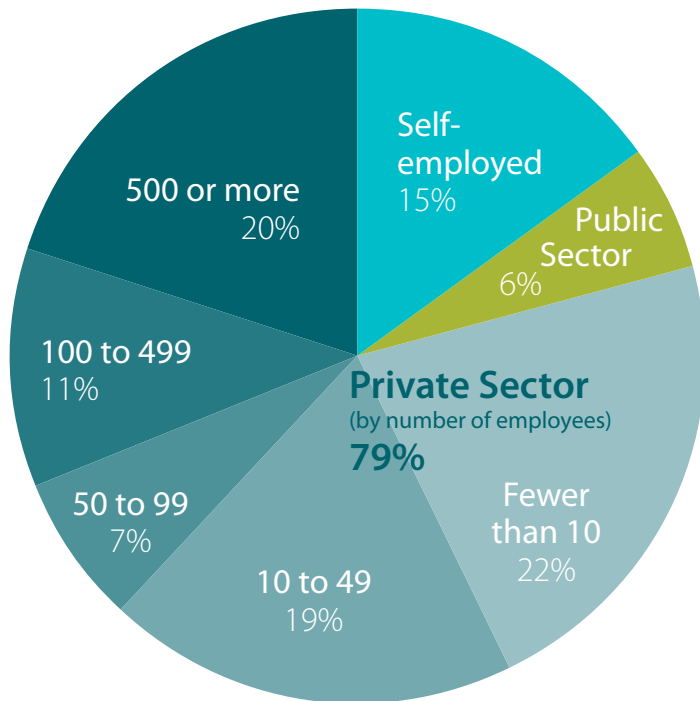
## by Employer Size and Type, California, 2012

### California's Uninsured

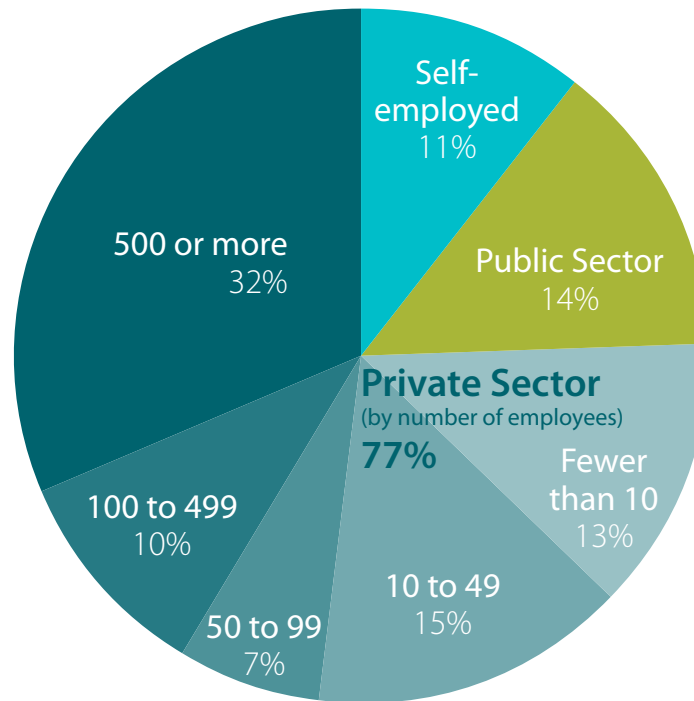
by Employer Size and Type

Slightly more than 30% of California's uninsured workers are employed by companies with 100 or more workers. About one in four workers in California is uninsured.

**Uninsured Workers**  
n=4.1 million



**Total Workers**  
n=17.7 million

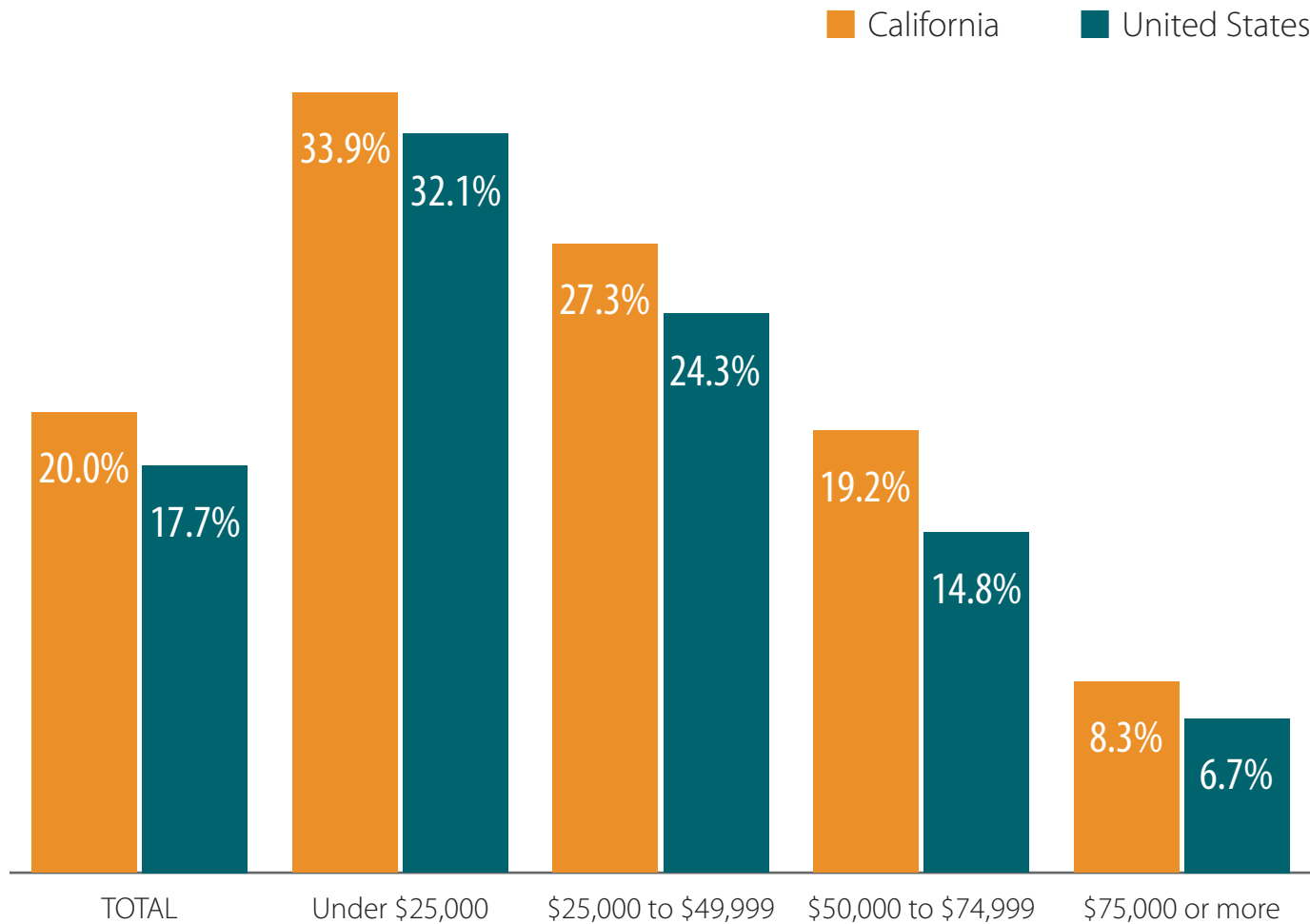


Notes: All numbers reflect the working population, age 18 to 64. Segments may not add to 100% due to rounding.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Likelihood of Being Uninsured, by Family Income

## California vs. United States, 2012



### California's Uninsured by Family Income

Californians with annual family incomes below \$25,000 are most likely to be uninsured. At all income levels, Californians are more likely to be uninsured than US residents.

Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Family Income of the Uninsured

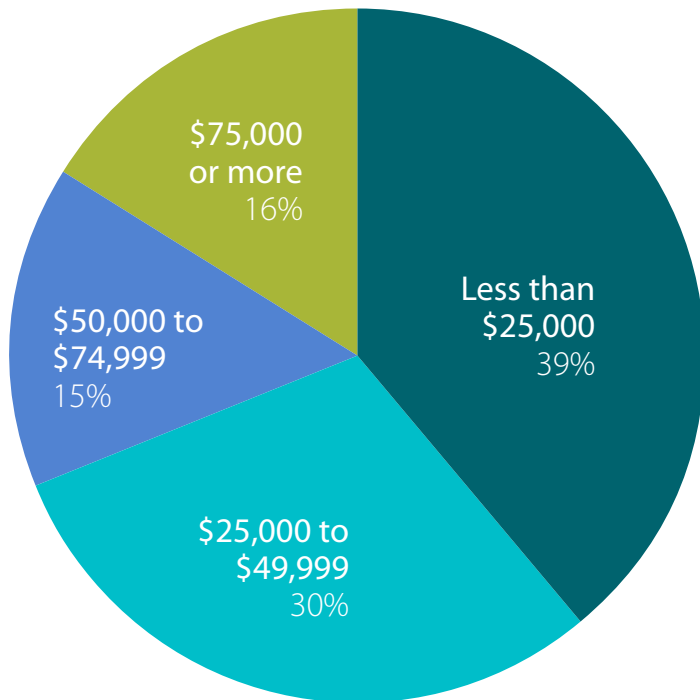
## California vs. United States, 2012

### California's Uninsured

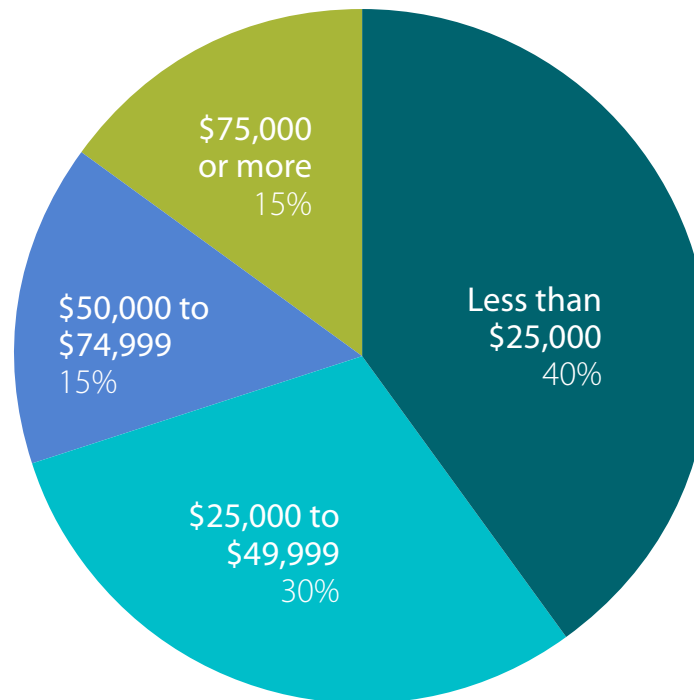
by Family Income

Nearly one-third of the uninsured, in California and in the US, have annual family incomes of \$50,000 or more.

**California**  
n=6.7 million



**United States**  
n=47.3 million



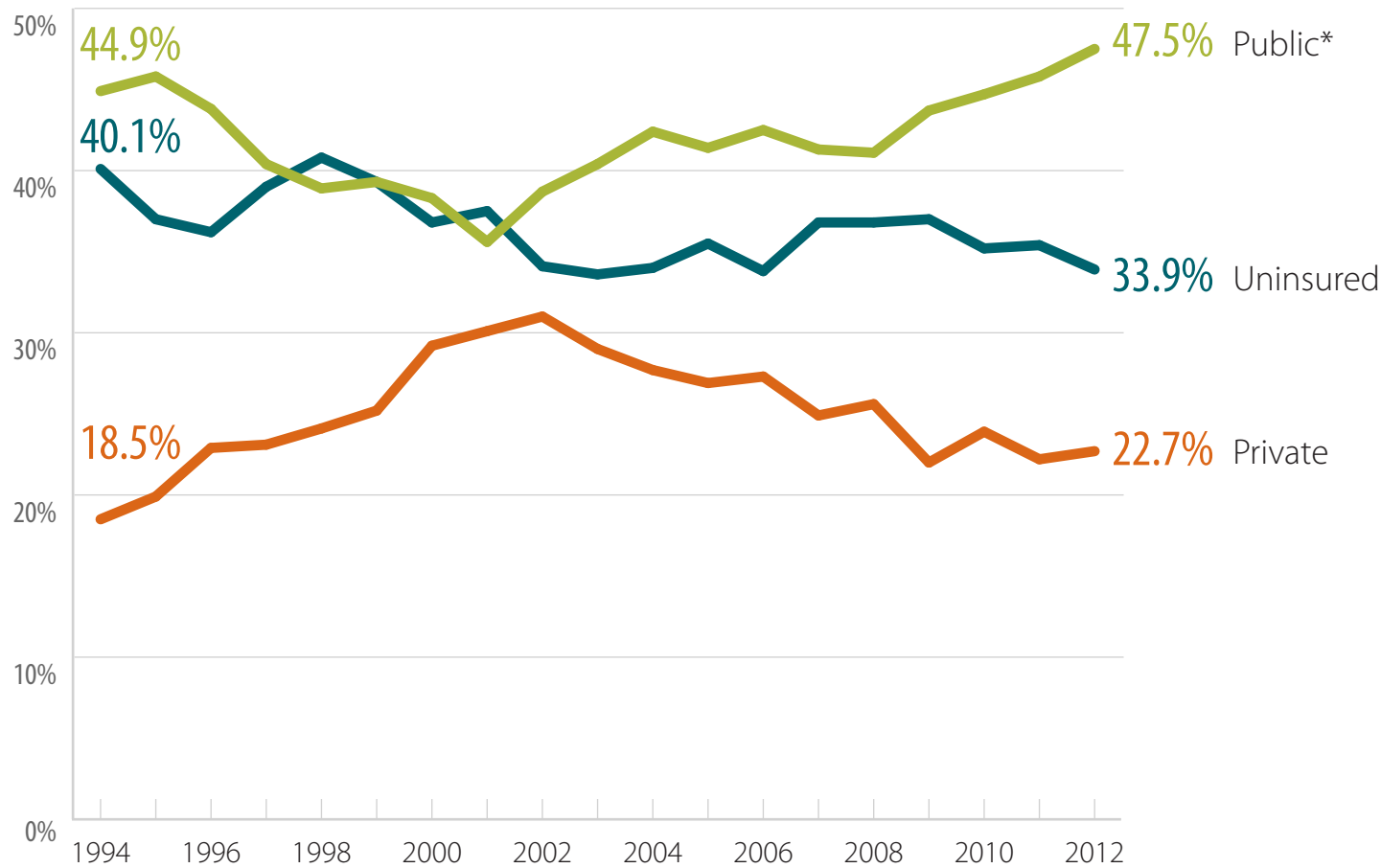
Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.



# Insurance Source Trends, Family Income Below \$25,000

California, 1994 to 2012



## California's Uninsured

by Family Income

Among Californians with family incomes below \$25,000, more were likely to be covered by public programs, and fewer were uninsured in 2012 than in 1994.

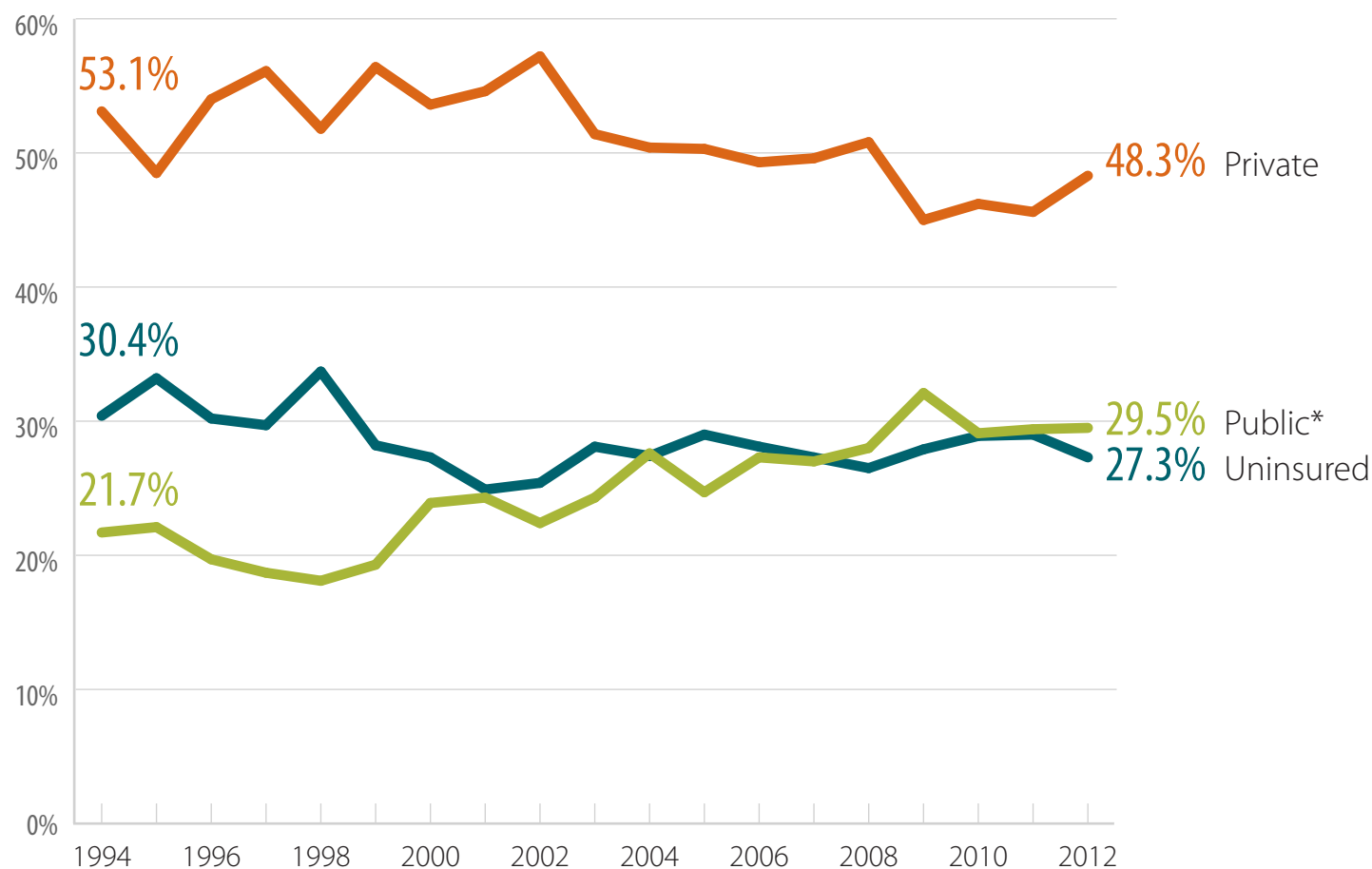
\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

# Insurance Source Trends, Family Income \$25,000 to \$49,999

## California, 1994 to 2012



### California's Uninsured

by Family Income

Among Californians with family incomes between \$25,000 and \$49,999, the percentage likely to be covered by public programs increased between 1994 and 2012.

\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

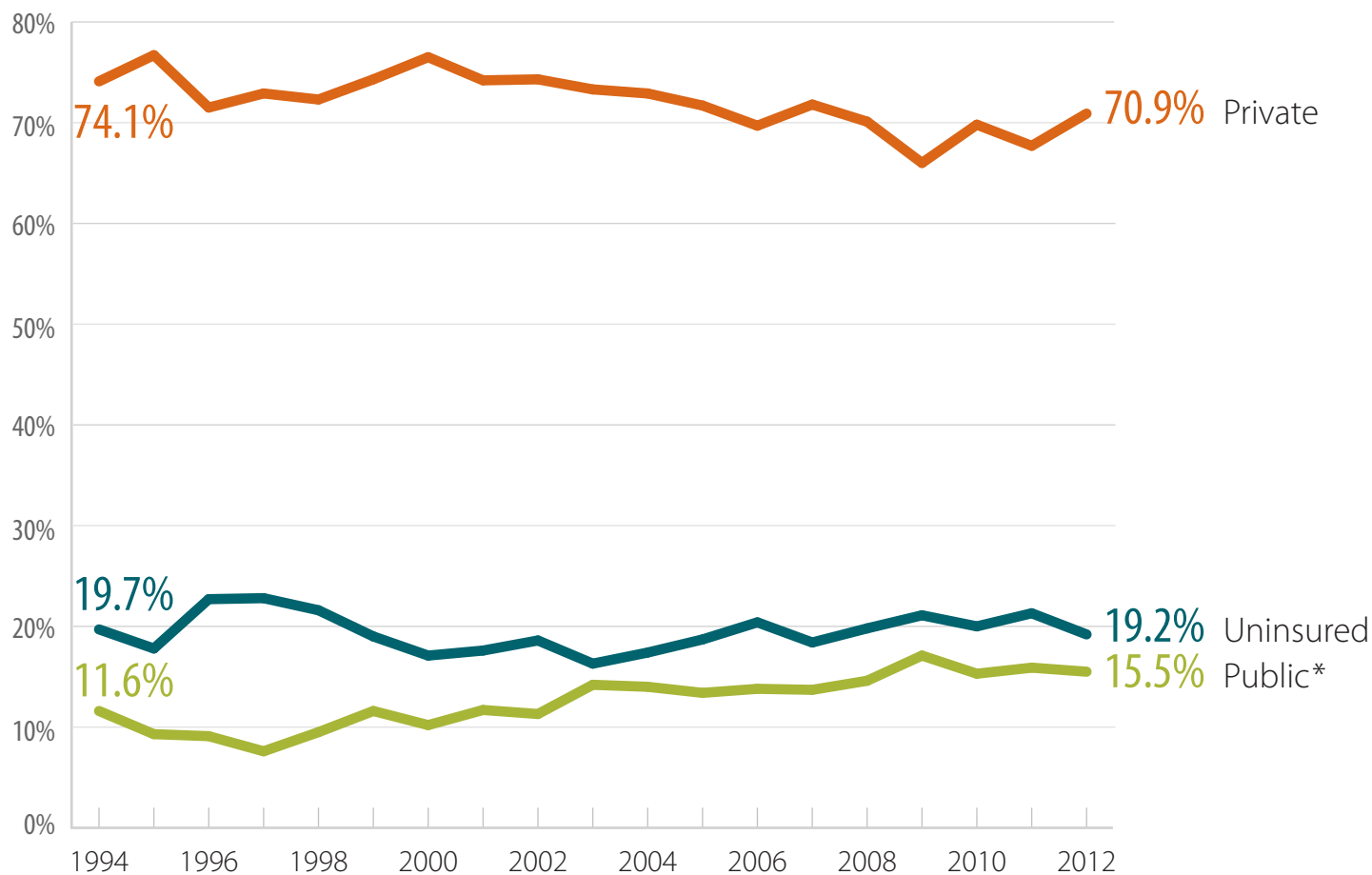
# Insurance Source Trends, Family Income \$50,000 to \$74,999

## California, 1994 to 2012

### California's Uninsured

by Family Income

About 15% of Californians with annual family incomes between \$50,000 to \$74,999 rely on public health insurance. This percentage has increased slightly since 1994.



\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

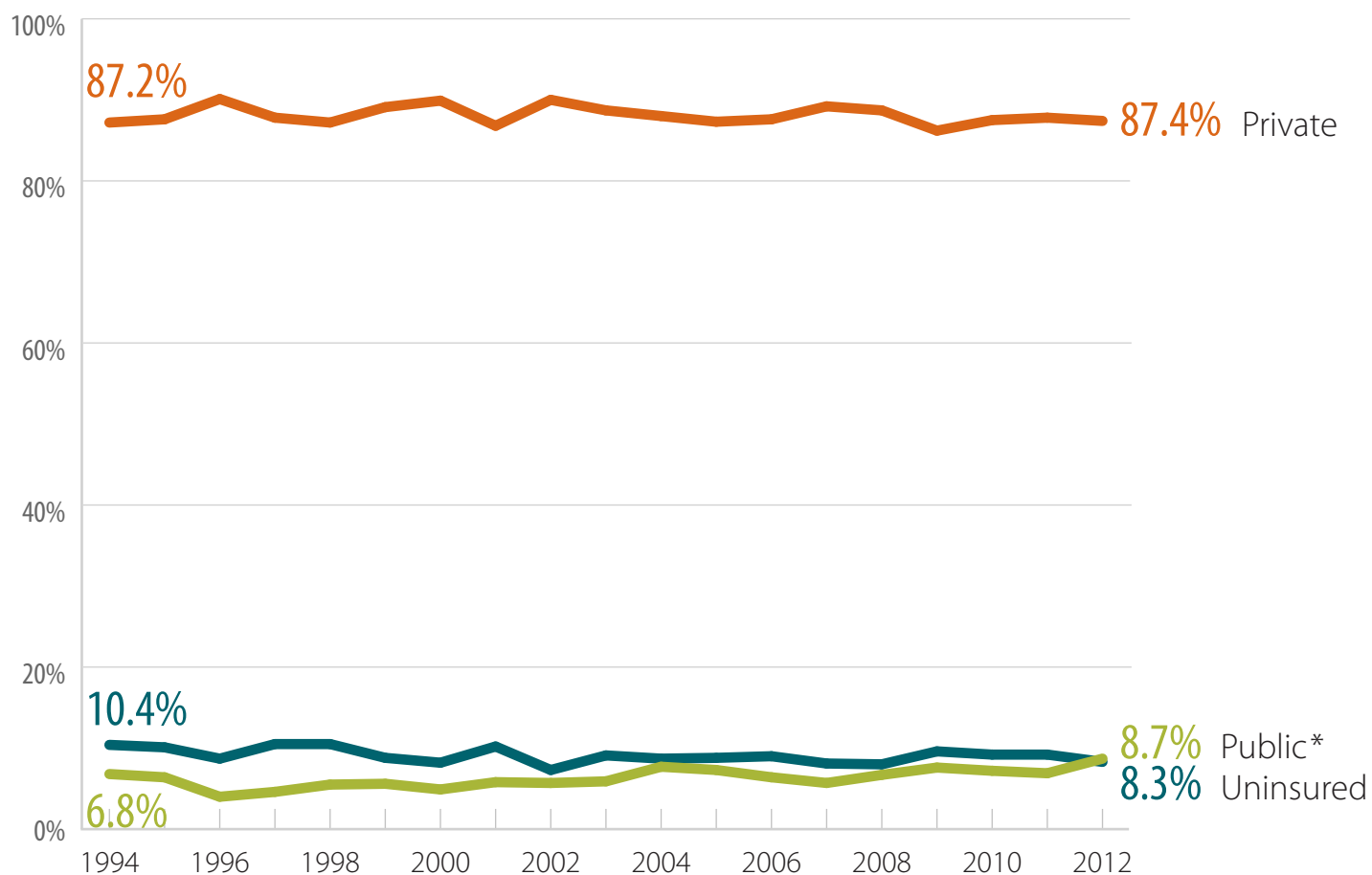
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

# Insurance Source Trends, Family Income \$75,000 and Over California, 1994 to 2012

## California's Uninsured

by Family Income

The vast majority of Californians with family incomes of at least \$75,000 are covered by private health insurance; however, 8% are uninsured.



\*Includes Medi-Cal, Healthy Families, and Tricare/CHAMPVA.

Notes: All numbers reflect the population under age 65. 1994–1998 data are not directly comparable with 1999–2012 data because of a methodological change in the way individuals with coverage were counted. Income is adjusted for inflation.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 1995–2013 March Supplements.

# Eligibility for Public Health Insurance Programs

## Uninsured California Residents, 2012

### California's Uninsured

by Age Group

Up to 75% of California's uninsured children were eligible for Medi-Cal or Healthy Families in 2012, but only 10% of adults were eligible. Beginning in 2014, under the Affordable Care Act, many more uninsured adults will become eligible for Medi-Cal.

	WITHOUT ADJUSTMENT FOR TIME IN UNITED STATES*		WITH ADJUSTMENT FOR TIME IN UNITED STATES†	
	NUMBER	SHARE OF TOTAL	NUMBER	SHARE OF TOTAL
<b>ADULTS (AGES 19 TO 64)</b>				
<b>Total Uninsured</b>	<b>5,575,177</b>	<b>100%</b>	<b>5,575,177</b>	<b>100%</b>
Eligible for Medi-Cal‡	257,956	5%	566,179	10%
Not Eligible	5,317,221	95%	5,008,998	90%
<b>CHILDREN (AGE 18 AND UNDER)</b>				
<b>Total Uninsured</b>	<b>1,119,639</b>	<b>100%</b>	<b>1,159,639</b>	<b>100%</b>
Eligible for Medi-Cal‡	370,317	33%	455,567	39%
Eligible for Healthy Families‡	378,392	34%	421,415	36%
Not Eligible	370,930	33%	282,657	24%

\*Excludes all noncitizens from eligibility.

†Excludes noncitizens from eligibility if in United States less than five years.

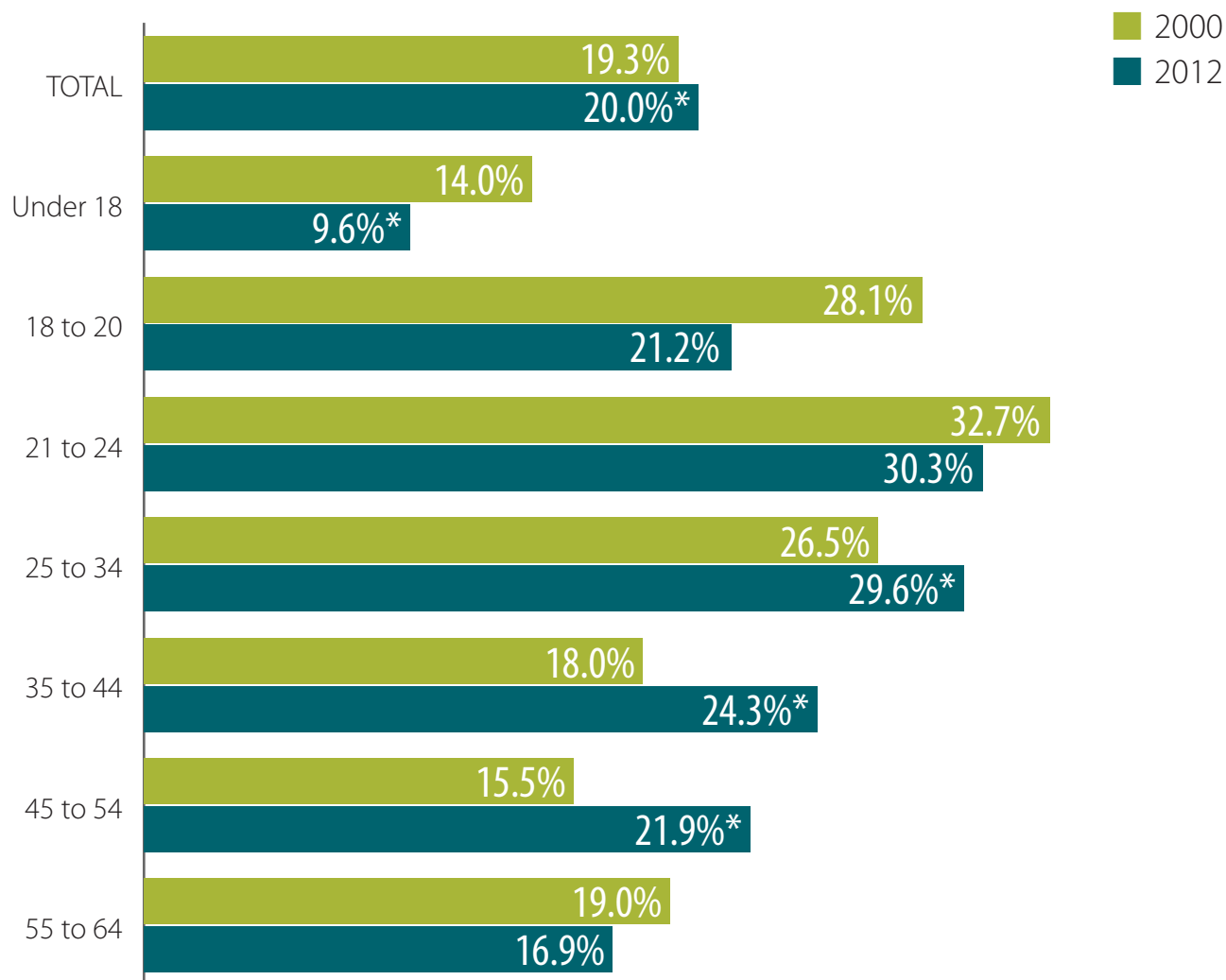
‡CPS collects data on citizenship but not immigration status. The lower number without adjustment underestimates eligible residents because it is restricted to citizens; the higher number with adjustment overestimates eligible residents because it includes all noncitizens who have resided in the US for at least five years (regardless of immigration status).

Notes: The uninsured may be eligible for other public programs. For more information, see *The Crucial Role of Counties in the Health of Californians: An Overview* at [www.chcf.org](http://www.chcf.org). May not add to 100% due to rounding.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Likelihood of Being Uninsured, by Age Group

## California, 2000 and 2012



### California's Uninsured

by Age Group

For adults 25 to 54, the likelihood of being uninsured rose between 2000 and 2012. In contrast, adults under 25 and those 55 to 64 were less likely to be uninsured in 2012 than in 2000.

\*Statistically significant from 2000 numbers at  $p \leq 0.05$  level.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2001 and 2013 March Supplements.

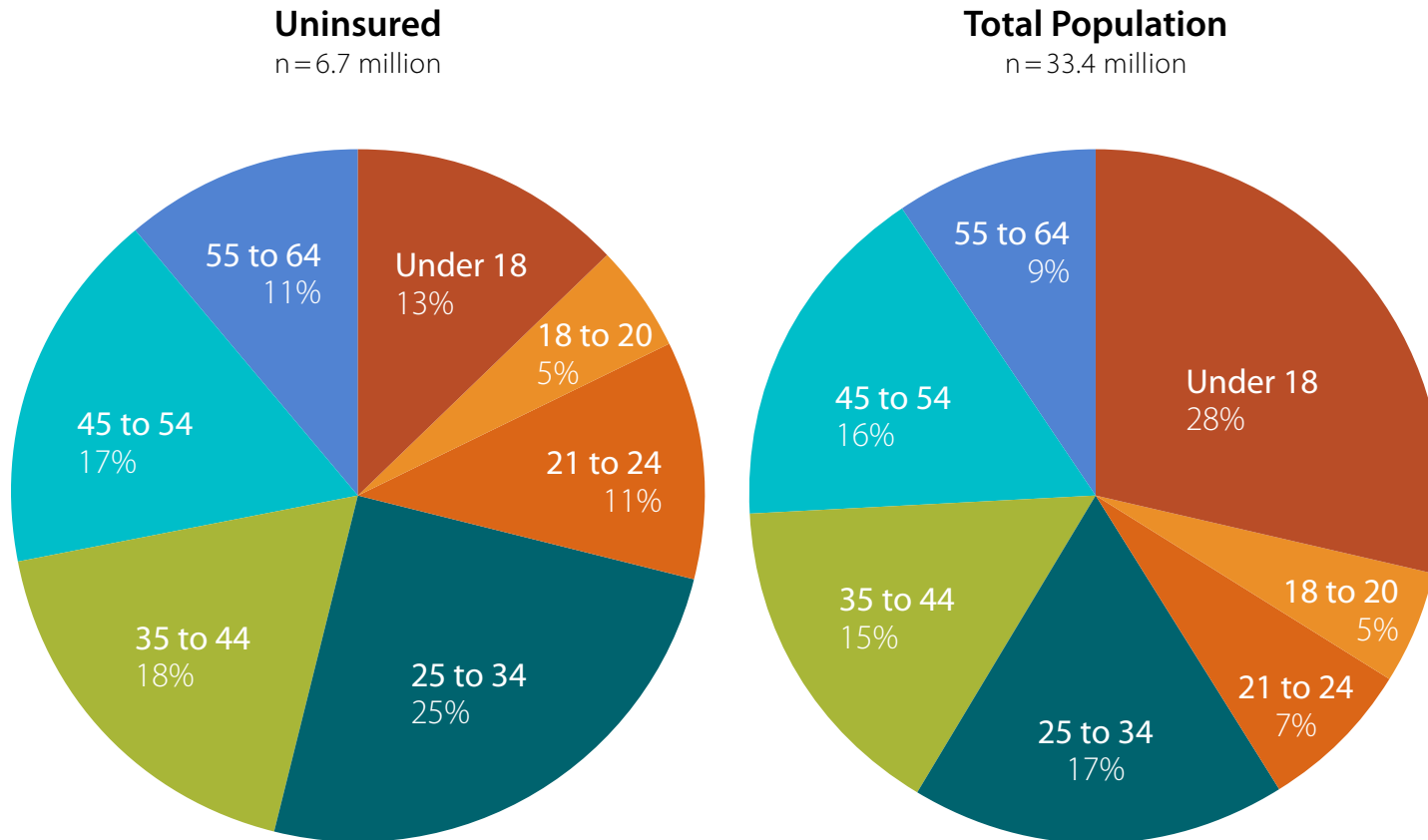
# Age Group of the Uninsured vs. Total Population

## California, 2012

### California's Uninsured

by Age Group

Thirteen percent of California's uninsured are children, but children make up almost one-third of the state's total nonelderly population. One in four of those uninsured is between age 25 and 34.



Note: Segments may not add to 100% due to rounding.

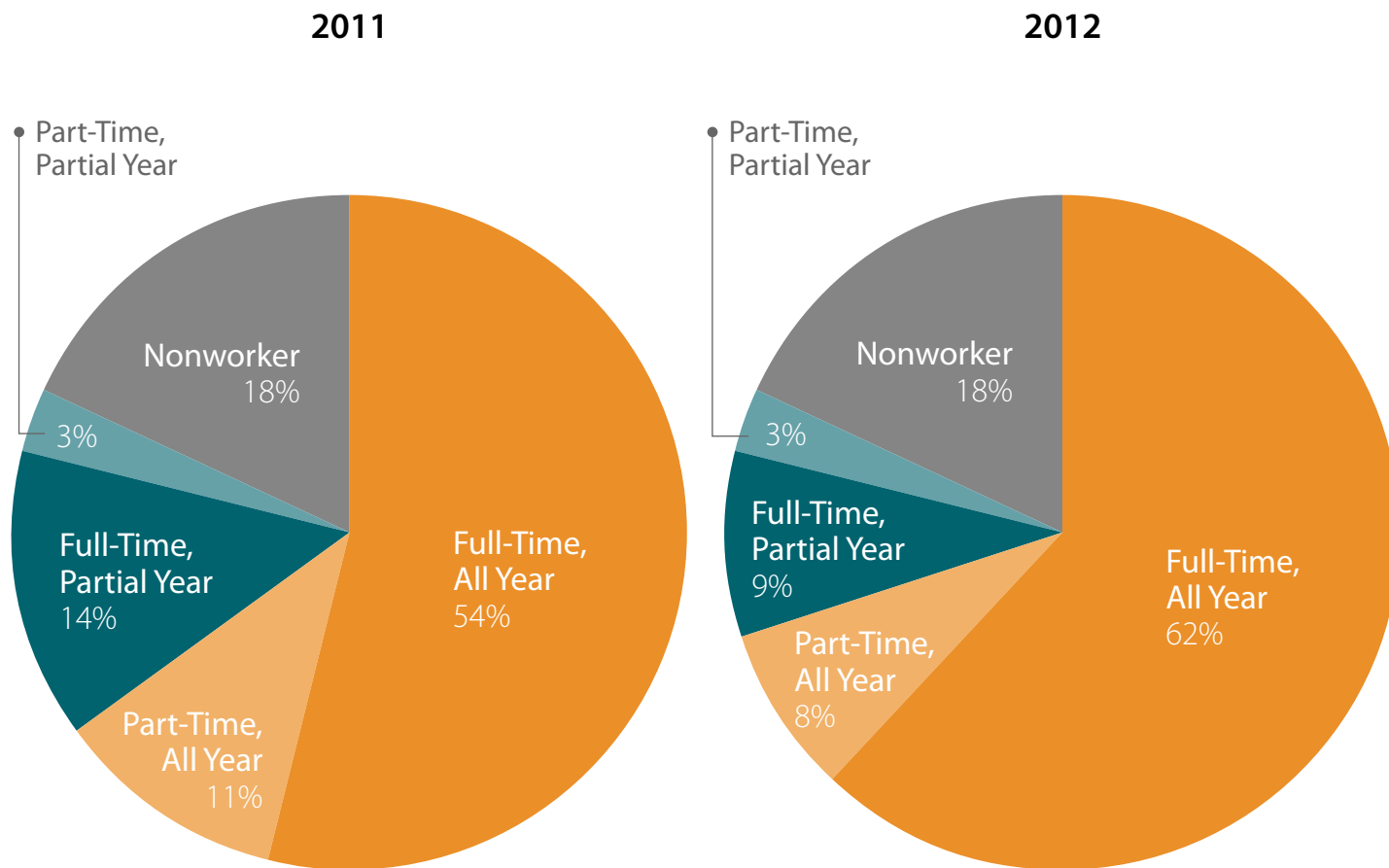
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Uninsured Children, by Work Status of Head of Household California, 2011 and 2012

## California's Uninsured

by Work Status

Sixty-two percent of California's uninsured children live in families where the head of household worked full-time over the calendar year 2012. This percentage is up from 54% in 2011.



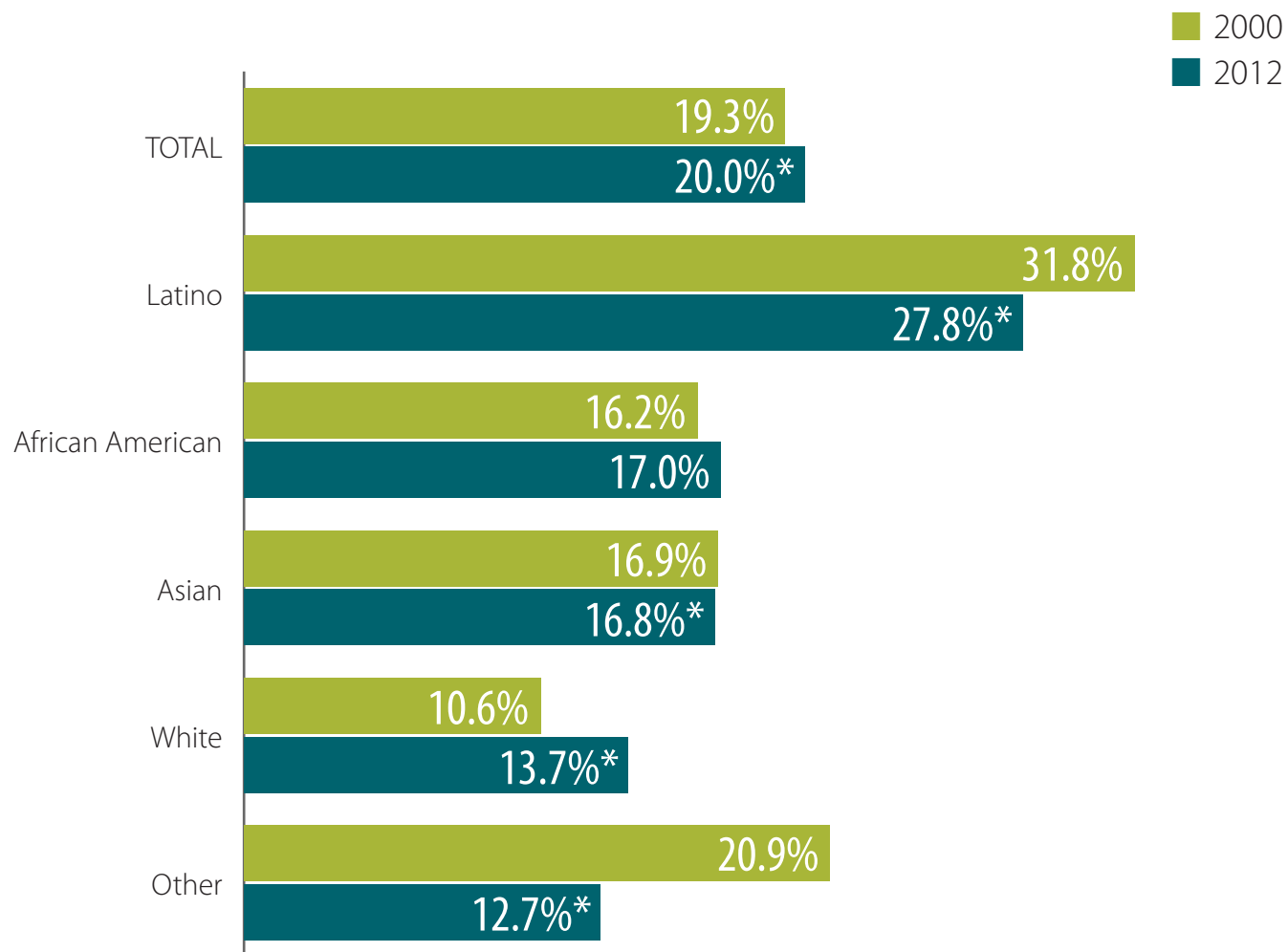
Note: All numbers reflect the population under age 18.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.



# Likelihood of Being Uninsured, by Race/Ethnicity

## California, 2000 and 2012



### California's Uninsured

by Race/Ethnicity

Latinos in California are much more likely to be uninsured than other ethnic groups, and twice as likely as Whites. Nearly three in ten Latinos are uninsured.

\*Statistically significant from 2000 numbers at  $p \leq 0.05$  level.

Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2001 and 2013 March Supplements.

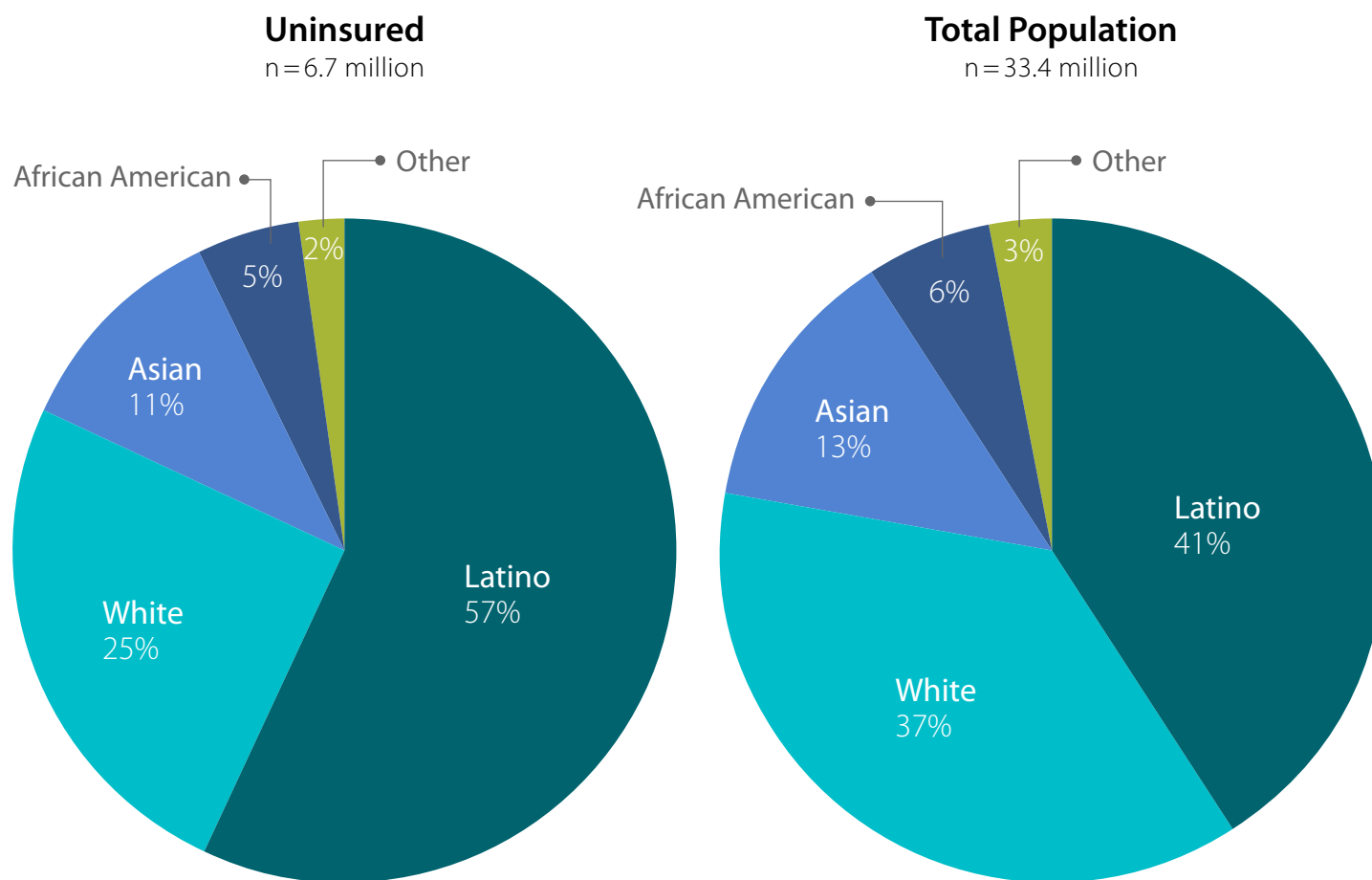
# Race/Ethnicity of the Uninsured vs. Total Population

## California, 2012

### California's Uninsured

by Race/Ethnicity

In California, Latinos represent 41% of the general population, but account for 57% of the uninsured population.



Note: All numbers reflect the population under age 65.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

# Highest Uninsured Noncitizen Rates by State, 2012

	TOTAL POPULATION		PERCENTAGE UNINSURED	
	IN MILLIONS	NONCITIZENS	CITIZENS	NONCITIZENS
<b>United States</b>	<b>266.9</b>	<b>7.7%</b>	<b>15.4%</b>	<b>45.2%</b>
Texas	23.2	11.8%	22.5%	63.6%
Nevada	2.4	10.8%	23.7%	54.5%
<b>California</b>	<b>33.4</b>	<b>14.5%</b>	<b>16.2%</b>	<b>42.9%</b>
New Jersey	7.4	11.8%	12.5%	42.2%
New York	16.4	10.6%	10.5%	33.7%

## California's Uninsured

by Citizenship

While California has the largest population of noncitizens in the nation, it is not the state with the largest percentage of uninsured noncitizens. Sixty-four percent of Texan noncitizens and 55% of noncitizens in Nevada were uninsured. Among noncitizens in California, 43% were uninsured.

Notes: All numbers reflect the population under age 65. Includes only those states with at least 10% noncitizens, among states with at least 75,000 noncitizens.

Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2013 March Supplement.

## About the Author

Paul Fronstin, Director, Health Education and Research Program  
Employee Benefit Research Institute

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Data tables for the presentation are available at:  
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# Realizing Health Reform's Potential

## *How Are State Insurance Marketplaces Shaping Health Plan Design?*

SARA ROSENBAUM, NANCY LOPEZ, DEVI MEHTA,  
MARK DORLEY, TAYLOR BURKE, AND ALICIA WIDGE

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1719  
Vol. 33

**Abstract:** Part of states' roles in administering the new health insurance marketplaces is to certify the health plans available for purchase. This analysis focuses on how state-based and state partnership marketplaces are using their flexibility in setting certification standards to shape plan design in the individual market. It focuses on three aspects of certification: provider networks; inclusion of essential community providers; and benefit substitution, which allows plans to offer benefits that differ from a state's benchmark plan. A review of documents collected from 18 states and the District of Columbia finds that 13 states go beyond the minimum federal requirements with respect to provider network standards, four states specify additional standards for including essential community providers, and five states and Washington, D.C., bar benefit substitution. These interstate variations in plan design reflect the challenges policymakers face in balancing health care affordability, benefit coverage, and access to care through the marketplace plans.

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### OVERVIEW

On October 1, 2013, the health insurance marketplaces<sup>1</sup> established under the Affordable Care Act (ACA) began accepting enrollment by individuals and families into qualified health plans offered by private insurers. Coverage begins in January 2014 for people who enroll by December 23, 2013, and the initial open enrollment period ends on March 31, 2014. Certification of the plans being sold depends on several factors, including that plans are offered by licensed insurance issuers and meet minimum federal standards. However, federal regulations give states some flexibility over the certification standards.<sup>2</sup>

States also have flexibility in choosing how its marketplace will operate. A state may establish and operate its own state-based marketplace or choose a "federally facilitated marketplace" operated by the federal government.<sup>3</sup> States may also elect to enter into a formal "state partnership marketplace," with the partnership with the federal government focusing on issues related to consumer assistance and/or plan management.<sup>4</sup> Exhibit 1 shows that as of June 2013, 16 states and the District of Columbia had opted for a state-based approach to the individual marketplace, while seven had elected to partner with the federal government.

Marketplaces in the remaining states are being run by the federal government.

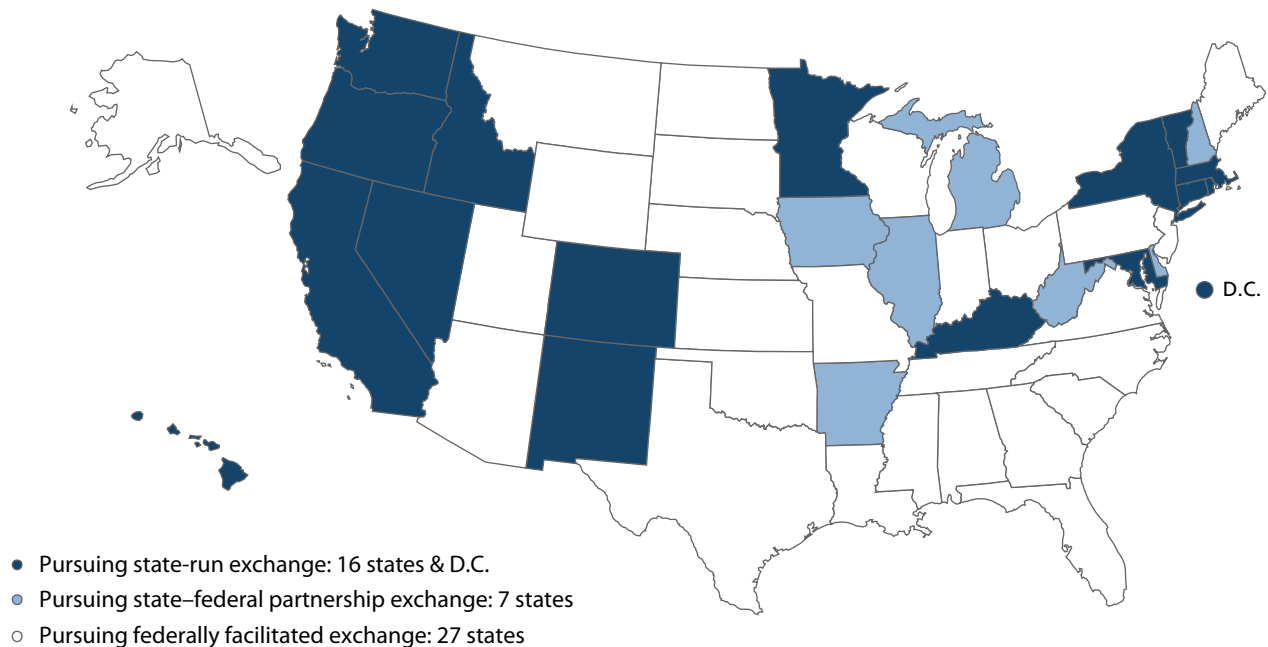
As described above, certification as a qualified health plan depends on two key factors. First, the plan issuer (the insurer) must be licensed and in good standing in the state. Second, the plan must meet minimum federal certification standards.<sup>5</sup> For example, the plan must provide information about benefits and rates, cover “essential health benefits” in a non-discriminatory fashion, and meet certain transparency requirements and minimum provider network adequacy standards.<sup>6</sup> One of the requirements for provider networks is that a plan must include certain “essential community providers.”<sup>7</sup> States operating their own marketplaces have the option to exclude plans that meet the certification requirements if they determine such exclusion to be in the best interest of individual and group buyers.<sup>8</sup>

Under federal law, states also have the power to set higher standards for health plans to qualify to sell in the exchange, as long as their standards do not “prevent the application” of (i.e., work against) federal

standards.<sup>9</sup> Federal regulations specify three areas in which states may adopt additional standards. First, states can decide whether they will permit plans to substitute one group of covered treatments for another (known as benefit substitution)—for example, offering less habilitative coverage and more rehabilitative coverage.<sup>10</sup> (Benefit substitution is not permitted in the case of prescribed drugs). Second, states can set more detailed provider network standards.<sup>11</sup> Third, states can set standards for the inclusion of certain “essential community providers” that treat medically underserved and vulnerable populations.<sup>12</sup> Examples of such providers include community health centers, family planning clinics, and clinics that receive Ryan White Care Act funding to furnish treatment to patients with HIV/AIDS. A more extensive list of essential community providers was issued by the federal government in April 2013.<sup>13</sup>

Because the marketplaces are new, there is limited evidence on how any particular certification standard ultimately may affect consumers’ access to

### Exhibit 1. What States Are Doing to Establish an Insurance Marketplace as of December 2013



Note: The U.S. Department of Health and Human Services denied Mississippi’s application for a state-run marketplace on February 7, 2013. Utah plans to operate its small-business marketplace. The federal government will operate the state’s individual marketplace.

In New Mexico, the federal government will operate the individual market in 2014.

Sources: National Conference of State Legislatures, Federal Health Reform: State Legislative Tracking Database, [www.ncsl.org/default.aspx?TabId=22122](http://www.ncsl.org/default.aspx?TabId=22122); Politico.com; Commonwealth Fund analysis.

care, the quality of care, or health outcomes. For their part, health insurers tend to view stricter regulation as adding to the price of plans. Therefore, in deciding whether and how to use their health plan certification flexibility, states must balance concerns about the possible effects of standards on access to care and care quality on the one hand, and costs on the other.

To learn how state-based and state partnership marketplaces are exercising their flexibility to shape plan design, we reviewed documents collected from 18 states and the District of Columbia (see p. 5 for more on our study methods). Our investigation focuses on three attributes of health plans: 1) provider networks; 2) the inclusion of essential community providers; and 3) benefit substitution.

## FINDINGS

### Provider Networks

**Federal standard.** Federal rules require that a plan's provider network be "sufficient in number and types of providers, including providers that specialized in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay."<sup>14</sup> The term "unreasonable delay" is not defined; without further definition, it would be up to a plan to define the term, and there could be considerable variation among plans in how reasonableness (in terms of travel time or wait time) is determined on matters such as routine care, appointments for preventive care, or appointments with specialists. While health plan industry accreditation standards (which differ from the federal certification process) do address network access and adequacy, these accreditation requirements are being phased in.<sup>15</sup>

**How states use their flexibility.** Thirteen of 18 states, as well as the District of Columbia, specify additional standards to supplement the federal rule on provider networks. [Appendix Table 1](#) presents examples of the most common criteria included in state approaches to defining a sufficient provider network. For example, 12 states have created some additional standards related to maximum travel time. Delaware specifies both

geographic distances and drive time for access to primary care services, as does Vermont. Colorado does not specify time and distance requirements, but instead requires plans to demonstrate network sufficiency based on "reasonable criteria established by the issuer." Colorado also offers examples of "reasonable criteria," which include distance to provider, access to specialty care through telemedicine, and cross-county geographic accessibility.<sup>16</sup> California specifies that services must be reasonably accessible by public transportation in order to ensure access to care in urban environments and requires plans to offer the same provider network across all coverage tiers. Using the federal standards are Arkansas, Connecticut, Maryland, Michigan, Oregon, and the District of Columbia.<sup>17</sup>

### Essential Community Providers

**Federal standard.** Under the ACA, essential community providers (ECPs) include a range of entities that are eligible to participate in a special federal prescription drug discount program (Section 340B) for medically underserved and vulnerable populations. Federal rules specify that qualified health plans "must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the qualified health plan's service area, in accordance with the Exchange's network adequacy standards."<sup>18</sup> The term "broad range" is not defined. Federal guidance establishes a safe harbor standard used in the case of plans operated in the federal marketplace: inclusion of 20 percent of all essential community providers in the plan's service area, plus all Indian providers in the service area, plus at least one ECP per provider category.<sup>19</sup> At the same time, the guidance gives plans much discretion over ECP inclusion, since plans can disregard the safe harbor and use an alternative standard with an explanation of how they will ensure access.

**How states use their flexibility.** Four states go beyond the federal standards and apply inclusion criteria for

essential community providers ([Appendix Table 2](#)). California, for example, requires plans to have contracts with at least 15 percent of Section 340B providers in a plan service area, with geographic distribution. But the state also eliminates “single service” providers from this requirement (e.g., family planning clinics).<sup>20</sup> By contrast, Colorado uses a more expansive definition of entities considered ECPs, moving beyond Section 340B participation to include providers that have a “demonstrated commitment” to serving the poor and utilize a sliding fee scale. Connecticut offers the most detailed approach: plans ultimately must include 75 percent of all ECPs and are specifically directed to contract with community health centers. Following the federal minimum are Arkansas, Delaware, Illinois, Iowa, Maryland, Michigan, Nevada, New Hampshire, New Mexico, New York, Oregon, Vermont, Washington, West Virginia, and Washington, D.C.

### Benefit Substitution

**Federal standard.** Federal rules allow issuers to substitute benefits that are “actuarially equivalent” to the state benchmark benefits being replaced. Federal rules permit benefit substitution only for benefits that are in the same benefit class. For example, preventive and wellness services and chronic disease management are in the same essential health benefit class, as are mental health and substance abuse disorder services. Under benefit substitution, a plan might increase mental health coverage while reducing substance abuse coverage. Federal rules allow states to adopt stricter substitution standards or to prohibit it completely.<sup>21</sup>

**How states use their flexibility.** Nine states use the federal standard (Arkansas, Colorado, Delaware, Iowa, Minnesota, New Hampshire, New Mexico, Nevada, and Oregon), either repeating it verbatim or defaulting to it through silence, as Minnesota does ([Appendix Table 3](#)). California, Connecticut, Maryland, Michigan, Washington, and the District of Columbia bar substitution entirely. Another four states (Illinois, New York, Vermont, and West Virginia) permit substitution but in ways that vary from the federal regulations. Vermont’s

standard essentially parallels the federal rule, while New York specifies the types of substitutions that are permissible. New York also, in its “nonstandard plan” categories, permits substitutions that augment certain benefit classes.<sup>22</sup> West Virginia, while allowing benefit substitution, requires parity between habilitative and rehabilitative benefits.

### DISCUSSION

This analysis shows how states that operate their own marketplaces or formally partner with the federal government to run them are starting to use their flexibility over health plan design. States vary in the extent to which they elect to apply federal standards or augment them. Among those examined here (18 states plus Washington, D.C.), states are most likely to add requirements to the provider networks standard and significantly less likely to add inclusion criteria for essential community providers. States vary greatly in their approach to benefit substitution, with few states barring substitution outright.

This variation reflects the degree to which states have used their flexibility to shape initial plan design, particularly in the early years when experience with the health insurance marketplaces is limited. It provides evidence that states are seeking to balance health plan affordability against the quality and comprehensiveness of coverage. Our discussions with state marketplace staff confirmed this. Staff noted that they faced several challenges in getting their marketplaces off the ground, including the complexities of interacting with their state insurance departments, delays in issuing federal rules, and the lack of experience with the new market for subsidized health plans. Staff noted that these challenges may hinder their ability to enact more extensive standards for benefit and coverage design, at least initially. The regulatory choices that states make may change, of course, as they gain greater experience with the marketplaces. Marketplace staff were extremely interested in hearing how other states developed certification standards, particularly those aimed at ensuring good-quality coverage and reasonable access to care.



These early efforts at the formulation of qualified health plan standards suggest that standard-setting in the marketplace will undergo an evolution over time. Tracking this evolution will be essential to measure its effects on health care access and quality over time.

#### ABOUT THE STUDY

Our prior research for The Commonwealth Fund showed that states that enacted legislation to establish their own marketplaces structured their laws to give them flexibility on matters such as qualified health plan design and operational oversight.<sup>a</sup> Building on our earlier work, we undertook this “downstream” analysis of state certification policies for health plans participating in the exchanges. We also included state partnership marketplaces, given the flexibility that states participating in these partnerships have to shape certification standards. We focused on the three areas in which state flexibility is given special emphasis under federal rules: provider networks, inclusion of essential community providers, and benefit substitution.

In conducting this analysis, we reviewed numerous documents related to the health plan certification process: state statutes and regulations, requests for proposals, governing board-issued policies, and other policy documents. As of early June 2013, when this phase of our analysis was completed, a total of 18 states and the District of Columbia had developed written specifications for qualified health plans sold to individuals and families through the marketplaces. This included 12 state-based marketplaces (California, Colorado, Connecticut, Maryland, Minnesota, Nevada, New Mexico, New York, Oregon, Vermont, Washington, and the District of Columbia) and seven federally facilitated marketplaces (Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia).

Our reviews were designed to gather information on how and to what extent each state included in the analysis uses its flexibility in addressing issues related to provider networks, essential community provider inclusion, and benefit substitution. In addition, we interviewed marketplace staff in seven states to gain further insight into their decisions regarding whether and how to expand or alter the federal minimum standards.

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<sup>a</sup> S. Rosenbaum, N. Lopez, T. Burke et al., *State Health Insurance Exchange Laws: The First Generation* (New York: The Commonwealth Fund, July 2012).

## NOTES

- <sup>1</sup> The name given by the Obama Administration to the Health Insurance Exchanges created by the Act.
- <sup>2</sup> 42 U.S.C. §§ 18031, 18041, added by the Patient Protection and Affordable Care Act §§ 1311, 1321.
- <sup>3</sup> 42 U.S.C. § 18041(b), added by PPACA § 1321(b).
- <sup>4</sup> 42 U.S.C. § 18041(c), added by PPACA § 1321(c).
- <sup>5</sup> 45 CFR Subpart C of Part 156.
- <sup>6</sup> 42 U.S.C. § 18031(c)(1)(B); 45 C.F.R. § 156.230.
- <sup>7</sup> 42 U.S.C. § 18031(c)(1)(C); 45 C.F.R. § 156.235.
- <sup>8</sup> 45 CFR §155.1000(c).
- <sup>9</sup> Public Health Service Act §2724(a).
- <sup>10</sup> Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value and Accreditation Final Rule. 78 Fed. Reg. 37 (Feb. 25, 2013), pp. 12834–72, 12844, <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>; 45 C.F.R. § 156.115(b).
- <sup>11</sup> 45 C.F.R. § 156.230.
- <sup>12</sup> 45 C.F.R. § 156.235.
- <sup>13</sup> CMS/CCIIO, Letter to Issuers on Federally Facilitated and State Partnership Exchanges (April 5, 2013), [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014\\_letter\\_to\\_issuers\\_04052013.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf).
- <sup>14</sup> 45 C.F.R. §156.230(a)(2).
- <sup>15</sup> 45 C.F.R. §156.275(c)(2)(iv).
- <sup>16</sup> Colorado Revised Statutes §10-16-704.
- <sup>17</sup> Arkansas and Maryland are using the federal minimum for 2014 and will revisit the need for additional standards for plan year 2015.
- <sup>18</sup> 45 C.F.R. §156.235.
- <sup>19</sup> Health insurance companies in state partnership marketplaces (and federally facilitated marketplaces) can meet the federal essential community provider (ECP) standard by either: 1) showing that at least 20 percent of available ECPs in the service area participate in the plan's network; or 2) demonstrating that at least 10 percent of the ECPs available in the service area participate in the plan's network. CMS, *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, April 5, 2013.
- <sup>20</sup> California Health Benefit Exchange, *Explanation of Updated 340B Provider List*, Jan. 29, 2013.
- <sup>21</sup> 45 C.F.R. § 156.115(b).
- <sup>22</sup> Nonstandard products are permitted to: 1) modify cost-sharing in any category; 2) add benefits to an essential health benefit category (i.e., higher visit limitations); and 3) add benefits that are not considered essential health benefits.

**Appendix Table 1. Thirteen States Have Provider Network Adequacy Standards Exceeding the Federal Minimum**

State	No Additional Standards	Maximum Travel Time	Provider/Enrollee Ratio	Maximum Appointment Wait Time	Hours of Operation	Specialist Standards	Specifies Provider Type to Be Included in Network
AR*†	X						
CA				X			X
CO		X	X	X	X		
CT	X						
DE †		X	X				
DC	X						
IL †		X	X	X	X	X	
IA †		X	X	X	X		
MD*	X						
MI	X						
MN		X	X	X	X		
NV		X	X				X
NH †		X	X	X	X		X
NM †		X	X	X	X		
NY		X	X				X
OR	X						
VT		X		X	X		
WA		X		X	X		X
WV †		X	X				

\* 2014 only—states will reassess whether federal standards are adequate for plan year 2015.

† These states are pursuing State Partnership Marketplaces.

Source: George Washington University analysis of state-based marketplace documents.

**Appendix Table 2. Four States Have Essential Community Provider Standards Exceeding the Federal Minimum**

State	No Additional Standards	Specific Provider Types Identified	Specific Geographical Access Measures	Expanding ECP Definition	Specific Participation Targets Identified
AR <sup>†</sup>	X				
CA		X	X		X
CO				X	
CT		X			X
DE <sup>†</sup>	X				
DC	X				
IL <sup>†</sup>	X				
IA <sup>†</sup>	X				
MD	X				
MI	X				
MN					X
NV	X				
NH <sup>†</sup>	X				
NM <sup>†</sup>	X				
NY	X				
OR	X				
VT	X				
WA	X				
WV <sup>†</sup>	X				

<sup>†</sup> These states are pursuing State Partnership Marketplaces.

Source: George Washington University analysis of state-based marketplace documents.

**Appendix Table 3. Nine States and the District of Columbia Have Substitution Standards for Essential Health Benefits Differing from Federal Standards**

State	Recites Federal Minimum or Is Silent	Prohibits Substitution	Permits Substitution with Variation
AR †	X		
CA		X	
CO	X		
CT		X	
DE †	X		
DC		X	
IL †			X
IA †	X		
MD		X	
MI		X	
MN	X (Silent)		
NV	X		
NH †	X		
NM †	X		
NY			X
OR	X		
VT			X
WA		X	
WV †			X

† These states are pursuing State Partnership Marketplaces.

Source: George Washington University analysis of state-based marketplace documents.

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# Realizing Health Reform's Potential

## *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces*

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**Abstract:** The new health insurance marketplaces aim to improve consumers' purchasing experiences by setting uniform coverage levels for health plans and giving them tools to explore their options. Marketplace administrators may choose to limit the number and type of plans offered to further simplify consumer decision-making. This issue brief examines the policies set by some state-based marketplaces to simplify plan choices: adopting a meaningful difference standard, limiting the number of plans or benefit designs insurers may offer, or requiring standardized benefit designs. Eleven states and the District of Columbia took one or more of these actions for 2014, though their policies vary in terms of their prescriptiveness. Tracking the effects of these different approaches will enhance understanding of how best to enable consumers to make optimal health insurance purchasing decisions and set the stage for future refinements.



### OVERVIEW

Purchasing health insurance is an extraordinarily complex process, with much at stake for consumers' financial protection and access to care.<sup>1</sup> To simplify the consumer shopping experience and set basic standards for plans, the Affordable Care Act introduces significant health insurance market reforms and establishes health insurance marketplaces (also referred to as exchanges), where consumers can compare and choose plans based on their overall cost and quality.<sup>2</sup> To help consumers understand the level of protection they are purchasing, health plans offered through the marketplaces must cover a largely similar set of essential health benefits and are categorized into levels—catastrophic, bronze, silver, gold, and platinum—based on the average percentage of health care expenses that will be paid for by the insurer.<sup>3</sup> The marketplaces will further enable consumers to compare and select plans through Web-based display, filter, and search functions—known as “choice architecture”—as well as through tools, such as a Summary of Benefits and Coverage, that provide standardized plan information.<sup>4</sup>

With these changes, consumers will have access to more comprehensive coverage and more information about their plan options than have traditionally been available.<sup>5</sup> However, significant variation in health plan design—for



instance, differing amounts of cost-sharing for specific services—may still occur. Experience with implementation of health insurance reform in Massachusetts, as well as with implementation of Medicare Part D and Medicare Advantage, provide some perspective: if insurers are given significant latitude to vary plan features or offer numerous plans with only minor differences between them, consumers might still have difficulty making comparisons and selecting a plan that offers them adequate financial protection and access to care at the best possible price.<sup>6</sup>

Whether state insurance marketplaces should seek to simplify plan choices to help consumers make optimal choices has been the subject of robust debate. Insurers have tended to support greater flexibility, emphasizing innovation and the diversity of consumer preferences. Consumer advocates, citing behavioral economics research demonstrating that having too many choices can impair decision-making, have encouraged measures to provide a manageable number of easily comparable options.<sup>7</sup> In determining their approach, marketplace administrators must contend with the twin challenges of “stocking the shelves” with enough plans to promote competition and consumer choice while ensuring that the number and variety of plans are not so overwhelming that consumers have difficulty identifying those that best fit their needs.

States running their own marketplaces have significant flexibility in how they balance these competing pressures.<sup>8</sup> This issue brief examines whether

and how state-based marketplaces have taken any of three actions to simplify plan choices: 1) limiting the number of plans or benefit designs insurers may offer, 2) requiring standardized benefit designs, or 3) adopting a meaningful difference standard (Exhibit 1). These actions, while not required by the Affordable Care Act, may help consumers by creating a more transparent and competitive shopping experience.

## FINDINGS

### Eleven States and the District of Columbia Took Some Action to Simplify Plan Choice

Eleven states and the District of Columbia took action to simplify plan choices in their marketplaces. The level of intervention varied, with some states giving significant discretion to insurers and others being more prescriptive. Four states and the District of Columbia took just one action—either adopting a meaningful difference standard or limiting the number of plans or benefit designs an insurer may offer.<sup>9</sup> Seven states took at least two actions, with four states taking all three. Six states did not take any action to structure plan choices (Exhibit 2). The federal government—which has adopted similar approaches in the Medicare Advantage and Medicare Part D programs—will manage plan choices in states using the federally facilitated marketplace by deploying just one of the above tools: requiring insurers’ plan offerings to meet a meaningful difference standard.<sup>10</sup>

### Exhibit 1. Policy Options to Simplify Marketplace Plan Choice

Action	Description
Limit Number of Plans or Benefit Designs	Limit the number of plans that insurers may offer within a specified geographic area within an individual or Small Business Health Options Program (SHOP) exchange, or limit the number of benefit designs while allowing insurers to offer multiple plans for each benefit design within the same area using different product types (e.g., health maintenance organization or preferred provider organization) and/or networks.
Standardize Benefit Designs	Require insurers to offer plans that reflect, at minimum, predefined deductibles, out-of-pocket maximums, and in-network cost-sharing amounts for some or all essential health benefits. Insurers may vary plan features that are not included in the standardized design, such as product type and networks.
Adopt Meaningful Difference Standard	Require a plan’s features, such as cost-sharing levels, scope of covered services, or networks, to be substantially distinct from those of other plans offered in the same area by the same insurer.

Market dynamics were paramount in some states’ decisions to act. Officials in Rhode Island, which did not take any formal action, reported that they did not set explicit limits on the number of plans offered but instead encouraged insurers to offer a limited number. Given Rhode Island’s small market, their priority for year one was to get all insurers on board to ensure consumers “had enough choice.”<sup>11</sup> Washington State officials similarly noted that they were more concerned with getting all insurers to participate in the marketplace and offer plans throughout the state than with insurers “flooding the market” and overwhelming consumers.<sup>12</sup>

In states that took a proactive approach to managing plan choices, officials emphasized the importance of promoting informed consumer choice through benefit standardization and providing a reasonable number of plan options.<sup>13</sup> In New York, for example, officials expressed a concern that, without limits, the choices in the marketplace would be “endless.”<sup>14</sup> In Nevada, officials have generally taken a “free market facilitator” approach but, out of concern that too many plans could discourage some consumers from making any choice at all, they adopted plan limits and a meaningful difference standard to “push” the market toward more manageable consumer choice.<sup>15</sup>

**Exhibit 2. State and Federal Action to Simplify Marketplace Plan Choice**

Number of Actions Taken	State	Limited Number of Plans or Benefit Designs	Standardized Benefit Designs	Adopted Meaningful Difference Standard
Three Actions	CA	X	X	X
	CT	X	X	X
	MA	X	X	X
	VT	X	X	X
Two Actions	NV	X	—	X
	NY	X	X	—
	OR	X	X	—
One Action <sup>1</sup>	CO	—	—	X <sup>2</sup>
	DC	—	— <sup>3</sup>	X
	KY	X	—	—
	MD	X	—	—
	UT	—	—	X
No Action	HI	—	—	—
	ID	—	—	—
	MN	—	—	—
	NM	—	—	—
	RI	—	—	—
	WA	—	—	—
<b>Total States Taking Action</b>		<b>9</b>	<b>6</b>	<b>8</b>

<sup>1</sup> The federally facilitated marketplace implemented a meaningful difference standard for 2014. Although not reviewed for the purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review. In states not conducting plan management for the federally facilitated marketplace, review for meaningful difference is the only action to manage plan choices in 2014.

<sup>2</sup> In Colorado, meaningful difference standards also apply to individual and small-group plans offered outside of the exchange.

<sup>3</sup> The District of Columbia intends to require insurers to offer standardized plans beginning in 2015.

## Nine States Are Limiting the Number of Plans or Benefit Designs an Insurer Can Have

To prevent insurers from flooding the exchange with a large number of plans—potentially dominating “shelf space” on marketplace websites and, thus, reducing competition and impairing consumer decision-making—nine states limited the number of plans or benefit designs insurers may offer (Exhibit 3). Of these, two states—Kentucky and Maryland—did not take any other action to simplify plan choices. Nevada combined limits with a meaningful difference standard. Of the remaining six states, four (California, Connecticut, Massachusetts, and Vermont) also required insurers to standardize a subset of plans and set meaningful different standards, while two (New York and Oregon) also required insurers to standardize a subset of plans.

States typically allowed insurers to offer between three and five plans per coverage level. California, in contrast, limited the number of different configurations of the covered benefits and cost-sharing (benefit designs) an insurer may offer. Participating insurers, however, may submit an unlimited number of plans using different networks or product types—such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs)—for each benefit design offered on the exchange.<sup>16</sup> For example, for a single benefit design, a California insurer may offer one plan with a broad provider network and another with a more restricted network. Massachusetts combined both approaches, restricting the total number of nonstandardized plans insurers may offer while allowing insurers to submit an unlimited number of standardized plans with different network configurations.<sup>17</sup>

### Exhibit 3. Maximum Number of Plans or Benefit Designs Allowed per Insurer in Marketplaces

State	Maximum*	Applicability
<b>FFM States</b>	No limit on number of plans or benefit designs	Not applicable <sup>1</sup>
<b>CA</b>	One nonstandardized benefit design per coverage level <sup>2</sup>	Per service area
<b>CT</b>	3 plans per coverage level <sup>3</sup>	Per market
<b>KY</b>	4 plans per coverage level <sup>4</sup>	Per market
<b>MD</b>	4 plans per coverage level <sup>4</sup>	Per market
<b>MA</b>	7 non-standardized plans across bronze, silver, gold, and platinum coverage levels <sup>4,5</sup>	Per exchange <sup>6</sup>
<b>NV</b>	5 plans per coverage level	Per service area
<b>NY</b>	4 plans per coverage level <sup>4,7</sup>	Per county
<b>OR</b>	5 plans per coverage level <sup>3</sup>	Per service area
<b>VT</b>	4 plans per bronze and silver levels; 3 plans per gold level; 1 plan per platinum and catastrophic levels <sup>7</sup>	Per exchange <sup>6</sup>

\* Numbers presented do not necessarily include variations of a single plan, such as certain plan variations that provide publicly subsidized cost-sharing protection to eligible low-income individuals, child-only variations, and variations of the same plan provided with and without embedded pediatric dental coverage. States typically did not include such plans for the purposes of calculating plan limits.

FFM = federally facilitated marketplace.

<sup>1</sup> Although not reviewed for purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review.

<sup>2</sup> In California, the exchange limited the number of nonstandardized benefit designs an insurer can offer per coverage level, but insurers may submit multiple plans for each standard and alternative benefit design within the same geographic service area using different product types and/or networks.

<sup>3</sup> In Connecticut and Oregon, insurers are limited to one catastrophic plan in the applicable area. For the bronze, silver, and gold coverage levels, Oregon specified that each qualified health plan issuer could offer one standardized plan, two nonstandardized plans per coverage level, and two “innovative” plans per coverage level. Like the nonstandardized plans, the “innovative plans” would not be required to comply with the standardized benefit design, but would be subject to an additional layer of review and approval by the exchange before they could be filed with the state insurance division. Oregon did not establish a standardized benefit design for the platinum level and allowed insurers to offer up to three nonstandardized platinum plans and two “innovative” platinum plans.

<sup>4</sup> In Kentucky, Maryland, Massachusetts, and New York, plan limits do not apply to catastrophic plans.

<sup>5</sup> In Massachusetts, plan limits do not apply to standardized plans—as in California, insurers may submit multiple plans for each standardized benefit design using multiple network configurations.

<sup>6</sup> “Per exchange” refers to the individual and small-group exchanges established in each state. In Massachusetts and Vermont, the individual and small-group markets are merged so plan limits apply to insurer participation in the exchange generally, rather than per market.

<sup>7</sup> In New York and Vermont, affiliated insurers will be considered one entity for purposes of calculating plan limits.

With either method, the number and variety of plans offered to consumers will depend, in part, on how limits are applied. In Kentucky, for example, insurers may offer only four plans at each coverage level statewide. In contrast, insurers participating in the marketplace in Oregon may offer up to five plans per coverage level in each service area in which they operate, giving them flexibility to design unique products within different service areas. States may also apply limits at the license or holding company level. For example, Maryland took the former approach while New York and Vermont took the latter, specifying that any insurers that are operating on different licenses but affiliated with the same holding company will be considered one entity for the purposes of calculating plan limits.<sup>18</sup>

### Six States Established Standardized Benefit Designs to Support “Apples-to-Apples” Comparisons

Six states—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—required insurers to offer a selection of plans with standardized benefit

designs so consumers can more easily compare features such as benefits and cost-sharing among plans across different levels of coverage (Exhibit 4). In all six states, insurers are allowed to offer a limited number of nonstandardized plans or benefit designs. For such products, states often explicitly encouraged insurers to incorporate innovative features, such as value-based insurance design, tiered networks, and payment and delivery system reforms.<sup>19</sup> Four of the six states (California, Connecticut, Massachusetts, and Vermont) also adopted meaningful difference standards to differentiate nonstandardized plans.

In defining their standardized benefit designs, all six states fixed deductibles and out-of-pocket maximums for in-network benefits, and many set in-network cost-sharing for most or all essential health benefits, including specific services such as ambulance or other forms of emergency transport. These steps provide consumers with a stable basis for comparing out-of-pocket costs for a broad array of health care services across coverage levels. Other states, such as Massachusetts, standardized only a subset of essential

### Exhibit 4. Approaches to Standardizing Plan Benefit Designs in Insurance Marketplaces

State	Range of Standardized Benefit Designs	In-Network Cost-Sharing Standardized	Out-of-Network Cost-Sharing Standardized	Benefit Substitution Prohibited
<b>FFM States</b>	N/A	N/A	N/A	No <sup>1</sup>
<b>CA</b>	All coverage levels	Yes	No	Yes <sup>2</sup>
<b>CT</b>	All coverage levels except catastrophic	Yes	Yes	Yes <sup>2</sup>
<b>MA</b>	All coverage levels except catastrophic	Yes	No <sup>3</sup>	No
<b>NY</b>	All coverage levels	Yes	No	Yes <sup>4</sup>
<b>OR</b>	Bronze, silver, and gold levels only <sup>5</sup>	Yes	No	Yes <sup>4</sup>
<b>VT</b>	All coverage levels except catastrophic	Yes	No	No <sup>6</sup>

FFM = federally facilitated marketplace.

<sup>1</sup> The federally facilitated marketplace generally allows benefit substitution. However, states with a federally facilitated marketplace may prohibit benefit substitution for insurers in their state and without otherwise establishing standardized plans.

<sup>2</sup> In California and Connecticut, benefit substitution is prohibited with respect to both standardized and nonstandardized plans.

<sup>3</sup> In Massachusetts, out-of-network cost-sharing is standardized for pediatric dental coverage only.

<sup>4</sup> In New York and Oregon, insurers are generally allowed to substitute one benefit for another within the essential health benefits. However, this practice is prohibited with respect to standardized plans.

<sup>5</sup> In Oregon, insurers offering plans in the individual and small-group markets both on and off the exchange are required to offer a standardized bronze plan and a standardized silver plan. The requirement to offer a standardized gold plan only applies within the exchange.

<sup>6</sup> In Vermont, benefit substitution is allowed. However, insurers must justify any substitution, including explaining how it supports insurer initiatives to promote wellness and innovation and providing a survey of supporting clinical literature.

health benefits (primary care, specialist, and emergency department visits; high-cost imaging; inpatient hospitalization; outpatient surgery; and prescription drugs), allowing insurers to vary cost-sharing for less-common services.<sup>20</sup> Connecticut is the only state to standardize cost-sharing for out-of-network benefits, potentially offering consumers a gauge of their total anticipated financial risk, given that it can be difficult to predict out-of-network costs.<sup>21</sup>

To further limit variability in benefit design and help consumers more easily compare health plans, states may prohibit insurers from substituting one benefit for another within an essential health benefit category, such as outpatient services or prescription drugs (a practice known as benefit substitution).<sup>22</sup> For example, under benefit substitution, if a state's benchmark plan covers blood screens for ovarian cancer, an insurer would be allowed to substitute coverage of that service for coverage of an actuarially equivalent service within the laboratory services category.<sup>23</sup> Prohibitions on benefit substitution, therefore, allow consumers to more easily compare plans based on features such as cost-sharing and premiums, while minimizing the need to factor in differences in benefit design. California and Connecticut prohibited benefit substitution in all plans offered in the marketplace, standardized or not. New York and Oregon prohibited changes to covered benefits in standardized plans, but allowed insurers to substitute benefits in nonstandardized plans.<sup>24</sup> Although they standardized cost-sharing, Massachusetts and Vermont allowed insurers to substitute benefits within standardized plans as well as nonstandardized plans.

### **Seven States and the District of Columbia Required Insurers to Offer “Meaningfully Different” Plans**

To help consumers distinguish among plans, seven states—California, Colorado, Connecticut, Massachusetts, Nevada, Utah, and Vermont—and the District of Columbia instituted meaningful difference standards, which commonly call for state regulators to review differences in plan features such as cost-sharing, networks, and formularies (Exhibit 5). Plans are

rejected or must be modified if they are too similar to others that the insurer proposes to sell within a given service area and coverage level. In some cases, states also encourage insurers to differentiate their plans through the use of innovative plan features, as previously discussed. Initially, at least, many states provided significant discretion to state or marketplace officials to determine if plans were meaningfully different, without quantifying what degree of difference in such features as networks, formularies, or cost-sharing would be considered meaningful.

## **DISCUSSION**

As the health insurance marketplaces under the Affordable Care Act launch and initial technical hurdles are overcome, consumers around the nation will gain more information and tools to shop for health plans in the individual and small-group markets. In an attempt to further facilitate consumer decision-making, many state-based marketplaces—and to a lesser extent, the federally facilitated marketplace—are going beyond the minimum requirements of the Affordable Care Act to set rules to “stock the shelves” of the new marketplaces with a manageable number of easily comparable plan choices.

In the first year of marketplace operations, consumers' ability to make “apples-to-apples” comparisons and select a plan that offers them the optimal level of protection is likely to vary according to the different approaches taken by state and federal marketplaces. For example, limiting the number of plans each insurer may offer may provide a more manageable number of plans for consumers to consider, while standardizing benefit designs will further enhance consumer choice by enabling them to better distinguish between the plans offered on the marketplace. In addition, the effectiveness of “meaningful difference” rules may depend on the degree of difference demanded by such standards and the regulators implementing them. If state regulators or marketplace officials require insurers to demonstrate their plans are meaningfully different on only one criterion, such as a \$50 dollar difference in deductibles, plans may not be substantially different in

**Exhibit 5. Examples of Meaningful Plan Differences Provided in State and Federal Guidance**

<b>State</b>	<b>Example</b>
<b>FFM States<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• \$50 or more difference in both individual and family in-network deductibles</li> <li>• \$100 or more difference in both individual and family in-network annual out-of-pocket maximum</li> <li>• Difference in network</li> <li>• Difference in formulary</li> <li>• Difference in covered essential health benefits</li> </ul>
<b>CA<sup>2</sup></b>	<ul style="list-style-type: none"> <li>• Difference in network design</li> <li>• Difference in level of provider integration</li> <li>• Innovative delivery system features</li> </ul>
<b>CO</b>	<ul style="list-style-type: none"> <li>• \$50 difference in deductible</li> <li>• \$100 difference in annual out-of-pocket maximum</li> <li>• Difference in formularies</li> <li>• Difference in networks and service areas</li> <li>• Difference in benefit design (essential health benefits, other benefits offered between plans)</li> </ul>
<b>CT</b>	<ul style="list-style-type: none"> <li>• \$50 difference in medical deductible</li> <li>• \$50 difference in drug deductible</li> <li>• \$100 difference in annual out-of-pocket maximum</li> <li>• Difference in payment structure (e.g., copayment versus coinsurance)</li> <li>• Difference in product type (e.g., HMO, PPO, etc.)</li> <li>• Difference in care management (e.g., gatekeeper model; patient-centered medical home; community health teams; wellness programs)</li> </ul>
<b>DC<sup>3</sup></b>	<ul style="list-style-type: none"> <li>• \$50 or more difference in both individual and family in-network deductibles</li> <li>• \$100 or more difference in both individual and family in-network annual out-of-pocket maximum</li> <li>• Difference in network</li> <li>• Difference in formulary</li> <li>• Difference in covered essential health benefits</li> </ul>
<b>MA</b>	<ul style="list-style-type: none"> <li>• Innovative plan designs that can help achieve premium cost savings for enrollees</li> <li>• Difference in network design (e.g., tiered or narrower networks)</li> <li>• Plan features intended to reduce costs through increasing transparency or efficiency (e.g., value-based insurance designs; patient-centered medical homes)</li> </ul>
<b>NV</b>	<ul style="list-style-type: none"> <li>• Difference in product type</li> <li>• Difference in premium and cost-sharing</li> <li>• Difference in network</li> <li>• Difference in formulary</li> <li>• Difference in covered benefits</li> </ul>
<b>UT<sup>3</sup></b>	<ul style="list-style-type: none"> <li>• \$50 or more difference in both individual and family in-network deductibles</li> <li>• \$100 or more difference in both individual and family in-network annual out-of-pocket maximum</li> <li>• Difference in network</li> <li>• Difference in formulary</li> <li>• Difference in covered essential health benefits</li> </ul>
<b>VT</b>	<ul style="list-style-type: none"> <li>• Difference in medical deductible</li> <li>• \$50 difference in drug deductible</li> <li>• Greater than \$1,000 difference in annual out-of-pocket maximum</li> <li>• 10 percent difference in cost-sharing for inpatient or outpatient care</li> <li>• \$10 or 10 percent difference in cost-sharing for primary care provider or specialist office visit</li> <li>• \$5 average difference in generic drugs</li> <li>• \$10 or 10 percent average difference in brand-name drugs</li> <li>• Different payment structure (e.g., copayment versus coinsurance)</li> <li>• Additional rating tier offerings</li> </ul>

FFM = federally facilitated marketplace.

<sup>1</sup> Although not reviewed for purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review. In states not conducting plan management for the federally facilitated marketplace, review for meaningful difference is the only action to manage plan choices in 2014.

<sup>2</sup> In California, within a given product design, the exchange may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

<sup>3</sup> The District of Columbia and Utah referred to the federal guidance on meaningful difference standards, which includes the examples highlighted.

practice. Even with these policies in place, insurers in most states will still have significant freedom to shape a portfolio of plan offerings.

The approaches we have discussed do not exist in a vacuum; their effectiveness will be significantly affected by the level of insurer participation in a marketplace, which in turn depends on factors such as the state's existing market dynamics and other marketplace design decisions affecting insurer participation.<sup>25</sup> For example, marketplaces adopting limits on plan offerings may still offer dozens of plans per coverage level if a large number of insurers participate, while marketplaces without limits may offer a smaller number of plans if few insurers participate or voluntarily limit plan offerings. Moreover, consumers' experience will depend not just on the plan choices available to them, but also on the user-friendliness and choice architecture of marketplace websites and their access to in-person assistance with selecting a plan and understanding the health insurance product they are buying.

Even with these external factors at play, differences in state and federal policymakers' initial approaches to facilitating consumer choice provide an important learning opportunity for policymakers. Since establishing its marketplace in 2006, Massachusetts has periodically updated its approach to managing plan choices based on feedback from consumers solicited through focus groups and surveys as well as analysis of consumers' plan selections.<sup>26</sup> Similarly, actions taken, or not taken, by state-based marketplaces for 2014 will serve as a starting point to analyze how different policies affect consumers' ability to enroll in the plan most suitable for their financial and health situations. In the longer term, tracking consumers' plan choices, their satisfaction with those plans, and whether they switch plans during future open enrollment periods could yield additional insights into how marketplace design decisions affect purchasing experiences.

As they evaluate how well their marketplaces are working for consumers, state and federal officials should compare the effectiveness of different approaches to facilitating consumer choice, including the examination of metrics such as the number and choice of plans available, differences and similarities in plan design, and consumers' reviews of the shopping experience and actual choice of plans. Over time, these findings could help states narrow in on the optimal number and variety of plan choices for consumers, given their local needs and circumstances.

### ABOUT THE STUDY

This issue brief examines policy decisions made by the 17 states (California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia that chose to establish state-based marketplaces.

For the purposes of this brief, we refer to Idaho, New Mexico, and Utah as state-based marketplaces. However, Idaho and New Mexico operate as “supported state-based exchanges” in 2014, leveraging the federal information technology infrastructure as they build their own systems. Utah has a “bifurcated” marketplace in which it operates the small-business marketplace while the federal government operates the individual marketplace. In all three cases, the states can set health plan certification requirements and review plans for compliance, although the federal government will have final authority over certification decisions for the individual marketplace in Utah. Although not reviewed for purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review.

Our findings are based on public information—such as state laws, regulations, subregulatory guidance, marketplace solicitations, and other materials related to marketplace development—and interviews with state regulators. The resulting assessments of state action were confirmed by state officials.

Source: S. Dash, C. Monahan, and K. Lucia, “Health Policy Brief: Health Insurance Exchanges and State Decisions,” *Health Affairs*, July 18, 2013.



## NOTES

- <sup>1</sup> K. Pollitz, E. Bangit, J. Libster et al., *Coverage When It Counts: What Does Health Insurance in California Cover and How Do Consumers Know?* (Washington, D.C.: Georgetown University Health Policy Institute, May 2009), <http://hpi.georgetown.edu/papers.html>.
- <sup>2</sup> Pub. L. 111–148, 124 Stat. 782 (2010) §§ 1311, 1312, 1321 (codified at 42 U.S.C. §§ 13031, 18032, 18041 (2012)).
- <sup>3</sup> Pub. L. 111–148, 124 Stat. 782 (2010) § 1302 (codified at 42 U.S.C. § 18022 (2012)). We present catastrophic coverage as a coverage level alongside the precious metal tiers—bronze, silver, gold, and platinum—although different rules apply. Instead of meeting a specified actuarial value level, catastrophic plans must provide no benefits other than three primary care visits and certain recommended preventive services until the enrollee has incurred the maximum out-of-pocket costs allowed under the law. Catastrophic plans can only be sold in the individual market, and eligibility is limited to individuals under the age of 30 or who have received an exemption from the individual mandate based on plan affordability or hardship.
- <sup>4</sup> L. Quincy, “Choice Architecture: Design Decisions that Affect Consumers’ Health Plan Choices,” *Health Affairs Blog*, July 13, 2012; Pub. L. 111–148, 124 Stat. 782 (2010) § 1001 (codified at 42 U.S.C. §§ 300gg-15 (2012)).
- <sup>5</sup> J. R. Gabel, R. Lore, R. D. McDevitt et al., “More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014,” *Health Affairs Web First*, May 23, 2012; K. Pollitz and L. Levitt, *Health Insurance Transparency Under the Affordable Care Act* (Washington, D.C.: Kaiser Family Foundation, March 8, 2012).
- <sup>6</sup> See, for example, L. Quincy and J. Silas, *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making* (Washington, D.C.: Consumers Union, Nov. 2012); R. Day and P. Nadash, “Simplifying Choices Among Health Plans: New State Insurance Exchanges Should Follow the Example of Massachusetts,” *Health Affairs*, May 2012 31(5):982–89; L. Quincy, *What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans* (Washington, D.C.: Consumers Union, Jan. 2012); Blue Cross Blue Shield of Massachusetts Foundation, *Health Reform Toolkit Series: Determining Health Benefit Designs to Be Offered on a State Health Insurance Exchange* (Boston: BCBSMA, Nov. 2011); J. M. McWilliams, C. C. Afendulis, T. G. McGuire et al., “Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making,” *Health Affairs*, Sept. 2011 30(9):1786–94; E. O’Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice* (New York: The Commonwealth Fund, April 2008); G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, Oct. 2001); and J. Hoadley, *Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries* (New York: The Commonwealth Fund, May 2008).
- <sup>7</sup> See, for example, S. Iyengar and M. Lepper, “When Choice Is Demotivating: Can One Desire Too Much of a Good Thing?” *Journal of Personality and Social Psychology*, Dec. 2000 79(6):995–1006.
- <sup>8</sup> S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).
- <sup>9</sup> The District of Columbia Health Benefits Authority expects to require insurers to offer standardized plans beginning in 2015. D.C. Health Benefit Exchange Authority, *Carrier Reference Manual v.5* (Washington, D.C.: Health Benefit Exchange Authority, June 2013).

- <sup>10</sup> U.S. Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, *Letter to Issuers on Federally Facilitated and State Partnership Exchanges* (Washington, D.C.: Department of Health and Human Services, April 5, 2013); and The Center for Medicare Advocacy, *The Obama Administration's 2010 Call Letter for Medicare Advantage and Prescription Drug Plans: Implications for Beneficiaries* (Washington, D.C.: The Henry J. Kaiser Family Foundation, May 2009). In 2010, the Centers for Medicare and Medicaid Services adopted new policies to facilitate beneficiary decision-making between plans, such as encouraging Medicare Advantage and Part D plan sponsors to eliminate plan options that are duplicative of other plan offerings or that have low enrollment.
- <sup>11</sup> Personal correspondence with exchange official, Rhode Island Health Benefit Exchange, May 14, 2013 (on file with authors).
- <sup>12</sup> Personal correspondence with exchange official, Washington Health Benefit Exchange, May 17, 2013 (on file with authors).
- <sup>13</sup> Personal correspondence with exchange official, Vermont Health Benefit Exchange, May 14, 2013 (on file with authors); and personal correspondence with exchange official, Oregon Health Insurance Exchange, May 13, 2013 (on file with authors).
- <sup>14</sup> Personal correspondence with exchange official, New York Health Benefit Exchange, May 15, 2013 (on file with authors).
- <sup>15</sup> Personal correspondence with exchange official, Silver State Health Insurance Exchange, May 15, 2013 (on file with authors).
- <sup>16</sup> California Health Benefit Exchange, *2012–2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond* (Sacramento, Calif.: California Health Benefit Exchange, revised Jan. 16, 2013).
- <sup>17</sup> Commonwealth Health Insurance Connector Authority, *Request for Responses: Health Benefit Plans—Seal of Approval* (Boston: Health Connector, Feb. 15, 2013); and Commonwealth Health Insurance Connector Authority, *Final Bidders Conference Questions* (Boston: Health Connector, March 8, 2013).
- <sup>18</sup> Personal correspondence with exchange official, Maryland Health Benefit Exchange, May 15, 2013 (on file with authors); Office of the New York Health Benefit Exchange, *Invitation to Participate in the New York Health Benefit Exchange* (Albany, N.Y.: New York Health Benefit Exchange, Jan. 31, 2013); and Vermont Health Connect, *Request for Proposals: Selection of Qualified Health Plans* (Williston, Vt.: Vermont Health Connect, Nov. 1, 2012).
- <sup>19</sup> Value-based insurance design is an approach to health insurance that reduces consumer cost-sharing for items and services that are deemed high value because the clinical benefits outweigh the costs or risks and increases cost-sharing or items and services of low or uncertain value. With tiered provider networks, providers are grouped by tier based on their average cost and/or quality of care and health insurers vary consumer cost-sharing for certain services depending on their providers' tier. S. Corlette, D. Downs, C. Monahan et al., "State Insurance Exchanges Face Challenges in Offering Standardized Choices Alongside Innovative Value-Based Insurance," *Health Affairs*, Feb. 2013 32(2): 418–26.
- <sup>20</sup> Commonwealth Health Insurance Connector Authority, *Request for Responses: Health Benefit Plans—Seal of Approval*, 2013.
- <sup>21</sup> K. Kyanko, L. Curry, and S. Busch, "Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?" *Health Services Research*, June 2013 48(3):1154–72.
- <sup>22</sup> In all states allowing benefit substitution, insurers must comply with the federal government's minimum rules for substituting benefits, including that the substitute benefit is actuarially equivalent to the benefit that is being replaced, as certified by a member of the American Academy of Actuaries, and that it is within the same benefit category. 45 C.F.R. § 156.115. States may adopt additional rules as well. In Vermont, for example, insurers must also explain how any substitutions support insurer initiatives, such as innovation and wellness, and, if they elect to not provide a service and related quantitative limits, they must submit a survey of clinical literature supporting the substitution of the service. Vermont Health Connect, *Request for Proposals: Selection of Qualified Health Plans*, 2012.

- <sup>23</sup> S. Corlette, K. W. Lucia, and M. Levin, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan* (New York: The Commonwealth Fund, March 2013).
- <sup>24</sup> While substitution is prohibited outright in standardized plans in New York, insurers may only substitute benefits within the preventive, wellness, and chronic disease management and rehabilitative and habilitative services categories in nonstandardized plans. New York Health Benefit Exchange, *Invitation to Participate in the New York Health Benefit Exchange*, 2013.
- <sup>25</sup> S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).
- <sup>26</sup> Blue Cross Blue Shield of Massachusetts Foundation, *Health Reform Toolkit Series: Determining Health Benefit Designs to Be Offered on a State Health Insurance Exchange*, 2011.

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ACA Implementation—Monitoring and Tracking

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

November 2013

Linda J. Blumberg and Shanna Rifkin, The Urban Institute  
Sabrina Corlette and Sarah J. Dash, Georgetown University Health Policy Institute



Robert Wood Johnson Foundation



# 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.

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## 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
<b>Strategies to Reduce Short-Term “Rate Shock”</b>		
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	<b>State Determination:</b> Minnesota New York Oregon Rhode Island  <b>Federal Default:</b> 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	<b>Closed to New Enrollment:</b> Colorado Minnesota Oregon  <b>Shutdown Date Unclear:</b> Alabama Illinois New Mexico  <b>Later Shutdown Date:</b> 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
<b>Strategies to Stabilize Individual Market and the Individual Market Exchange</b>		
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.<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup>

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;<sup>4</sup> 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.<sup>5</sup>

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## 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.<sup>6</sup> 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.<sup>7</sup> 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.<sup>8</sup> 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).<sup>9</sup>

**Table 2. State High-Risk Pools**

State	High-Risk Pool	Enrollment (as of December 31, 2011) <sup>a</sup>	Per Member Per Month Expenses
Alabama	Alabama Health Insurance Plan <sup>b</sup>	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.<sup>10</sup> 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.<sup>11</sup> Some enrollees have been told their plans will not be renewed effective December 31, 2013.<sup>12</sup> 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).<sup>13</sup> 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 <sup>a</sup>	Unclear	Yes
Maryland <sup>b</sup>	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 <sup>c</sup>	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.<sup>14</sup> 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.<sup>15</sup>

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.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup> 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).<sup>20</sup>

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.<sup>21</sup> 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.<sup>22</sup>

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).<sup>23</sup>

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.<sup>25</sup> 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 Curve<sup>24</sup>**

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.<sup>26</sup> 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.<sup>27</sup> 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.<sup>28</sup> 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.<sup>29</sup> 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.<sup>30</sup> 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.<sup>31</sup> 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."<sup>32</sup>

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.<sup>33</sup> 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.<sup>34</sup>

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 assistors 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.<sup>35</sup> The law also requires the inclusion of a new category of providers called "essential community providers," which provide care to underserved populations.<sup>36</sup> 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).<sup>37</sup>

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.<sup>38</sup> 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.<sup>39</sup> Minnesota and New York based their network adequacy standards for exchange plans on existing HMO network adequacy standards.<sup>40</sup>

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.<sup>41</sup> 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,<sup>42</sup> 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).<sup>43</sup>

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.<sup>44</sup>

## 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.<sup>45</sup> 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.<sup>46</sup>

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.<sup>47</sup> 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.<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup>

## 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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43. ORS 743.817
44. McCarty S and Farris M. "ACA Implications for State Network Adequacy Standards." Robert Wood Johnson Foundation, August 2013.
45. C.F.R. 45 § 155.1055

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47. In New York, carriers can also offer up to two non-standardized products as well.
48. Additionally, insurers in Maryland within the same holding company that collectively report \$10 million in aggregate annual earned premiums in the individual market outside the exchange have to offer in the exchange if they offer outside the exchange.

49. Dash, Sarah, Kevin Lucia, Katie Keith and Christine Monahan, "Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges," *The Commonwealth Fund*, July 2013.
50. At least one non-study state with a federally facilitated exchange (Delaware) is requiring bronze-level coverage.

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