CRITICAL ISSUES IN HEALTH REFORM

Transitioning to New Market Rules

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Many of the current major federal health reform proposals under consideration by policymakers would impose stricter issue and rating rules, primarily for the individual and small group markets. The structure of the transition to these new rules will determine the degree to which market disruption can be mitigated.

Insurers would be prohibited from denying coverage based on health status or pre-existing conditions and would be limited or prohibited from varying premiums based on age, health status, or other factors. New benefit requirements could also be imposed. The extent to which stricter issue and rating rules result in market disruption, defined as significant rate or mandated benefit changes contributing to a high cancellation rate by individuals or groups, will depend on how the transition to the new rules is structured.

Transitioning to new market rules may be done in several ways. One option is to gradually phase in the new requirements over time for all current and new policies. Another option is to forgo any phase-in period and simply impose the new rules all at once. And yet another option is to impose the new rules for all new policies issued, but to grandfather current policies under the current rules. Under this approach, individual policyholders could retain the coverage they have under the current rules but would transition to new rating rules over time. Any new insurance purchases, including those of current policyholders who opt for new coverage, would need to conform to the new issue, rating, and benefit design rules. This paper will focus on issues related to the latter approach.

Changing health insurance market rules can lead to market disruption and adverse selection.

Moving to stricter issue and rating rules would increase the potential for adverse selection, especially in the individual health insurance market. Guaranteed-issue provisions give individuals the ability as well as the incentive to delay purchasing insurance until they have need for health care services, unless this is mitigated by an effective coverage mandate. Likewise, limiting or prohibiting the use of health status and age as premium rating factors can lower the premiums for older and less healthy individuals and raise the premiums for younger and healthier individuals relative to what they would pay otherwise. In the absence of an effective coverage mandate, this may result in younger and healthier individuals opting out of coverage, leaving a higher-risk insured population and higher premiums on average relative to current premiums.

If stricter issue and rating rules are imposed for new policies issued, but current policies can be grandfathered under the current rules subject to a transition period, then individuals and groups more likely to drop their current policies for new policies would be those with higher than average premiums, such as older and less healthy individuals or groups with an older workforce. They could potentially have lower premiums under the new rating rules. Similarly, higher-risk individuals who might have been denied coverage or charged higher premiums under current rules may have access to coverage at lower premiums under the new rules. Meanwhile, lower-risk individuals and groups who are charged commensurately lower premiums under the current rules would initially more likely opt to maintain their current coverage rather than

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http://www.actuary.org/pdf/health/individual_mandate_may09.pdf

Market Reform Principles
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Risk Pooling
http://www.actuary.org/pdf/health/pool_july09.pdf

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moving to new plans under the new more restrictive rules. Taken together, this would result initially in a higher-risk population being enrolled in new plans, and a lower-risk population remaining in the grandfathered plans. The higher average premiums needed to reflect the higher-risk population of the new plans could offset any premium decreases for older and less healthy individuals required by narrower premium variations.

As will be addressed in more detail below, an individual mandate and risk adjustment mechanisms would help to reduce the impact of adverse selection between the new plans and the grandfathered plans.

The more significant the changes, the greater the potential for market disruption.

Rules governing the small group market and especially the individual market vary widely by state. All states require guaranteed issue for the small group market, whereas only a few require guaranteed issue for the individual market. In addition, although the majority of states allow premiums in the small group market to reflect group characteristics such as age, gender, number of employees, location, industry, and health status, in aggregate these variations are usually limited at least to some extent. In the individual market, not only may premiums vary by these types of characteristics, but the allowable aggregate variations are wider, and often are not limited.

The impact of moving to more restrictive issue and rating rules will vary by state, depending on the state's current market rules. The potential for disruption in the individual market is greatest in the states that currently allow insurers to deny coverage or limit coverage for certain conditions and charge wide variations in premiums. Any market disruption will be less dramatic in states that already have guaranteed issue and limit the variation allowed in rating rules.

An effective and enforceable individual mandate can help reduce market disruption.

Imposing an individual mandate can lessen the market disruption caused by moving to guaranteed issue and more restrictive rating rules. If existing policies can be grandfathered under the current issue and rating rules, an individual mandate can help reduce adverse selection against the new plans by requiring all individuals to obtain coverage. This will help ensure that newly insured, lower-risk individuals enroll in the new plans, not just higher-risk individuals, thereby reducing the upward pressure on premiums for the new plans.

For an individual mandate to be effective, however, the associated incentives or penalties must be meaningful compared with the premiums expected. Otherwise, people may choose to pay the penalty rather than obtain insurance. This particularly can be an issue for those who are young and healthy and may face premiums much higher than their expected medical expenses.

In addition, an individual mandate should be imposed at the same time that the guaranteed issue requirement and rating rules are implemented, not afterwards. Otherwise, higher-risk individuals would likely obtain coverage early on, with lower-risk individuals waiting to obtain coverage until the mandate is in place. If an individual mandate is instead implemented later in the reform process, other mechanisms could be used to help minimize adverse selection during the initial phases of the transition period such as allowing pre-existing condition exclusion periods or having limited open enrollment periods, no pre-existing condition exclusions, but

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imposing penalties for late enrollment. Rules also would need to be developed regarding people with periods of lapsed coverage who later reapply. A possible solution could be that these individuals would be subject to the same penalties as late enrollees, perhaps after a grace period, such as the HIPAA 62-day period that is currently allowed for purchase of new coverage after job termination. However, it is unlikely that these alternatives would be as effective as an enforceable mandate.

Risk-sharing mechanisms can help mitigate adverse selection.

The potential for adverse selection between plans may be most pronounced during the transition period, when one set of plans is subject to new rules, and another set of plans is grandfathered under the current rules. Even after the entire market has transitioned to the final rules, however, some plans may end up with a disproportionate share of high-risk individuals. If plan premiums are not allowed to reflect health status or other demographic characteristics, plans could be at risk for large losses as a result of this selection. To protect their financial viability, plans could develop strategies to avoid enrolling less healthy individuals, such as dropping the types of benefits that are attractive to those who are less healthy. Risk adjustment could be used to adjust plan payments to take into account health status and other risk characteristics of plan participants. This would help ensure that plan payments are commensurate with expected costs, and would reduce incentives to avoid enrolling higher-risk individuals.

Nevertheless, risk adjustment can be complex to administer and needs to be designed to ensure that incentives are still in place to manage the medical costs for those with severe conditions. However, even a well-designed risk adjustment system will not be able to fully adjust for spending differences across individuals and plans. Some type of government reinsurance mechanism could further limit insurers' potential losses by protecting against unexpected high-cost claims.

Grandfathered plans would need to be clearly defined.

Grandfathering plans would allow individuals and small employer groups that have coverage to maintain such coverage. Rules defining "grandfathering" have to be very clear and specific so that employers, individuals, and regulators have a common understanding of what constitutes a grandfathered plan, and what changes, if any, may be made in benefits; employer and employee contributions; employee and dependent eligibility, including termination of eligibility; and whether low-income tax subsidies or credits would be available for participants in grandfathered plans. Since comprehensive reforms are likely to contain changes in rating rules, clarity in the application of those rules to grandfathered plans would assist in mitigating market disruption. Multi-year migration stages to the reform plans, consisting of several years of smaller rate increases instead of one large increase, should be defined. Effective reform requires that all coverage be ultimately provided under the new market reform rules. Accordingly, the termination point of any grandfathering provisions should be clearly stated so that employers and individuals have time to make appropriate moves to adopt reform plans.

State reform efforts provide lessons on the need for transition periods.

There are examples of state level reforms that ultimately were reversed because of the resulting market disruption. While the reforms in these particular states do not necessarily mirror the federal reforms being considered, there are still lessons to be learned. Kentucky implemented guaranteed issue and more restrictive rating rules in the mid 1990s that included many of the characteristics currently being considered—guaranteed issue in the individual market and the elimination of health status as a premium rating factor in both the individual and small group market. The extensive changes required in such a short period of time contributed to many insurers

exiting the individual market, resulting in few options for this market. These reforms were ultimately reversed.[1]

Market disruption can also result by introducing more, rather than less, flexible market rules. In 2003, New Hampshire changed rating rules for small employers from "no permitted variation by health status" to a "substantial permitted variation." This change was effective in 2004 with a one year transition period. It created so much premium disruption that it was ultimately reversed.[2]

These lessons demonstrate the need to implement reforms while mitigating substantial disruption to the consumer. Health care reform is a complex process, and while the final rules will need to be the same in all states, individual states will likely require varying transition periods to achieve those final rules. However, in order to ensure effective nationwide implementation, there needs to be a defined end-date by which time all states are in compliance.

[1] Carl Westman, "Health Care Reform in Kentucky," The Actuary, April 2006. There were many reasons for the failure of reforms in Kentucky, including the lack of transition rules.
[2] Edwin Park, "Lessons from New Hampshire," April 2006. (http://www.cbpp.org/cms/index.cfm?fa=view&id=223)