Spotlight

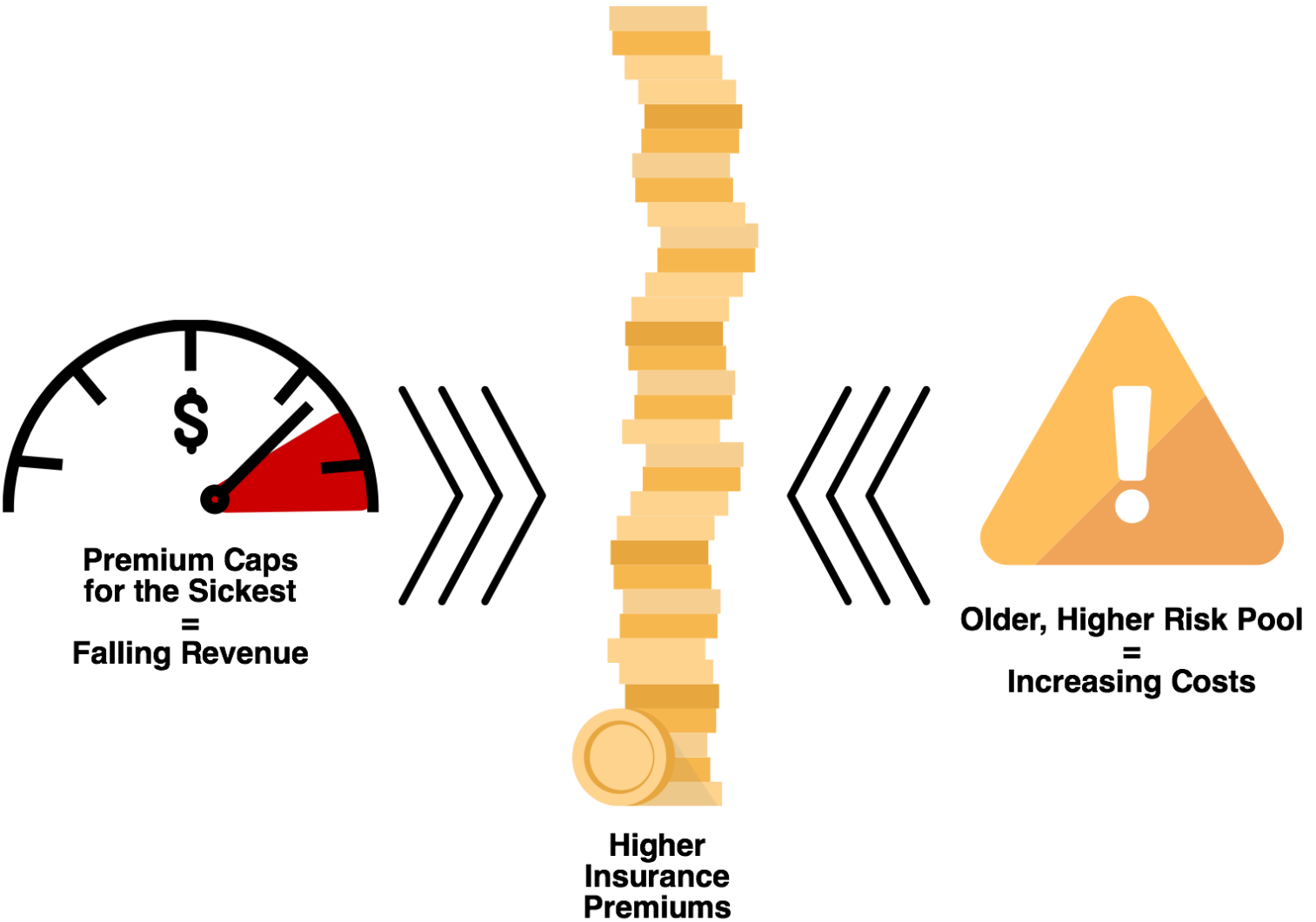
#471 — August 6, 2015

Adverse Selection

Examining the impact on North Carolina's Health Insurance Exchange

John Locke Foundation

Katherine Restrepo
Health Care Policy Analyst
krestrepo@johnlocke.org
919 828 3876



The Affordable Care Act's (ACA) health insurance exchanges are just one mechanism to expand coverage that primarily benefits low-income individual market policyholders and those with pre-existing conditions who cannot afford or access employer-sponsored health insurance.

North Carolina's health insurance exchange currently ranks 4th in enrollment nationwide with Blue Cross and Blue Shield of North Carolina (BCBS NC), United Health, and Coventry Health Care of the Carolinas selling non-group policies. Of the 560,000 North Carolinians who have shopped for coverage through the exchanges, roughly 94 percent qualify for subsidized health plans that offset the cost of premiums and cost sharing.[1]

For the exchanges to remain viable, the federal health law enforces the following components:

- Individual mandate – The law makes it compulsory for citizens to purchase a government approved plan.
- 3:1 community-rating ratio – In an attempt to keep premiums affordable for those with pre-existing conditions, a high-risk individual cannot be charged more than three times the amount of a low-risk individual's health insurance premium.
- Subsidies – Because young and healthy individuals are required to purchase expensive health insurance plans that subsidize the costs of plans for the old and sick, subsidies are employed to offset premiums and cost sharing for eligible policyholders with annual incomes between 100-400 percent of the Federal Poverty Level (FPL).[2]

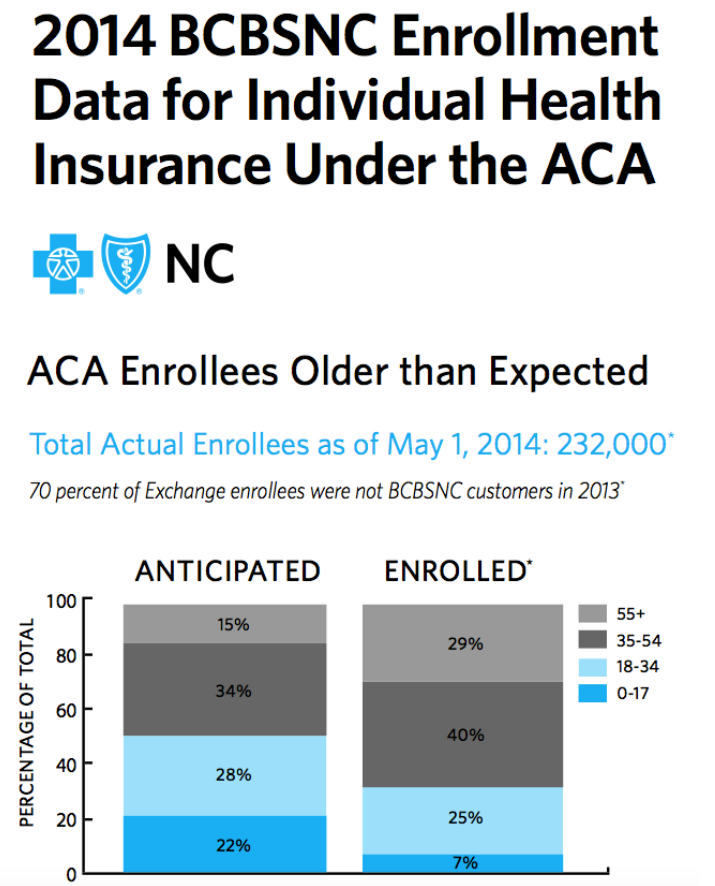
Despite the mechanisms in place designed to sustain the exchanges, insurers suffer adverse selection[3] because they must now accept all policy applicants, including those with pre-existing conditions and those who decide to purchase insurance after they are diagnosed with a severe illness. This is equivalent to someone buying homeowner's insurance after her house burns down.

Adverse selection is further exacerbated because insurers have limited information on a policyholder's medical history and are prohibited from adjusting premiums according to actual risk. This situation makes it difficult for insurers to set necessary rates. Since the exchanges were first implemented in 2014 under the ACA, carriers selling government-approved policies now have a full year's worth of claims data[4] to identify key factors that have caused medical claims to exceed premium payments.

Unanticipated Enrollment Mix

The market for ACA non-group policyholders could remain on precarious footing for the next few years. Severe instability ensued prior to the exchanges' first enrollment period in October 2013. To mitigate a public backlash regarding plan cancellations for millions of Americans,[5] the Obama Administration urged insurers to extend these "subpar" policies[6] until 2017. This unilateral decision produced an imbalance between anticipated and actual individual market risk pools starting in 2014. Many policyholders — especially the young and healthy — decided to hold onto these plans, creating a higher-risk enrollment mix leading to an adverse selection problem.

This unforeseen change caused BCBS NC to suffer its first financial loss in over 15 years, amounting to a $50.6 million revenue decline.[7]



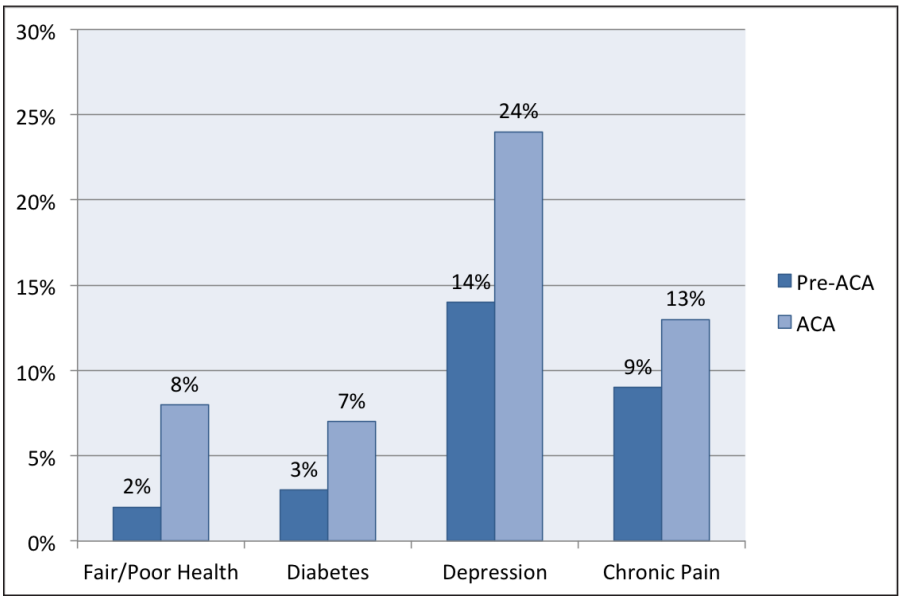
Health Status

Under the ACA, guaranteed issue[8] restricts insurers from denying coverage to applicants with pre-existing conditions. Further limits on risk-adjusting a policyholder's premium based on health status benefits high-risk customers whose premiums are less than their risk status would justify at the expense of low-risk customers, whose premiums are higher than their risk status would justify.

Market economist Paul J. Feldstein provides a contextual explanation on how these regulations induce adverse selection:

> *If 100 people were in a risk group, each with a 1 percent chance of needing a medical treatment costing $100,000, the pure premium for each (without the loading charge) would be $1,000 (0.01 x $100,000). Each year, one member of the group would require a $100,000 treatment. Now, if a person who needs that particular treatment (whose risk is 100 percent) is permitted to join that group at a premium of $1,000 (based on a mistaken risk level of 0.01), that high-risk person receives a subsidy of $99,000, as her premium should have been $100,000 based on her risk level. Because the $1,000 premium was based on a risk level of 1 percent, the insurer collects insufficient premiums to pay for the second $100,000 expense and loses $99,000.*[9]

The following chart illustrates a snap shot of self-reported health status data from BCBS NC comparing pre-ACA to ACA policyholders during the first enrollment year in 2014.[10]



Claims data from January through June of this year also reveal that 2015 BCBS NC ACA individual market policyholders are older and sicker when compared to 2014 customers. According to the state's largest insurer, claims data also show increasing hospital admissions, imaging services, Emergency Department usage, chronic health conditions, and specialty medications.[11] BCBS NC has also identified a classic example of adverse selection in which one in five customers signed up for coverage, paid the first month's premium, used services, and then dropped his plan. So, of the 397,000 second-round BCBS exchange enrollees thus far, the net figure really equates to approximately 317,600.[12]

Community Rating

As a promise made by the Obama administration for health premiums to be affordable for those with pre-existing conditions, the ACA enforces a maximum 3:1 community rating ratio in which a high-risk individual cannot be charged more than three times the amount of a low-risk individual's health insurance premium. Tighter government price controls were leveraged to maintain a viable risk pool, but instead have triggered unintentional adverse selection. Higher premiums burdening low-risk individuals as a means to subsidize the cost of the chronically ill discourages low risk customers from purchasing federally approved health coverage. Others have opted to hold onto pre-ACA policies extended by the Obama administration until 2017. It cannot be emphasized enough that the "young invincibles," or healthy policyholders between ages 18-34, are instrumental to preventing an actuarial imbalance. The entire scheme is unsustainable if younger, healthier individuals are not in the system to subsidize those who are older and less healthy.[13]

A Weak Individual Mandate

The individual mandate is viewed as the centerpiece of the federal health law. Some perceive the individual mandate as, "the best way to eliminate the problem of adverse selection."[14] Without this critical element, the ACA's exchanges can not work to their full capacity. Yet the

law's penalty lacks muscle. According to the Treasury Department, approximately 7.5 million people were subject to an average $200 fine for opting out of coverage in 2014. The penalty for not having government-approved insurance in 2014 was the greater of either $95 or one percent of annual income.[15, 16]

An increasing monetary penalty in forthcoming years may compel more people to purchase ACA-approved health plans, but wouldn't it be better for insurers to lure low-risk consumers to the market by offering flexible products at a more affordable price?

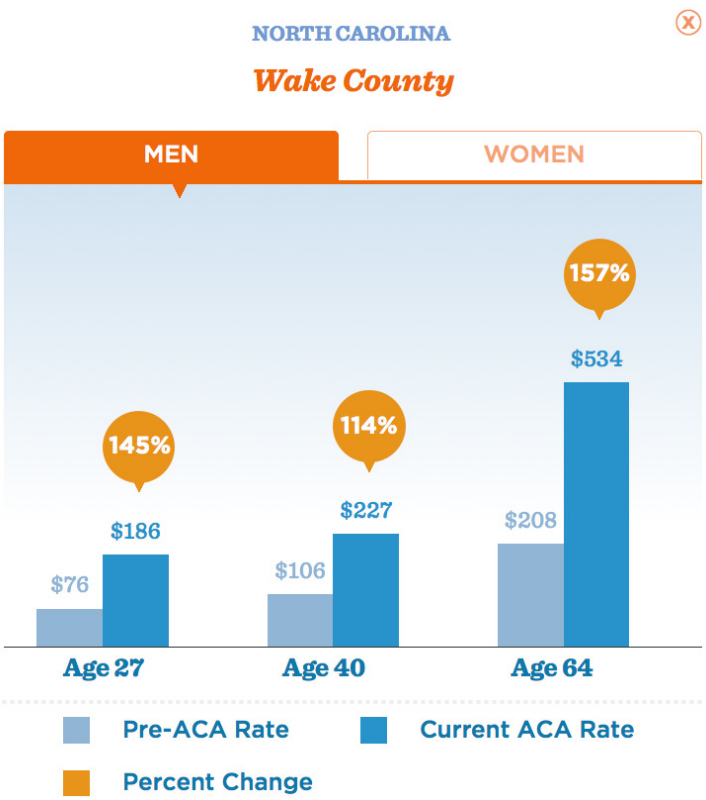
The Three R's

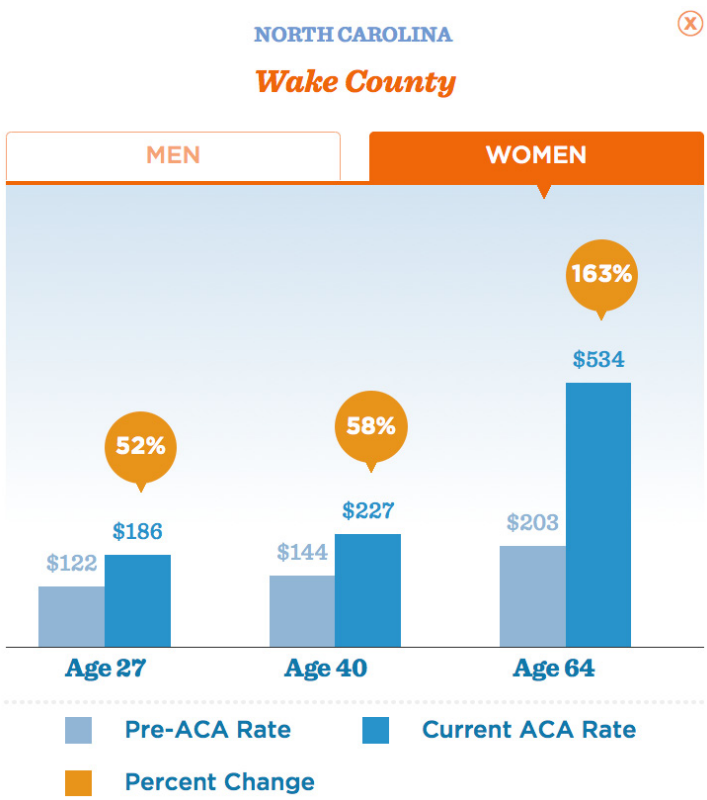
Theoretically, insurers greatly benefit from the Affordable Care Act because government coerces individuals to purchase their products. Yet the decision for North Carolina carriers to sell expensive, government standardized products on the exchanges still brought on the risk of experiencing adverse selection. As an incentive to engage in new federally regulated exchanges, insurers are supported by three provisions built into the law that alleviate initial market disruption:[17]

- *Risk adjustment* operates as a give and take among insurers. Those with higher-risk pools will be relieved with funds from insurers with lower-risk pools. Coventry Health Care, for example, will divert $29.4 million back to the pool because its customers are lower-risk.[18]
- *Risk corridors* operate where funds are shifted from plans with lower than expected claims to offset other plans where actual payments have surpassed projected amounts.
- *Reinsurance* acts as an insurance company's own insurance policy, in which a fee is assessed on each person, including dependents, covered by most employer-sponsored health insurance. The fund will total over $20 billion up to 2017, and insurers can dip into this fund and be reimbursed 80 percent of a consumer's annual claims that exceed $45,000. Both the risk corridors and reinsurance will phase out by 2017.[19]

Rate Shock And Subsidies

BCBS NC covers approximately 86 percent of the non-group market. The state's exchange's failed design has caused the insurer to lose $123 million on its ACA customers. The net loss even factors in a total of $343 million in payouts from the federal government, which includes the ACA's risk adjustment, risk corridor, and reinsurance provisions. Due to adverse selection, the carrier awaits approval by the North Carolina





Department of Insurance (DOI) to increase 2016 rates by an average 34.6 percent.[20]

BCBS puts the underlying rate increase in perspective with the following example:

> *A 40-year old male with a Blue Value Silver Plan may now be paying $315 per month for a plan with a $2,500 deductible. Next year, however, that person could be ponying up $418 per month with the same deductible.*[21]

Meanwhile, Coventry Health Care of the Carolinas has asked for an average 18 percent increase, while United HealthCare requested an average 12.5 percent.[22]

According to the Manhattan Institute, percentage increases for North Carolina health insurance premiums in the individual market initially ranked 4th highest nationwide. This data was calculated by comparing pre-ACA premiums to post-ACA premiums sold within each state. The Manhattan Institute averaged the five cheapest health plans sold in every county of the state for individuals at three ages: 27, 40, and 64. To create a more sound comparison, the pre-ACA average rates included extra charges for pre-existing conditions. These average rates were then compared to the five least-expensive bronze plans on the exchanges in each county.[23]

The graphs on the previous page compare pre-ACA rates to post-ACA rates for male and female individual policyholders in Raleigh, North Carolina. Note that the ACA underlying rates do not factor in subsidies.

Depending on one's income, an exchange policyholder may qualify for a heavily subsidized health plan that shifts the underlying rate shock for ACA plans onto taxpayers. While the Obama Administration has advertised that individuals with household incomes between 100-400 percent of the FPL are eligible for financial assistance, this marketing tactic to encourage enrollment has proven to be misleading. In North Carolina, subsidies do not extend beyond 309% ($35,504) FPL for individuals under age 34.[24]

Conclusion

The ACA focuses on expanding coverage through a massive redistribution of wealth in the amount of $1.2 trillion over the next decade.[25] It's clear that low-income individuals and those with chronic conditions benefit the most from the law's sliding scale subsidies, but market-oriented tactics[26, 27] can make health insurance (and more importantly medical care) more accessible and affordable and can lessen the risk for insurers to experience adverse selection.

Katherine Restrepo is Health Care Policy Analyst for the John Locke Foundation.

Endnotes

1. Centers for Medicare and Medicaid Services, "March 31, 2015 Effectuated Enrollment Snapshot." March 31, 2015. cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html
2. Georgetown University Health Policy Institute Center For Children And Families, "2015 Federal Poverty Level Guidelines." Jan 23, 2015. ccf.georgetown.edu/wp-content/uploads/2015/01/2015-Federal-Poverty-Guidelines.pdf
3. Paul J. Feldstein, "Health Policy Issues: An Economic Perspective." 5th ed. Pp 75-78. 2011.
4. Megan McArdle, "Life Under Obamacare," Bloomberg View. May 6, 2015. bloombergview.com/articles/2015-05-06/oregon-shows-how-obamacare-could-remake-insurance-market
5. Anna Gorman, Phil Galewitz, Jay Hancock, Julie Appleby, "What Consumers Need To Know About The Obama Plan For Canceled Health Policies." Kaiser Health News. Nov. 15, 2013. khn.org/news/obama-plan-for-canceled-health-policies/
6. The Obama administration defines subpar policies as not meeting the law's benefit and actuarial value requirements. Actuarial value is the percentage of medical expenses covered by an insurer.
7. John Murawski, "Blue Cross and Blue Shield of NC posts first loss in 15 years." The News & Observer. Feb. 27, 2015. newsobserver.com/news/business/article12479192.html
8. The Henry J. Kaiser Family Foundation, "Health Insurance Market Reforms: Guaranteed Issue." June 2, 2012. kff.org/health-reform/fact-sheet/health-insurance-market-reforms-guaranteed-issue/
9. Paul J. Feldstein, "Health Policy Issues: An Economic Perspective." 5th ed. P 75. 2011.
10. Barbara Morales Burke and Chris Privett, "Meet Our New Customers: Who We Enrolled During the Affordable Care Act's First Open Enrollment Period." Blue Cross and Blue Shield of North Carolina. Accessed July 29, 2015. blog.bcbsnc.com/2014/05/meet-new-customers-enrolled-affordable-care-acts-first-open-enrollment-period/
11. Blue Cross and Blue Shield of North Carolina, "What's Shaping 2016 Rates for ACA Customers?" June 1, 2015. mediacenter.bcbsnc.com/internal_redirect/cms.ipressroom.com.s3.amazonaws.com/49/files/20155/2015%20Rate%20Filing%20Fact%20Sheet%2006%2002%2015.pdf
12. Katherine Restrepo, "That's Right North Carolina, A Potential 26 % Average Rate Increase For Obamacare Customers." Forbes. June 5, 2015. forbes.com/sites/katherinerestrepo/2015/06/05/thats-right-north-carolina-a-potential-26-percent-average-rate-increase-for-obamacare-customers/
13. Parija Kavilanz, "'Young invincibles' imperil health reform," CNN Money. April 9, 2010. money.cnn.com/2010/04/09/news/economy/health_reform_young_invincibles_threat/
14. Paul J. Feldstein, "Health Policy Issues: An Economic Perspective." 5th ed. P 77. 2011.
15. ObamaCare Facts, "ObamaCare's Individual Mandate: What is the Tax Penalty for Not Having Health Insurance?" Accessed July 25, 2015. obamacarefacts.com/obamacare-individual-mandate/
16. Phil Galewitz, "Feds Say 7.5M Paid An Average Penalty Of $200 For Not Having Health Insurance." Kaiser Health News. July 21, 2015. khn.org/news/feds-say-7-5m-paid-an-average-penalty-of-200-for-not-having-health-insurance/
17. The Henry J. Kaiser Family Foundation, "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors." Jan 22, 2014. kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/
18. John Murawski, "Blue Cross gets $295 million ACA payout, seeks rate increase." The News and Observer. July 7, 2015. newsobserver.com/news/business/article26689651.html
19. Stephen T. Parente, " The Short Unhappy Life of ObamaCare." Wall Street Journal: Commentary. June 10, 2014. wsj.com/articles/stephen-t-parente-the-short-unhappy-life-of-obamacare-1402441569
20. Patrick Getzen,"ACA Causing BCBSNC Premiums To Rise." News and Observer: letter to the editor. July 9, 2015. newsobserver.com/opinion/letters-to-the-editor/article26892613.html
21. Blue Cross Blue Shield of North Carolina, August 6, 2015.
22. WRAL, "Insurers seek sizable rate increases on Affordable Care Act health plans." June 1, 2015. wral.com/insurers-seeking-sizable-rate-increases-on-affordable-care-act-health-plans/14682626/
23. Manhattan Institute For Policy Research, "The Obamacare Impact." 2014. manhattan-institute.org/knowyourrates/
24. David Hogberg," 'Young Invincibles' Still Won't Get Subsidies on ObamaCare Exchange."Amy Ridenour's National Center Blog. National Center for Public Policy Research. Sept. 25, 2013. conservativeblog.org/amyridenour/2013/9/25/young-invincibles-still-wont-get-subsidies-on-obamacare-exch.html
25. Douglas W. Elmendorf, "Letter to Rep. John Boehner on Repeal of Obamacare Act, as passed by the House of Representatives on July 11, 2012." Accessed July 29, 2015. cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf
26. James C. Capretta and Tom Miller, "How to Cover Pre-existing Conditions." nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions
27. John H. Cochrane, "Health-Status Insurance: How Markets Can Provide Health Security." Cato Institute. Feb. 18, 2009. cato.org/publications/policy-analysis/healthstatus-insurance-how-markets-can-provide-health-security