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FACT SHEET
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USING A HEALTH-INSURANCE EXCHANGE TO POOL RISK AND PROTECT ENROLLEES

Several leading health-reform proposals include a new entity — often called an "exchange" — that would offer a choice of health insurance plans to individuals and, if designed well, provide insurance options that are affordable, comprehensive, and easy for consumers to compare. Most current proposals, however, do not spell out all of the steps needed to ensure that an exchange meets the goals of protecting vulnerable enrollees, simplifying consumers' choice of plans, and promoting competition among insurers that is based on the cost and the quality of their products rather than on their ability to maximize profits by attracting healthy, less costly individuals and deterring sicker, costlier ones.

To accomplish these goals, an exchange must have properly structured rules for benefit design. Without such rules, many insurers participating in the exchange likely will create products designed to deter enrollment by less-healthy people. This would lead healthy and sick people to separate into different insurance plans, a situation known as "adverse selection," which can cause plans attracting less-healthy enrollees to become increasingly unaffordable over time. In addition to harming vulnerable individuals, adverse selection would undermine the very sort of competition based on price and quality that should drive insurers to offer better-value benefits, and it could unravel health-insurance exchanges over time.

Another downside of an exchange with lax rules for benefit design is that plans would vary dramatically from one another, causing widespread confusion for beneficiaries and increasing the chances that people will unknowingly select coverage that later turns out to be inadequate.

To ensure that an exchange provides affordable, comprehensive coverage to all enrollees, enables people to make informed choices, and protects competition based on price and quality, it will need four key components:

- *minimum standards for benefit design* to ensure that individuals get the care they need at an affordable price. Without being overly prescriptive, the standards should assure that plans provide coverage for a comprehensive set of necessary services, such as physician visits, inpatient hospital care, and prescription drugs, and define the scope of coverage. The standards should also include a limit on beneficiaries' out-of-pocket costs. With these protections in place, individuals would not have to worry about choosing the "wrong" insurance.

- *limits on the degree of variation in different benefit designs* to prevent insurers in an exchange from creating benefit packages meant to deter less-healthy enrollees and attract only individuals in good health. Such limits — which are a basic feature of the Medigap market, in which private insurers sell supplemental coverage to Medicare beneficiaries — also are essential if consumers are to be able to compare the price and quality of different plans.

- *a limit on the number of different plan choices* in an exchange, which is crucial to helping individuals make intelligent decisions about coverage, rather than being overwhelmed by a bewildering number of choices.

- *a requirement that insurers in an exchange offer the full range of different benefit designs and base premiums on a single pool of all the people in an insurer's various plans.* This requirement, which the Massachusetts health-reform plan includes, would protect sicker individuals from having to pay higher premiums than healthier people for the same coverage simply because they are enrolled in a plan that disproportionately enrolls sicker individuals.

The Limits of Actuarial Value

Some have called for an actuarial-value standard and have assumed it renders such rules unnecessary. Such an assumption is mistaken.

- An actuarial-value standard involves setting a dollar amount for the value of the coverage that a plan provides for a typical group of enrollees and requiring all plans to offer a benefit package estimated to be worth at least that value. (An actuarial standard also could be a specified percentage of health costs that a plan must cover for a typical group of enrollees, rather than a dollar amount.)

- But an actuarial-value standard alone would not equip an exchange to meet the goal of providing coverage that is affordable, comprehensive, and easy to compare, and it would do little to prevent insurers from designing plans intended to attract healthy individuals and deter less-healthy enrollees. Two plans with the same actuarial value could have very different coverage levels and out-of-pocket costs, with one plan providing less coverage for certain treatments that sicker people are more likely to need (such as lengthy hospital stays or certain chemotherapy drugs) while offering items attractive to healthier individuals (such as lower premiums or discounts on a health-club membership). The experience with the Medicare Advantage program, in which private insurers have developed and marketed plans designed to attract healthier beneficiaries and deter sicker ones, illustrates the risk. Medicare Advantage plans can scale back traditional Medicare benefits so long as the coverage does not have a lower actuarial value than traditional Medicare. This has resulted in an array of benefit designs that vary widely from one another and can have dramatically different impacts on beneficiaries' out-of-pocket costs.

- Furthermore, an actuarial standard would not guarantee that insurers would offer comprehensive coverage; plans would simply need to include benefit packages that met the minimum dollar value or percentage. A plan could offer a package fashioned to attract people expecting not to be sick by skimping on basic coverage. An enrollee who then became seriously ill during the year could end up without needed medical care.

The Limits of Risk Adjustment

"Risk adjustment" is an essential step in reducing adverse selection in an exchange. By itself, however, it will not be sufficient to prevent insurers from using benefits design and other features to deter enrollees who are in poorer health. As the Congressional Budget Office has explained, existing risk-adjustment systems "tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high health spending." In other words, risk adjustment is very difficult to do with complete accuracy. When done well, it succeeds in compensating for some — but not all — of the differences in health costs between healthier and less-healthy beneficiaries. As the CBO has warned, the inability of current risk-adjustment systems to fully adjust for differences in health care costs "could cause premiums for enrollees in plans that attract higher-cost beneficiaries to rise substantially over time." This is why risk adjustment needs to be combined with the measures outlined here.

Conclusion

Setting minimum standards for benefits, limiting the number of and variation between plans, and requiring each insurer to cover a broad group of people with varying levels of health costs would create a strong framework for the benefits available within an exchange. By promoting competition based on price and quality, these four steps would hold down the costs in the insurance exchange and help make it as efficient as possible, while making sure that it serves individuals who need to obtain coverage through it.