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Managing Risk in Health Insurance Markets

A Challenge for States in the Midst of Health Care Reform

September 2009

By Courtney Burke and Katherine Swartz

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Acknowledgments

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About the Rockefeller Institute and the Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The Institute focuses on the role of state and local government in the American federal system. The New York State Health Policy Research Center, a program of the Rockefeller Institute, provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house staff of health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

Executive Summary

Congress may pass health reforms this fall, but regardless of federal actions, New York and other states still will have considerable jurisdiction over managing risk in their small group and individual insurance markets. Insurers in these markets constantly face the threat of adverse selection — the outcome when a larger share of the people purchasing policies have higher medical care costs than would be found in a random sample of the population. When this happens, it is difficult, if not impossible, for insurers to accurately estimate the medical costs of those they are insuring. The risk of adverse selection is a major reason that premiums per person in the two markets are higher than in large group markets and why some people are denied coverage in states that permit denials of applications. When states can manage this risk so it is substantially reduced, more insurers will be willing to sell insurance policies; competition between the insurers will ensure efficiency in the markets, making premiums more affordable; and more people will have access to health insurance. Options for managing risk can range from moving everyone into a common-risk pool, including some groups in a pool, or carving out high-risk individuals from other lower-risk groups.

A review of state initiatives indicates there are three major sets of strategies that states currently use for managing risk in health insurance markets: those that affect the entire state's population and avoid adverse selection; those that involve only certain parts of the population and may not avoid adverse selection; and those that target only a small segment of the population.

States have extensive experience with strategies that target only a segment of the population, such as high-risk pools. Such strategies may help a targeted group obtain coverage but they have not been successful at ensuring universal coverage, nor can they deal effectively with unpredicted risk. A combination of newer risk management strategies implemented simultaneously is likely to improve coverage efforts.[1] Such a combination of risk management strategies could include a personal responsibility requirement for the purchase of insurance, creating an insurance exchange, and merging the small group and individual insurance markets. To implement federal or state reforms using these strategies, several considerations need to be addressed. This paper provides suggestions for states as they implement these risk management strategies:

- States should be prepared to fund the additional costs associated with requiring individual responsibility for health insurance. The cost of this requirement may be greater in New York because there are more low-income persons, the cost of living is higher, and insurance is more expensive than in most other states.

- Community rating, an unusual feature of New York's health insurance market, combined with a requirement for obtaining health coverage, could be a relatively successful combination of strategies for managing risk in the state.
- If there is a requirement for insurance, New York and other states would benefit from a fully functioning and integrated information technology platform because it could immediately determine who would be eligible for subsidies, as well as the amount of subsidy a person would get to help them fulfill a personal responsibility requirement.
- Creating an insurance exchange will require that there be both a minimum number of insurers participating and a minimum number of potential enrollees for the exchange to be viable and function efficiently. Exchanges could be done through a multistate collaborative, regionally within states, or one exchange within one state. In New York, it may make sense to have one insurance exchange downstate and one upstate because such a division would account for current upstate-downstate differences in the insurance markets and the cost of medical care.
- No matter how an insurance exchange is created or structured, it should be the exclusive marketplace or ensure equality of benefits plans and premiums both in and outside of the exchange.

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I. Introduction

The Congressional debates over federal health insurance reform are unlikely to be resolved before late fall. What is emerging from the draft legislation and discussions about ideas for increasing coverage, however, is a consensus that private health insurance will remain a significant source of health insurance coverage for most nonelderly Americans. Although a public insurance option may win approval, any major shift away from private insurance is likely to occur incrementally.

A growing number of policy analysts and policymakers also are publicly acknowledging that requiring everyone to have coverage (with subsidies for lower-income people and exemptions for some people) is the only way to achieve widespread coverage and avoid adverse selection in insurance markets. It is too early to know if Congress will include such a requirement as part of health reform legislation. Details, such as what a minimum standard of health insurance should encompass, what might constitute financial hardship, and how generous income-based subsidies can be will have to be determined. Congress also appears to be moving toward an agreement on the need for state or regional insurance pooling mechanisms — known as exchanges — where people without access to employer-sponsored insurance can be pooled together to obtain affordable policies.

Whatever features the final legislation contains, states almost certainly will continue to have a significant role in regulating and managing health insurance sold within their boundaries. (And, of course, if Congress fails altogether to pass health reform legislation, then states will be under ever greater pressure to expand

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access to health insurance and control the growth in health care spending.) One of the critical issues facing states in this context is how they can manage adverse selection risk within the small group and individual markets.

For states, managing the risk of adverse selection in these markets is critically important: If such risk can be controlled, more insurers will be willing to sell policies in the markets, competition between the insurers will ensure efficiency in the markets and premiums will be more affordable, and more people will have access to health insurance. Currently, such risk is not effectively managed by most states and insurers either do not participate in the small group and individual markets or they go to great lengths to avoid covering people they suspect will have high medical costs.[2]

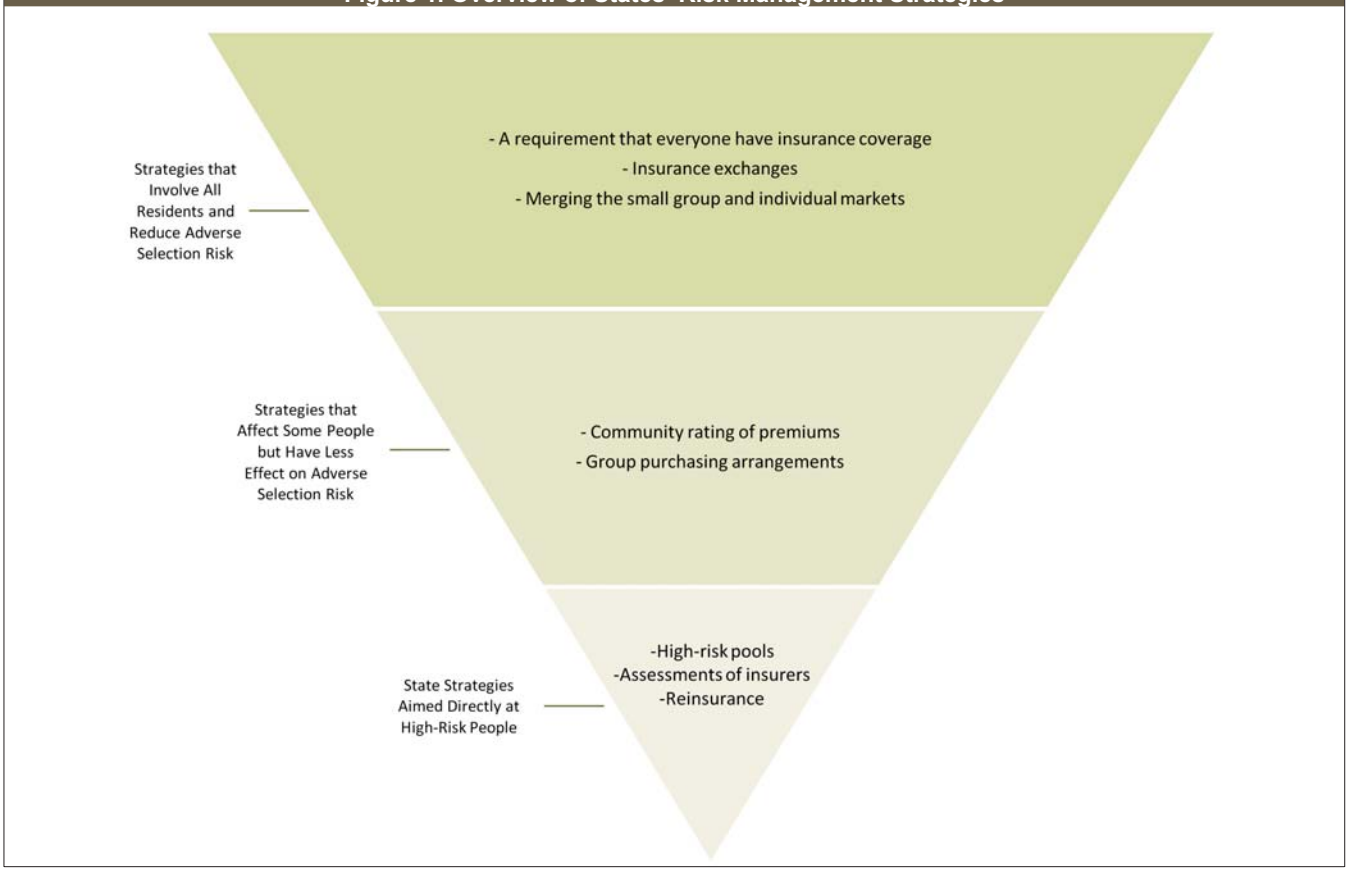
This paper examines the options states have for managing risk in their insurance markets. The following section describes risk management strategies that affect almost everyone in a state, then those that affect some but not all people, and finally those that are targeted specifically at high-risk people. As the strategies affect fewer people in a state, they also do less to affect adverse selection risk — creating trade-offs for states. Section III discusses how New York currently tries to manage risk and reduce adverse selection in its insurance markets. Section IV raises some cautionary notes about implementation and design issues that states need to bear in mind if they intend to use these strategies to help expand insurance coverage. Finally, some recommendations are offered for how states might manage risk depending on whether the current Congressional proposals for health care reform become law or not.

II. Overview of States' Primary Risk Management Strategies

States' interest in managing adverse selection risk in their small group and individual health insurance markets derives from their efforts to expand access to private health insurance as well as their regulatory role overseeing financial reserves held by insurers and increases in premiums. The states differ in the extent to which they regulate these insurance markets, with some states doing very little and other states using their regulatory powers to actively manage the risk of adverse selection.

A review of state strategies to manage risk shows three major sets of strategies that either are in use or have been proposed to reduce the risk of adverse selection in the small group and individual insurance markets. One can group these strategies in an inverted pyramid, with the first category affecting nearly everyone in a state and addressing adverse selection risk; the second category affecting a smaller group of people and/or doing less to address adverse selection; and the third category affecting only the people who are thought to be risky in terms of having a high probability of very high-cost medical care and doing little to affect

Figure 1. Overview of States' Risk Management Strategies



adverse selection risk. Thus, as the strategies affect fewer people, they also do less to address the risk of adverse selection. Figure 1 shows the major strategies in each of the three tiers.

B. Strategies That Involve All State Residents and Reduce Adverse Selection Risk

At the top — or the widest part — of the inverted pyramid are those risk management strategies that involve everyone in a state. The strategies include: a requirement (mandate) that everyone obtain health insurance (subsidized or otherwise, with potential exemptions for those who still cannot afford coverage); insurance exchanges; and merging the small group and individual markets. These strategies would affect everyone who needs to purchase insurance in the small group or individual markets in a state; they cast the widest "net" possible in terms of spreading risk across this large group of people.

Note that the first strategy that involves everyone in a state is also one of the elements that has notable support in Congress: *requiring everyone to obtain health insurance coverage* — with publicly funded programs for the poor and income-based subsidies for low-income people as well as exemptions for people who would have a financial hardship due to paying for insurance. Such a "personal responsibility" requirement by itself reduces the risk of adverse selection in the small group and individual markets

because it brings low-risk people into the risk pools of these markets. Low-risk people generally are younger and healthier; they often decide not to purchase coverage because they think the premiums for insurance are more than what they would spend on health care in a year. If they are participants in the insurance pools for the individual markets, they will reduce premiums, since adverse selection is no longer a risk for insurers in the market.

The personal responsibility requirement could be used with any of the strategies described in this paper, of course, but by itself it will do more to reduce the risk of adverse selection than any of the other strategies. To date, Massachusetts is the only state that has implemented a requirement that individuals have health insurance coverage. But Massachusetts' experience reveals that the individual mandate was important in drawing many lower-risk individuals into the market.[3]

The personal responsibility requirement will do more to reduce the risk of adverse selection than any of the other strategies.

Second within the largest part of the pyramid are *health insurance exchanges*. Such exchanges would provide a market in which small firms or individuals could choose among alternative insurers offering a choice of minimally credible insurance plans. A critical part of the insurance exchange concept is that everyone is in one risk pool, thereby spreading the risk of high medical expenses among all the people who come to the exchange to purchase insurance. As the Congressional committees have noted, some of the insurance plan choices offered through the exchanges may attract a disproportionate share of higher-risk people (i.e., there might be adverse selection among the choices). To date, the Congressional committees have suggested leaving it to the states to create mechanisms to adjust premiums or payments to the plans to counter such adverse selection. The risk adjustment factors that have been suggested are those deemed relevant for estimating the actuarial risk of plan enrollees, such as age. In order to avoid adverse selection, exchanges must be sure that mechanisms for calculating risk do not rate individuals separately based on which products (i.e., benefit package or cost-sharing arrangement) they select.

Massachusetts, Washington, and several other states operate statewide insurance exchanges. Massachusetts' exchange (the Commonwealth Connector) has received substantial attention in the Congressional debates about health care reform because of its role in conjunction with the requirement that people obtain insurance. Both individuals and small groups from anywhere in Massachusetts can purchase insurance products via the Connector. The Connector helps people determine if they are eligible for income-based subsidies for the purchase of insurance. If so, they have a choice of five managed care plans that sell a standardized benefits policy offered through the Connector's Commonwealth Care exchange. People who are not eligible for the subsidies and small firms that want to offer group insurance through the Connector have health plan choices through the Connector's Commonwealth Choice exchange.[4]

A third risk management option that involves most of a state's population is *merging the small group and individual markets*. In most states, between two and five percent of the nonelderly population have individual, nongroup health insurance policies and perhaps 20 to 25 percent have small group coverage. In 2006, just before Massachusetts merged its individual and small group markets, there were about 45,000 people with individual coverage and about 900,000 people with small group coverage in the state. Adverse selection is a larger problem in the individual market than the small group market, and this, in turn, is a major reason for higher premiums in the individual market compared with the small group market. By merging the small group and individual markets, a state can combine the risk pools of the two markets. This substantially reduces the premiums for people whose only option for insurance is the individual market, while modestly raising premiums for people in small groups. Prior to the merger, Massachusetts estimated that the premiums for individuals would decline by 15 percent and premiums for small firms would increase about 1.5 to 2 percent.[5] The assumption behind merging the two markets is that substantial reductions in the premiums faced by individuals will cause many more young, healthy people to purchase coverage, thereby reducing the risk of adverse selection.

B. Strategies That Affect Some People But Have Less Effect on Adverse Selection Risk

Risk management strategies in the middle part of the pyramid in Figure 1 affect smaller numbers of people and do less for directly addressing adverse selection risk than the strategies in the top row. Risk management strategies in this second category include community rating of premiums and facilitating group purchasing arrangements. In general, these strategies are intended to help people or small firms that may be viewed as having a greater probability of high medical expenses and therefore have trouble accessing insurance at reasonable prices. The underlying assumption for both of these strategies is that they can reduce premiums for high-risk people and firms by creating situations where low-risk people and firms also are in the same risk pool.

Community rating of premiums occurs when the premium for a particular insurance policy is the same for everyone who wants to purchase the policy. The premium does not depend on the applicant's age, gender, region of residence within the state, marital status, or occupation. (Sometimes states allow modified community rating of premiums, where the premiums can be modestly adjusted for age — with younger people paying 75 percent of what people 55 to 64 years of age may have to pay, for example.) The intent of community rating is to subsidize the premiums of older people or those in poorer health by pooling such people with younger, healthier enrollees.

At first glance, pure community rating might seem to be a strategy that belongs at the top of the inverted pyramid since it

applies to everyone in a state. However, the policies in the top row also address adverse risk selection — and community rating by itself does not do this. In fact, it can exacerbate adverse selection when purchasing health insurance is a voluntary decision, as it is now. In general, community rating causes the premiums for younger, healthier people to be higher than what they would pay in markets with medical underwriting of premiums or age-adjusted premiums. As a result, young, healthy people may decide community rated premiums are too high and choose not to buy insurance in the individual or small group markets. However, if a large enough number of young and healthy individuals (or small firms) purchase insurance — as would be the case with a requirement that everyone have coverage — then premiums are lower with community rating in a market.

States can make it easier for small firms to obtain efficiencies that reduce their premiums.

Group purchasing arrangements are intended to pool risks among small firms (or small groups) so that together they might obtain efficiencies that reduce their premiums. States can make it easier for small firms to band together through cooperative arrangements or insurance marts to obtain insurance in the small group market. Such purchasing arrangements have existed for many years in some areas of the country. Cleveland, for example, has the Council of Smaller Enterprises (COSE), which has provided health insurance options to small businesses in northeast Ohio for more than 35 years. Unfortunately, other notable group purchasing cooperatives have failed in recent years, including PacAdvantage[6] (closed at the end of 2006), the Florida Community Health Purchasing Alliances (closed in 2000), and the Alliance in Colorado (closed in 2002). The purchasing alliances or co-ops failed mostly because they could not attract large numbers of small employers and covered lives — a lesson that the proposals for statewide insurance exchanges have taken to heart, since the statewide exchanges are similar in spirit to many of the co-ops and alliances that were in place for a few years in the 1990s. Several design issues that appear to have affected the success or failure of group purchasing arrangements are discussed in the section on implementation and design considerations.

C. State Strategies That Directly Target High-Risk People

Since people with a greater probability of having high-cost medical care (high-risk people) are a source of concern with adverse selection, some strategies are directly targeted at such people. The rationale for these strategies is that if high-risk people are removed from the insurance markets or segregated to self-contained groups, the markets will be able to operate more efficiently and premiums will be lower for those remaining in the markets. Three strategies fall into this group in the bottom row of the inverted pyramid: high-risk pools; assessments of insurers to share costs of high-risk people; and state-funded reinsurance.

High-risk pools exist in 34 states but currently cover fewer than 200,000 people nationally. High-risk pools are intended to help

people who have been rejected for individual insurance due to past medical problems and are viewed as likely to have very high medical expenses in the future. Premiums generally are more than 125 percent of the average premiums available in the regular individual market, but the premium revenues do not cover all the costs of people enrolled in the high-risk pools, and states have had to use general revenues to make up the difference. As a result of the high costs of subsidizing the high-risk pools, a number of states have closed enrollment to them. With fewer than 200,000 people covered by the high-risk pools, this strategy does not yet offer an option for covering all of the people who may have high probabilities of incurring medical expenses in the top one to five percent of the expenditure distribution. Moreover, estimating who is likely to be in the top one to five percent of the expenditure distribution in any given year is very difficult — people who are low risk in one year may have high expenditures in the following year, and people who have very high costs in one year may have average costs in the following year.

It is often suggested that high-risk pools be expanded so they can cover more high-risk people, thereby reducing adverse selection risk in the individual markets. But as they are currently construed, high-risk pools are not (and never were) intended to be large. Significant changes in the financing of the pools and in the mechanisms for determining who would be ceded to the pools would have to be made before the high-risk pools could be a viable option for reducing adverse selection risk.[7]

Assessments of insurers to share the aggregate costs of high-risk people are another way of spreading the costs among everyone who has insurance. This strategy is a means of redressing any effects of adverse selection that occur *within* the small group and individual markets — it forces the insurers in the markets to share the high costs by reimbursing insurers that end up with a disproportionate share of expenses. Note that this strategy does not reduce overall risk of adverse selection in the small group and individual markets — it simply shares the cost of adverse selection that occurs. Moreover, it does not reduce premiums in either market since the insurers pass along the assessments to their enrollees. Ultimately, the burden of high-cost people is shared by all those who have small group or individual insurance policies. An insurer's assessment generally is based on the insurer's share of all the health insurance policies sold in a market, although alternative structures have been used to set assessments. One drawback to assessments is that they do not contain incentives for insurers to manage the care and spending of high-cost people.

Government-sponsored reinsurance for insurers with enrollees who have high annual medical costs is a third strategy that targets the risk from covering high-cost people.[8] When states have considered reinsurance as a way of reducing the risk of adverse selection and expanding coverage to groups of uninsured people, they have done so with a state-funded reinsurance program where the

financing comes from a dedicated tax or from general revenues. Reinsurance available in the market generally has not been available for programs targeted at expanding access to health insurance for uninsured people because the reinsurers are wary of adverse selection. An advantage of reinsurance over the high-risk pools and the assessments on insurers is that reinsurance directly targets the risk of adverse selection — an insurer will know that if it enrolls a person who has medical expenses above the threshold at which reinsurance is triggered, the insurer no longer has to bear the full costs of the high-cost individual.

It is noteworthy that the strategies at the bottom of the inverted pyramid have not worked well in either managing the risk of adverse selection or in greatly expanding the numbers of people with private health insurance. If states really are to effectively address the risk of adverse selection and increase the number of people with health insurance, they have to use combinations of strategies in the upper parts of the pyramid.

If states are to effectively address the risk of adverse selection, they have to use combinations of strategies in the upper parts of the pyramid.

III. New York's Current Risk Management Strategies

Currently, New York State uses several different strategies to manage the potential for adverse selection and any associated costs that occur in its small group and individual (direct pay) health insurance markets: pure community rating; government-sponsored reinsurance of targeted populations; insurer assessments that help spread the cost of high-risk populations; and, on a regional scale, what might be considered insurance exchanges for small businesses. These strategies reflect previous efforts to expand access to private health insurance to individuals and small firms. They also reflect risk management initiatives that primarily focus on the middle of the inverted pyramid in Figure 1 — affecting a targeted share of the state's population and not entirely addressing adverse selection.

New York moved to pure *community rating* of policies sold in its small group and individual (self pay) insurance markets in 1993. Vermont is the only other state with pure community rating of policies sold in these markets. It is widely believed that pure community rating causes younger and healthier people to not purchase coverage, and that this leads to adverse selection in these markets.[9] But the evidence for this is not clear. Buchmueller and DiNardo (2002) compared the experience of New York's markets with those in Pennsylvania and Connecticut before and after New York imposed pure community rating. All three states saw a decline in coverage in their small group markets in the mid-1990s, and the decline among younger workers was almost identical in the three states. It is hard to conclude that New York's pure community rating per se caused the decline in enrollment in New York's individual and small group markets. New York's use of pure community rating affects only those people whose only options for purchasing health insurance are the small group and individual markets.[10]

New York's experience with pure community rating was built in part on the experience of Rochester, New York. Until the late 1990s, Rochester experienced decades of relatively low premiums for policies sold in its insurance markets due to community rating of those policies. An important feature of the relatively low rate of premium growth in the Rochester area was the fact that Rochester Blue Cross and Blue Shield insured more than 70 percent of the area residents. Because of the commanding market position of Blue Cross and Blue Shield, community rating has been maintained, and that has kept the cost of the care affordable for more people."[11] With lower premiums, young, healthy people did not abandon the market. This experience, plus the Buchmueller-DiNardo findings, suggest that community rating and a requirement for health coverage could be a relatively successful combination of strategies for managing risk in New York.

New York also has a state-funded *reinsurance pool* in its Healthy NY program, which began operating in 2001 and currently covers about 155,000 people. Healthy NY is for low-income people who do not qualify for Medicaid.[12] People can enroll as individuals or sole proprietors with incomes below 250 percent of the poverty level or through small firms (with 1 to 50 eligible employees). If they enroll through small firms, 30 percent of the employees must earn $40,000 or less (in 2009), the firm must not have offered group health insurance in the last 12 months, at least half of the eligible employees must participate in the program, and the firm has to contribute at least half of the premium. All HMOs in the state must participate in Healthy NY and the benefits package is relatively lean compared to Medicaid's covered services or most private health insurance policies' benefits.

The reinsurance portion of Healthy NY has changed since it began. Originally, the reinsurance was targeted at high-cost people — people with annual costs above $30,000, which in 2000 would have been people in the top one percent of the medical expenditure distribution in the country. The reinsurance covered 90 percent of the total claims for an individual in the range of claims between $30,000 and $100,000. Thus, the HMO and individual were responsible for all claims below $30,000; 10 percent of claims between $30,000 and $100,000; and all claims above $100,000 if someone had total claims greater than $100,000. Shifting the risk of enrollees having medical expenses in this range caused the premiums for Healthy NY to be half of those in the individual market for people with incomes above 250 percent of the poverty level.[13] However, very few people had such high expenses. In 2003, the range of per person total annual claims eligible for reinsurance was changed to claim amounts between $5,000 and $75,000. This caused the premiums for Healthy NY to drop again. Note, however, that the reinsurance pool is no longer targeting people with very high medical costs.

Arizona is the only other state with a fully operating state-funded reinsurance program that is designed to reduce

premiums in the small group and individual markets. Arizona's reinsurance program differs from New York's in that it has an "aggregate loss" reinsurance design while New York has an "excess-of-loss" design.[14]

The aggregate loss design does not focus strictly on people with very high medical expenses; it is activated when the sum of all reimbursable claims for everyone with a particular policy exceed a predetermined threshold. Total claims for all the people who hold a particular policy (or all the small firms that bought a particular policy) could exceed a threshold if a large number of people were to use more medical care than expected, perhaps because of a widespread flu causing many people to be hospitalized for a few days. Excess-of-loss reinsurance, in contrast, is activated when an individual's total reimbursable claims exceed a threshold. In both designs, the originating insurer is responsible for some share of the costs above the threshold at which the reinsurance is activated. The advantage of the excess-of-loss relative to the aggregate loss design is that it has strong incentives for insurers to manage the care of people who are very sick and have high medical expenses.

New York also has an assessment mechanism that is used to spread costs of high-cost individuals in the individual market so insurers that insure a disproportionate number of costly individuals can receive partial reimbursement for their costs — essentially a stop-loss pool. However, the program has been underfunded in recent years, making it relatively ineffective, covering only 32 and 46 percent of claims for health maintenance organizations (HMOs) and point of service (POS) plans, respectively.[15]

Finally, New York currently has a handful of what might be considered insurance exchanges in the downstate area, and one initiative that might be considered a group purchasing arrangement for individuals (Working Today). The small business exchange, known as HealthPass, provides one-stop shopping for small businesses and sole proprietors in the five boroughs of New York City and the six New York counties surrounding New York City that make up downstate New York. Through HealthPass, small businesses can offer their employees 30 policy options from four major insurers in the New York metropolitan area; sole proprietors have a choice of five different policies offered by one major insurer (Oxford). HealthPass is not subsidized, although government funds were used to start the program and philanthropic support has enabled the program to expand its scope of operation. A similar but subsidized program, known as Brooklyn HealthWorks, also offers coverage to businesses in Brooklyn, and Working Today offers coverage through the Freelancer's Insurance Company.

IV. Implementation and Design Considerations

As New York and other states contemplate how best to build on what programs and initiatives already exist in the state and

If national reforms are enacted, states must be prepared to play a large role in implementing policies and determining how federal reforms intersect with states' programs and regulations.

how better to manage risk in the health insurance market if there are federal reforms, there are several issues to consider. For instance, states must consider how federal reforms could change the landscape of risk in their insurance markets. If national reforms are enacted, the state also must be prepared to play a large role in implementing policies and determining how federal reforms intersect with states' programs and regulations. If federal reforms require all individuals to obtain insurance coverage, states might be tasked with determining who would be exempt from this requirement. They also might need to determine subsidy levels for lower income individuals, how best to provide wrap-around services for persons whose needs are not met by federal minimum benefit standards, how best to enroll people in an insurance exchange, how to coordinate an exchange with other public health insurance programs, and so on.

A. Whether and How to Maximize Insurance Coverage

There is a possibility that two risk management strategies discussed in this paper — personal responsibility and an insurance exchange — may be passed in some form at the federal level. However, if these reforms are not passed, New York or other states may choose to enact them. As previously noted, New York's and most other states' risk management strategies to date have focused primarily on the middle section of the pyramid (i.e., community rating, group purchasing).

If federal reform does not happen and New York is seeking ways to substantially increase health insurance coverage rates, it could consider implementing risk management strategies that impact most of the population, especially personal responsibility and a statewide insurance exchange. The experience of Massachusetts suggests that implementation of an individual mandate would have broader support if it were coupled with a "shared responsibility" plan.[16] In other words, employers, insurers, government, and individuals should be supporting insurance reform through some form of financial contribution.[17]

Merging the individual and small group markets is another risk management option that is likely to be left up to states. An analysis conducted by the United Hospital Fund indicates that merging the small group and individual markets in New York could result in an additional 11,500 to potentially 23,400 individuals receiving coverage in the state.[18] The Urban Institute estimates that merging the markets "increases coverage by over 74,000 people relative to the public expansion alone."[19]

Increased coverage rates from a market merger are more likely to occur in the individual market because premiums for individuals will be lower than they are now if the markets are merged. Although some original estimates predicted that premiums for small groups might increase if the markets were merged, the Urban Institute's modeling of a market merger in combination with a public program expansion predicts that the migration of some

high-cost low-income people out of the private insurance market would "bring down the average cost of single policyholders in the private market. As the premiums in the private merged market decline as a result of the exit to Medicaid and the broader pooling, more healthy previously uninsured single people enter private coverage."[20]

As noted earlier, estimates in Massachusetts were that the premiums for individuals would decline by about 15 percent, while premiums for small firms would increase only 1.5 to 2 percent once the markets were merged in 2007. The merger of the markets occurred at the same time that the Connector started operations, so it is not possible to definitively estimate what the actual effect of the merger was on the premiums for individuals and small firms. Nonetheless, the experience of Massachusetts suggests that a combination of risk management strategies implemented simultaneously, including a personal responsibility requirement, an insurance exchange, and a small group and individual market merger is likely to be more effective at increasing coverage than any one strategy by itself.[21]

New York also could examine ways to adjust its stop-loss fund (or reinsurance pool) for the individual market for people with incomes above 250 percent of the poverty level. (People with incomes below 250 percent of the poverty level are eligible for Healthy NY.) In recent years, however, the stop-loss pool has not been fully funded. If the program were adequately funded, Empire Blue Cross and Blue Shield estimates that premiums could decrease significantly.[22] To explore this policy option further, it would be helpful to supplement Empire's estimates with an independent analysis of the estimated reduction in premiums. It also would be useful to estimate how much insurance take-up in the direct pay market would increase if premiums were decreased by 15 percent and whether the cost to the state of fully funding the program would be worth the investment in terms of the rate of coverage increase.

Finally, New York could choose to modify one of its existing risk management methods — reinsurance. However, the impact of modifying reinsurance on coverage will be dependent on what changes are made to the program (e.g., whether it is part of a merged individual and small group insurance market or not, whether the reinsurance corridor is changed, whether eligibility requirements are changed, etc.). Currently, the program provides coverage for approximately 155,000 people, a relatively small percent of the state's total uninsured population, estimated between 2.5 and 3 million.[23] (More than 450,000 people have enrolled in Healthy NY since the program began in February 2001, suggesting that it serves at least two groups of people — those who need short-term insurance when they are between group insurance plans and those who maintain the coverage for long periods.) Harder to quantify is the impact on coverage from reinsurance's effect on stabilizing premiums. Stabilizing premiums increases the

likelihood that more employers will provide coverage, increasing accessibility.[24]

B. Affordability

As economist Elliot Wicks has noted, "All insurance involves subsidies from low-risk to high-risk but there may be better/fairer ways … to spread risk/subsidize risk such as direct government subsidies to just high-risk people, vouchers to buy 'normal' market coverage, high-risk pools, subsidies from all other insurers, [and] government funded reinsurance in [the] individual market (subsidies from government are probably fairer, risk spread through tax system based on ability to pay)."[25] If either the federal government or New York decides to require that individuals obtain insurance coverage, they also must consider reasonable ways of exempting individuals for whom insurance is unaffordable or providing subsidies to make it affordable.

Massachusetts alleviates the financial burden of personal responsibility by providing subsidies and exempting certain populations from the requirement. An individual mandate in New York would require more subsidy funding than most other states because there are more low-income persons in New York, the cost of living is higher, and insurance is expensive. Yet such subsidies would be a crucial part of this policy intervention to ensure affordability.

Expanding Medicaid and providing subsidies for the uninsured in Massachusetts who have incomes below three times the poverty level is perceived by many to be so costly that the health reforms in Massachusetts will not survive in the current economic downturn. But in June 2009 the Massachusetts Taxpayers Foundation released a report stating that the health reforms did not lead to uncontrolled costs in the state.[26] In particular, the report concludes by saying, "…thus far the underlying financial model of shared participation is working well, with major strides in reducing the size of the uninsured population and only a marginal impact on state spending."

Effectively interfacing with other public health insurance or insurance assistance programs will be one of the biggest implementation challenges facing New York.

C. Administration of Subsidies and Program Eligibility

Effectively interfacing with other public health insurance or insurance assistance programs will be one of the biggest implementation challenges facing New York should it or the federal government establish an insurance exchange or a requirement for insurance coverage. In New York, determining eligibility for subsidies in an insurance exchange would involve interfacing with the Medicaid program, Child Health Plus, Family Health Plus, Healthy NY, the Medicaid buy-in, and so on.

In order to effectively determine who is eligible for a subsidy and at what level, New York and other states will need to be able to quickly determine individuals' income levels. Income tax data is one source for this information, but states also may draw upon public insurance program data (assuming their public insurance programs are currently able to identify persons potentially eligible

for public insurance). Massachusetts was able to implement its Commonwealth Care program with its subsidies within the year that the health reform legislation was enacted because it could use the software programs designed for Medicaid and the Children's Health Insurance Program (CHIP) to determine eligibility.

The situation of New York is complicated by the fact that counties still largely administer Medicaid eligibility, although new efforts are underway to centralize Medicaid eligibility for services other than long-term care. The fact that Massachusetts had a fully functioning information technology platform for enrollment prior to implementation of personal responsibility was an overlooked but essential part of successful implementation in this state.

D. Enforcement of Personal Responsibility

If federal reforms include a requirement that all persons obtain health insurance or if New York chooses to implement personal responsibility, the state can draw upon the experiences of Massachusetts to determine how best to enforce personal responsibility. Massachusetts used the tax filing system to help enforce its individual mandate. New York could use a similar method. Most researchers agree that "enforcement of the mandate through tax system is the most efficient approach."[27] New York might also consider coupling individual responsibility with regulatory reforms such as guaranteed renewability. "Guaranteed renewability effectively pools risks and protects consumers from price spikes."[28]

E. Implementation Issues With an Insurance Exchange

Geographic Scope: The insurance exchange in Massachusetts (the Connector) has been utilized by an estimated 175,000 individuals and businesses. Most of the people who have obtained health insurance through the Connector are individuals; only about 19,000 people have enrolled through small firms. New York is already home to a quasi-regional exchange, HealthPass, which, as noted earlier, also can be characterized as a group purchasing arrangement for small businesses. If HealthPass were expanded to other parts of the state and opened to persons purchasing insurance in the direct pay market, it might have a significant impact on coverage. It may make sense to create two exchanges in New York, where the most obvious geographic difference in the insurance markets exists: upstate and downstate. Whether the state has a regional or one statewide exchange, the basic insurance products in each exchange should not vary much.

Avoiding Adverse Selection: Researchers agree that insurers competing outside of group purchasing arrangements "cherry-pick the healthiest groups."[29] To avoid this type of adverse selection in an insurance exchange, Linda Blumberg of the Urban Institute and Karen Pollitz of Georgetown University's Health Policy Institute suggest that an insurance exchange should

be the exclusive marketplace or ensure equality in and outside of the exchange. Similarly, Sarah Lueck, a health policy analyst at the Center on Budget and Policy Priorities (CBPP), recommends that "insurers should compete on the basis of price and quality; less-healthy individuals are not charged higher premiums if they end up in plans that disproportionately enroll less-healthy people; all enrollees get at least a basic level of comprehensive benefits; [and] consumers are able to compare plans."[30] It would be essential for any insurance exchange to follow these principles in order to avoid adverse selection. It is widely believed that one of the reasons that California's now-defunct PacAdvantage was unsustainable was because it attracted higher risk individuals.

Other Design Features of an Exchange: HealthPass is in part successful because of its "flexible, user-friendly design." The program offers small businesses a broad choice of benefit options and premium levels while keeping the processes for enrollment, billing, and member services simple."[31] Successful design components in HealthPass should be retained in any new or expanded group purchasing arrangement. Blumberg and Pollitz also recommend that an exchange require insurers to provide data and create accurate risk adjusters, require enrollment through a centralized place or entity, and monitor enrollment and disenrollment.[32]

V. Conclusion

Insurers in the small group and individual health insurance markets face the threat of adverse selection. The risk of adverse selection is a major reason that insurers charge higher per person premiums in these markets than is the norm for large employer groups, and deny or restrict coverage to some people in states where that is permitted. There are strategies to manage this risk that New York and most other states have not fully explored or implemented, which could be effective at decreasing the number of uninsured. Among these strategies are merging the small group and individual markets, creating a statewide insurance exchange, and instituting a requirement that people be personally responsible for obtaining health insurance coverage. However, with each new strategy there are essential considerations, for example, ensuring that subsidies to individuals to pay for insurance are adequate, that rating regulations and product offerings are equal in and outside an exchange, and that any changes are coordinated with changes in federal legislation.

Every state will need to work through these considerations in tandem with whatever federal legislation emerges this year to expand insurance coverage and control costs. And as the proverbial saying goes, the devil is in the details in whether the reforms will have the intended results. If state policymakers can implement strategies with the details that manage risk, they will greatly advance efforts to reduce the number of uninsured.

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Endnotes

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