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Assembly
California Legislature



ASSEMBLY COMMITTEE ON HEALTH
DR. RICHARD PAN, CHAIR

Health Insurance Informational Hearing: What Policy Makers Need to Know About Risk Pools and Adverse Selection

Tuesday, January 15, 2013

1:30 p.m.

State Capitol, Room 4202

PURPOSE AND INTRODUCTION

As part of implementing the health reforms enacted by the federal Affordable Care Act (ACA), state legislators across the United States (US) are making policy choices affecting how individuals will purchase health insurance in 2014. To effectively implement the ACA, each state will need to evaluate its current health insurance markets and existing state regulatory climate so as to craft state-based policies consistent with the ACA and appropriate given the unique characteristics of the state.

The subject of much debate, the ACA, enacted in March 2010, is the largest piece of health policy legislation in over 45 years. One of its main objectives is to dramatically increase the number of individuals with health insurance coverage in this country. By mandating health insurance coverage for all with subsidies to offset the costs for low-income people; expanding Medicaid eligibility; establishing virtual market places, known as health insurance exchanges, to assist individuals and small employers in purchasing health insurance; allowing young adults to remain covered under their parents' health insurance; and, requiring significant nationwide reforms of state health insurance markets such as requiring health insurers to take all comers despite preexisting conditions, the ACA should lead to the largest expansion of healthcare coverage since the creation of Medicare and Medicaid in the 1960s.

The purpose of this informational hearing is to highlight for policymakers issues affecting health insurance risk pools and related insurance concepts such as adverse selection and risk adjustment. The Assembly Health Committee is convening this hearing to provide California policymakers a better understanding of the ACA provisions aimed at limiting the potential for adverse selection. In addition, speakers will identify state level policy options to minimize adverse selection and policymakers will learn from experts how insurance companies and

insurance consumers are likely to respond to the sweeping changes contemplated in the ACA. The goal being to ensure state policymakers are informed about policy options to both keep insurance costs down and at the same time ensure effective care for those sickest among us.

Adverse selection is inherent in all insurance and particularly with respect to health insurance. Adverse selection is the tendency for individuals to select different health insurance products based on what is most cost effective to meet their anticipated short term health needs and expected use of health services. Adverse selection results when consumers who anticipate needing health care services and the protection of health insurance, seek out and buy coverage while those who consider themselves healthy, stay out of the market or purchase only minimal coverage. Adverse selection is of concern because it leads to an uneven distribution of risks and healthcare costs. The more adverse selection there is in a particular product or market the higher the costs for that product or market. Traditional tools used to minimize adverse selection have the effect of incentivizing insurance companies and risk bearing organizations (medical groups that are paid fixed monthly payments based on a per member per month basis called capitation) to potentially avoid populations that have higher medical needs. Many of those risk avoidance strategies will no longer be available because of the ACA. The ACA also establishes programs such as reinsurance, risk adjustment and risk corridors to discourage avoidance of high risk populations.

Health reform is long overdue given the profile of health care and health care costs in this country. The US spends more per person on healthcare than any other country in the world, more than two times the average of industrialized nations (see figure 1).¹ The US also has the fastest rate of increasing healthcare spending of any industrialized nation. US healthcare expenditures take up about 17.6% of the country's Gross Domestic Product, more than twice the average of industrialized nations. But for all the money spent, the US is getting far from "first world" results. The last time the World Health Organization (WHO) ranked quality of healthcare between countries, the US was 37th.² US life expectancy and infant mortality rank below that of almost every other industrialized nation, somewhere between 34th and 51st. There are some 16 million people uninsured in the US, about 16% of the population and a similar number of underinsured individuals, people who have health insurance inadequate to meet their healthcare needs.³

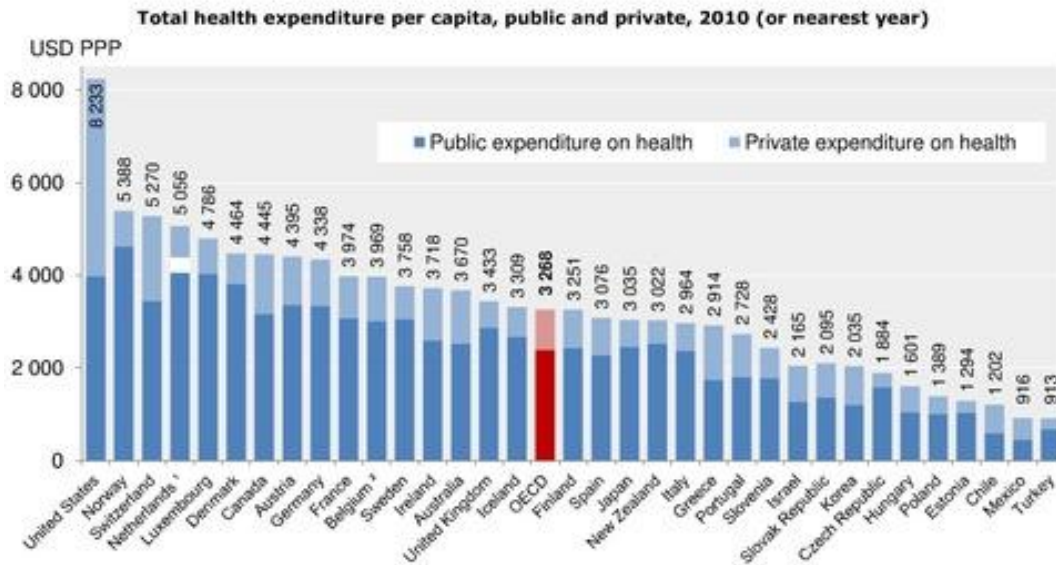
¹ Organization for Economic Cooperation and Development (OECD) Health Data - <http://www.oecd.org/health/healthpoliciesanddata/oecdhealthdata2012.htm>

² WHO - <http://www.who.int/research/en/>

³ Income, Poverty and Health Insurance Coverage in the United States:2010, United States Census Bureau

Figure 1

US spends two-and-a-half times the OECD average

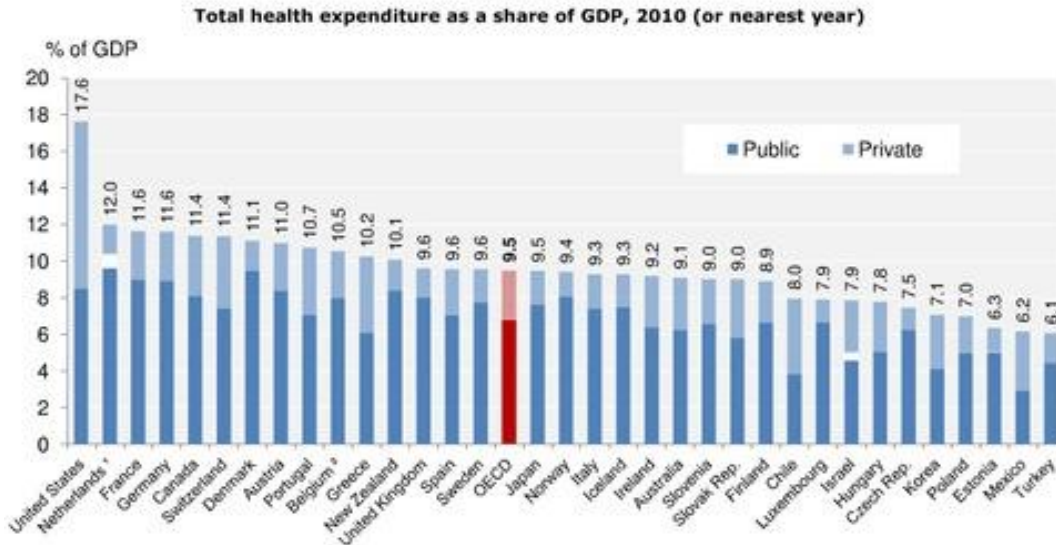


1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
 2. Total expenditure excluding investments.
 Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2012.

Figure 2

At 17.6% of GDP in 2010, US health spending is one and a half as much as any other country, and nearly twice the OECD average



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Source: OECD Health Data 2012.

BACKGROUND ON CALIFORNIA'S INSURANCE MARKET

Most Californians have some form of health insurance coverage, however a sizeable percentage have no insurance coverage at all. In California for the nonelderly population, approximately 50% of people have health coverage through employer-based insurance. Another 18% of Californians get coverage through public programs, such as Medi-Cal or Healthy Families, 12% obtain insurance directly or through federal veterans benefits and 20% are uninsured.⁴ Private insurance can be obtained in the group market, either through large employers (51+ employees) or small employers (<50 employees)⁵ or in the individual market where insurance is purchased directly from insurance companies. Some employers pay the health claims of their employees directly and contract with insurers for the provider network and claims administration (known as self-insurance).

Federal and state laws regulating health care coverage can vary depending upon the market, type of insurance product or regulator. For example, California already requires insurers selling insurance in the small group market to take all comers regardless of health status, claims experience or demographic profile (known as guaranteed issue or guaranteed availability). However this is not currently the case in California's individual insurance market. California's individual and small group health insurance markets serve just fewer than 15% of the state's population - about 5 million people altogether. Premiums for individual coverage vary by age as much as five-fold. In 2014, ACA rules will limit these differences in both individual and small employer markets to a three-to-one ratio, increasing premiums for younger enrollees and reducing them for older ones in many instances. Insurance currently purchased in the individual market provides less comprehensive coverage, paying an average of 55% of medical expenses, compared to 80% to 90% of expenses for group coverage.⁶ The ACA requires guaranteed issue in the individual market in 2014.

In California, health insurance regulation is divided between two regulators, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). Health Maintenance Organizations (HMOs) and a few large Preferred Provider Organization (PPO) products are licensed by the DMHC. Approximately 21.6 million Californians are covered by products regulated by the DMHC. California also has hundreds of medical groups which contract with HMOs for primary and specialty care services. These risk bearing organizations are monitored by the DMHC. Additional PPO and traditional indemnity products are licensed by the CDI and those products insure approximately 2.6 million Californians.⁷ More products in the

⁴Legislative Analyst's Office CalFacts 2013

⁵ ACA and California law revise the definition of small employer to 1-100 as of 2016.

⁶ <http://www.chcf.org/publications/2011/04/ca-individual-small-group-eve-reform#ixzz2FchBeOx6>

⁷Ready for Reform? Health Insurance Regulation in the California Under the ACA. Kelch Associates, CHCF June 2011

individual market are licensed by CDI. Both departments administer consumer assistance and complaint programs as well as independent medical review programs which allow individuals to obtain external review of treatment decisions made by insurance companies. Self-insurance is not state regulated.

HEALTH INSURANCE RISK POOLS

Insurance risk is directly associated with an individual's anticipated or potential costs. In regards to health insurance, this means individuals with pre-existing conditions or a history of health service use have higher potential costs and thus higher associated risk. The risks, or costs, associated with poor health can be spread across large or small populations or pooled in a variety of arrangements. Spreading risk across a broad group of individuals (both healthy and sick) enables health insurance companies or risk bearing organizations to spread the costs for high cost patients across the entire pool to minimize volatility and absorb losses helping to moderate premium costs.

A relatively well studied concept related to health insurance coverage is that of adverse selection. As will be discussed in detail below, adverse selection leads to an uneven distribution of risk across the insurance spectrum, significantly disrupting the health insurance market as a whole. It is an important concept to understand as changes are made to broaden insurance coverage.

ADVERSE SELECTION, A DEFINITION

Most individuals have a relatively good understanding of their health status and expected short term healthcare needs.⁸ The evidence has demonstrated that when given a choice, healthy people who do not expect to use much healthcare resources either choose to buy no insurance at all or choose cheaper, less comprehensive plans.⁹ These less comprehensive plans typically have lower monthly premiums (monthly payments to stay insured), higher deductibles (the amount of out of pocket expenses that must be paid for by the insured person before insurance will begin to cover a percentage of costs), higher copayments (amounts patients must pay for a service not covered by insurance), and higher annual or lifetime out of pocket maximums (caps on amounts of coverage or out pocket costs). Since these individuals expect to need very little healthcare, they tend to choose products that are the most affordable on a day to day basis, essentially

⁸ Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Department of Health and Human Services. Federal Register, Vol 77, No 136, July 15, 2011.

⁹ Cutler, David M., Healthcare and the Public Sector, Working Paper 8802, National Bureau of Economic Research, February 2002.

buying coverage to protect themselves from catastrophic losses. Less healthy individuals who expect to need or use more healthcare services will tend to choose more comprehensive products, with lower deductibles, copayments and out of pocket maximums.⁹ These individuals choose more comprehensive products that cover more of the services they need, seeking out coverage at a premium that is the lowest possible given the level of coverage they believe is needed. This logical, seemingly natural tendency for individuals to preferentially choose the lowest cost health insurance product that best fits their anticipated healthcare needs is described by the term adverse selection or selection bias.^{9,10}

CONSEQUENCES OF ADVERSE SELECTION

Adverse selection leads to inequities of coverage in a free market health insurance system. A main consequence is the uneven distribution of risks and healthcare expenditures across the various insurance products.⁹ Cheaper, less comprehensive products will tend to have a larger share of healthier individuals. After all, these individuals chose the cheaper products because they did not anticipate needing much healthcare. Thus, the cheaper products will tend to have enrollees who use fewer resources and have lower costs. The more expensive, comprehensive products in contrast, will have a larger share of less healthy individuals, who tend to use more healthcare resources and have higher costs. This uneven distribution is termed a heterogeneous risk distribution.¹⁰

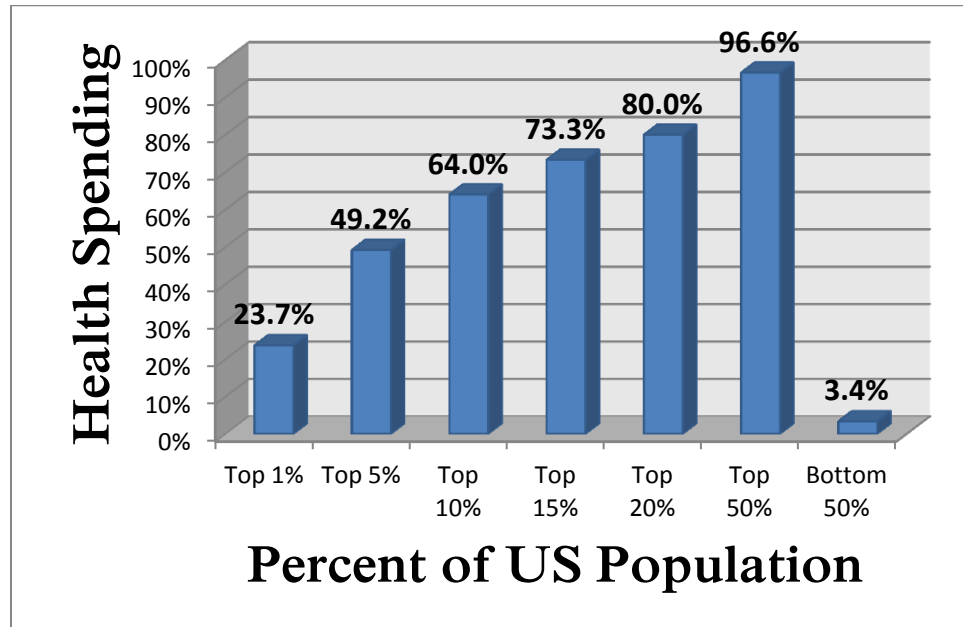
The distribution of health risk has major implications for insurance companies and risk bearing organizations and the people they enroll. To this point, an important trend to understand is that the distribution of healthcare spending in the US, as it is in almost all industrialized countries is skewed. For example, in any given year, the top 10% of individuals with the highest healthcare expenditures use up about 65% of the nation's total expenditures. By comparison, 50% of individuals have healthcare costs that are only about 3.4% of the total (see figure 3).¹¹ Studies have suggested that even a small, statistically insignificant difference in the distribution of healthy versus less healthy individuals across different insurance products can affect costs significantly.¹¹ Thus, the comprehensive products with a larger percentage of less healthy individuals will have to deal with significantly higher costs. This often forces these insurance companies to increase premiums, copayments, deductibles, out of pocket maximums or all of the above. As insurance companies charge their customers more for insurance, only those individuals who really need health care and can pay for it are willing to enroll or remain in the product. This skews the health status, risks and costs even more until the company has to charge

¹⁰ Cutler, Zeckhauser, Adverse Selection in Health Insurance, National Bureau of Economic Research, January 1998.

¹¹ Illustrating the Potential Impacts of Adverse Selection on Health Insurance Costs in Consumer Choice Models, Kaiser Family Foundation, November 2006

so much to cover the costs of caring for its less healthy enrollees that it can no longer stay in business, a phenomenon described as a death spiral.¹⁰

Figure 3



Another consequence of adverse selection is that insurance companies are discouraged from providing improved coverage desired by beneficiaries with chronic conditions. For example, people with mental illness have adverse selection challenges because they have higher than average total health care costs, including costs not related to the mental health condition.¹² Research cited by Barry et.al, indicates that higher health care costs associated with mental illness have been shown to pose budgetary risks and market instability in multiple health care contexts in the United States and elsewhere.¹³ Thus, health insurance companies are at risk if they provide better mental health coverage than their competitors because they may attract more people with mental health conditions. Even if the mental health costs are managed, the associated increased costs of providing medical care to this population can be a disadvantage for the company.

One last consequence of adverse selection is that it leads to an inefficient, often inappropriate distribution of health insurance across the population.¹⁰ As already discussed, individuals balance their perceived need for health insurance with the costs, with healthier individuals choosing more low cost, low coverage products and high risk individuals choosing higher cost,

¹² Barry, Weiner, Lemke, Busch: Risk Adjustment in Health Insurance Exchanges for Individuals with Mental Illness (Am J Psychiatry 2012; 169:704-709)

¹³ ibid

more comprehensive products. However, if a person incorrectly judges his or her health status, experiences an unexpected or sudden illness or accident, he or she may end up with healthcare coverage that is inadequate for his or her actual healthcare needs. Health insurance that does not provide adequate coverage or covers only a relatively small portion of the actual costs, can lead to personal debt and even personal bankruptcy. Inadequate insurance and insurance with aggressive risk management tactics can lead to inefficient care if care is delayed because of high cost sharing or limited network issues resulting in treatment delivered in more costly settings such as emergency rooms, hospitals and intensive care units. Conversely, individuals who can afford more comprehensive coverage may end up being over insured, with the potential for them to use excessive healthcare resources, a term described as moral hazard.⁹ This mal distribution of risks and costs not only wastes limited healthcare resources that could be better utilized by others, but excessive tests, procedures and treatments have their own inherent risks.

MANAGING RISK

Given the skewed distribution of healthcare expenditures between the healthy and the sick, insurance companies have an incentive to aggressively manage their populations in some cases using techniques to attract the healthy and avoid those most likely to need or use health care services. Under the current healthcare system, insurance companies have many tools that focus on limiting risks and costs. Table 1 outlines some of these methods, termed front and back end strategies.

Table 1
Strategies to Manage Risks and Costs

Front End	Back End
Barring enrollment based on Pre-existing conditions	Limits on the amount, duration or scope of coverage
Medical underwriting to classify risks and adjust premiums	Cost sharing
Targeted enrollment	Utilization management and procedures for challenging coverage denials
Exclusions and waiting periods	Network size, composition and payment
Open and special enrollment periods	Tiering provider networks
	Coverage rescissions and cancellations

In the current insurance market, one method insurers can use to manage risks and costs is to deny coverage to those with pre-existing conditions and other high risk characteristics. This is an

example of a front end strategy.¹⁴ Another strategy is to charge different premiums based on an individual's age or pre-existing conditions. More subtle front end strategies that help attract healthier patient populations include marketing specifically to a healthier patient pool (i.e., products aimed at students or healthy young adults) or selling primarily to large employer groups so that risk is automatically more spread out. Offering gym memberships or accounts to purchase outdoor sporting equipment are strategies aimed at enrolling individuals with a certain baseline level of health. Those with chronic medical conditions are much less likely to be attracted to or able to benefit from these incentives. Denying coverage for medical conditions that were present prior to enrollment, having a freeze period after enrollment where no services will be covered for a certain period of time or only allowing enrollment during certain months of the year are other ways of limiting the enrollment of individuals who already have known medical issues or anticipate they will need to utilize healthcare resources soon.¹⁴

While the back end strategies described below are permissible, some insurance companies are more aggressive in their use of these tactics than others. Less access to specialists, a more restricted referral process, more exclusions of coverage, higher copayments, deductibles and out of pocket maximums are all mechanisms that could impact the health mix of the patient population and deter individuals with serious and chronic conditions who fear limitations on their access to in network providers. Other back end strategies include a more stringent utilization review process to determine what care will not be covered or a more difficult appeals process for enrollees to challenge coverage denials. Tiering provider networks based on performance or price offers an additional technique for shielding a company against risk to the extent tiering algorithms are proprietary and substantial variation exists among plans.^{14,15} The ultimate back end strategy would be to cancel an individual's insurance after enrollment if they develop a specific high cost medical condition or if their annual costs exceed a certain level, known as rescission.¹⁴ Rescission has been prohibited under state and federal law.

ACA MECHANISMS TO REDUCE ADVERSE SELECTION

The economic, legal and health policy literature highlight many potential mechanisms to reduce adverse selection and its consequences which can be controversial and complex. Many of these propositions have their opponents as well as proponents. The ACA includes key reforms that, among other things, are aimed at reducing adverse selection.

¹⁴Rosenbaum; Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law and Federal Reform Options, Executive Summary, O'Neill Institute, Legal Solutions in Health Reform, Fall 2009.

One main reason that adverse selection occurs is that there are so many insurance products available with varying levels of coverage and costs from which to choose. A lack of transparency about coverage and cost differences can lead to excessive market fragmentation and increase the opportunities for adverse selection. For this reason, the ACA requires insurance companies to only offer products at specified actuarial values. Under the ACA, products have to meet minimum actuarial requirements categorized as “catastrophic, bronze, silver, gold or platinum” levels of coverage. In addition, the ACA requires companies participating in exchanges to offer at least one silver and gold level product. California has taken it a step further requiring insurers both inside and outside the exchange to offer all tiers of products, allowing only insurance companies participating in the exchange to offer catastrophic plans, and allowing the exchange to standardize the products it offers.¹⁵ Furthermore, the ACA will require all non-grandfathered¹⁶ health insurance plans in the individual and small group markets to cover at a minimum ten essential health benefits including ambulatory and emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services and chronic disease management and pediatric oral and vision care. Thus, insurance companies will not be competing for enrollees primarily based on significant differences in the comprehensiveness of coverage. The ACA contemplates coverage among insurers based on price, quality and service instead of based on benefits or enrollee risk. Standardization of benefits is aimed at emphasizing price and quality comparisons but some also believe that it may limit the potential for insurance company innovation and creativity.¹¹

Another ACA strategy to reduce adverse selection is to prevent insurance companies from pricing their products based on health status.¹⁴ The ACA requires all individuals to buy at least minimum coverage thus reducing the chances that high cost individuals will be pooled into only a few insurance products and charged a higher price. Guaranteed issue will also ensure that these less healthy individuals will have roughly equal access to all products. Insurance companies have pointed out, that in order to not have price or coverage differences based on pre-existing conditions, mandatory health insurance for all is essential.¹⁴ In addition, insurance market reforms in the ACA applicable to individual and small group insurance in the commercial market are intended to prevent exchanges from ending up with disproportionately high cost, unhealthy populations. For example, the ACA mandates a single risk pool so that insurance companies must combine the experience for all individual products or all small group products offered in the exchanges and in the outside commercial market. Another method to help spread risk already implemented in state and federal law is to prohibit rescission (insurance companies

¹⁵ Weinberg, Micah and Haase, Leif Wellington, State-Based Coverage Solutions: The California Health Benefit Exchange, The Commonwealth Fund, May 2011.

¹⁶ Products sold after March 2010, the date the ACA was enacted. Products designated as “grandfathered” are those products in place as of March 2010 that cannot alter cost of benefits substantially.

dropping an individual coverage if he or she develops a specific medical condition or exceeds a certain expenditure level). The goal is to increase the likelihood that all insurers are taking on some part of overall risk.

The ACA proposes several programs to compensate for adverse selection that may still result for any product or company. For example, risk adjustment is the idea of compensating insurance companies or healthcare providers who enroll patients with higher risk and higher expected health expenditures such as those with cancer, chronic heart or lung disease, dementia and psychiatric illness.¹¹ Under risk adjustment, companies that have an overall less healthy pool based on risk factors or health expenditures receive supplemental payments that come from payments made by companies who end up with lower overall risks and costs. Another method is to have all expenditures over a certain amount be paid out of a central pool funded by a uniform tax on all insurance companies.¹¹ These options are intended to level the playing field for insurance companies that end up caring for a larger share of the less healthy, costlier population. Opponents of risk adjustment note that it is difficult to identify and quantify all the risk factors that lead to higher healthcare utilization and so risk adjustment will frequently be incomplete. Some argue that insurance companies can also engage in the practice of “upcoding,” labeling more people as having those identified risk factors to maximize their compensation when in fact these individuals are not utilizing more resources. Lastly, diverting funds from some insurance companies to give to others may result in these companies placing less emphasis on efficiency, utilization review and avoiding excessive or non-evidence based care.¹¹

RISK ADJUSTMENT, REINSURANCE, RISK CORRIDORS

As discussed above, the ACA creates programs to eliminate incentives for health insurance companies to avoid those with pre-existing conditions or who are already in poor health. These programs also aim to reduce uncertainty that could lead to increased premiums in 2014. This latter risk will likely be greatest in the first three years of the exchange; however, risk should decrease as the new market matures and insurers gain actual claims experience with this new population.¹⁷ The programs are risk adjustment, reinsurance and risk corridors. Discussed conceptually above, risk adjustment will be a permanent program to spread the financial risk borne by health insurance companies. It is intended to reduce or eliminate premium differences among products based solely on favorable or unfavorable risk selection in the individual and small group markets. All non-grandfathered plans in the individual and small group markets are subject to risk adjustment, inside and outside the exchanges. States have the option to establish a risk adjustment program, but are not required to do so.

¹⁷ 45 CFR 153

The risk corridor program provides additional protection for health insurance companies in health benefit exchanges. It addresses the uncertainty in rate-setting in the first several years of the ACA by creating a mechanism for sharing risk between the federal government and health insurance companies. Health insurance companies with costs that are at least 3% less than the companies' cost projections will remit charges for a percentage of those savings to the federal Department of Health and Human Services (HHS), while companies with costs at least 3% higher than cost projections will receive payments from HHS to offset a percentage of those losses. The ACA directs HHS to administer the risk corridors program from 2014 through 2016.

The transitional reinsurance program is intended to help stabilize premiums for coverage in the individual market due to individuals who will have high health expenditures during the first three years of exchange operation. All health insurance companies, self-insured group health arrangements, and third party administrators on their behalf, will make contributions to support reinsurance payments to insurance companies with individual market products that cover individuals with high medical costs. States have the option to establish a reinsurance program. If a state elects not to establish a program, HHS will establish the program and perform the reinsurance functions for the state. Payments will be based on a portion of costs per enrollee paid once claims costs reach a certain level or "attachment point" and until a payment limit or "cap" is reached.

Table 2

Program	Reinsurance	Risk Corridors	Risk Adjustment
Purpose	Provides funding to insurers that incur high claims costs for enrollees to offset high cost outliers	Limits insurer losses (and gains) to protect against inaccurate rate setting	Transfers funds from lower risk insurers to higher risk insurers to protect against adverse selection
Administration	State option to operate, regardless of whether the state establishes an Exchange	Federal Health and Human Services	State option to operate if the state establishes an Exchange
Participants	All insurers and third party administrators on behalf of group health plans contribute; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments	Qualified Health Plan (meets specified ACA standards including participating in Exchanges)	Non-grandfathered individual and small group market plans, inside and outside the Exchange
Duration	Three years (2014-16)	Three years (2014-16)	Permanent

CONCLUSION

It is unlikely that the ACA will eliminate adverse selection altogether. Even in states, like California where the health benefit exchange is estimated to have 1.8 million individuals eligible for subsidies,¹⁸ there continue to be concerns about the health mix of the exchange population as compared to the insurance market outside the exchange. As long as coverage is available outside the exchange, healthy individuals and groups may find cheaper policies, or employer-sponsored groups may self-insure, leaving only unhealthy groups in the exchange.¹⁹ As discussed, the ACA contains many provisions which apply to health insurance available in health benefit exchanges and in the commercial insurance market outside the exchanges.

As discussed in this paper, adverse selection, the tendency for individuals to select different health insurance plans based on what is the most cost effective plan to meet their perceived short term health needs, leads to significant imbalances in the distribution of risk and healthcare expenditures in the insurance market. In the current healthcare system, insurance companies and risk bearing organizations, in their efforts to manage risk, can exclude those with potentially high costs from getting coverage, charge high risk individuals more than others buying the same product and design products that are most attractive to low risk, healthier individuals. These practices can have a significant impact on access to health care for those who most need the protection of health insurance and ultimately raise health care costs for everyone when individuals remain uninsured or underinsured but still need and seek care in the system. But as discussed above, there are well studied mechanisms to minimize adverse selection and more evenly distribute risks and costs. Some of these mechanisms are included in the ACA reforms and will be implemented in California. The hearing is intended to identify policies that could inadvertently lead to adverse selection and insurance market instability. For example, could poorly designed wellness incentives, an ACA policy option, create loopholes that encourage adverse selection? The hearing will identify from a state policy perspective what more there is to do in California in order to incentivize effective care especially for those with the highest healthcare expenditures.

¹⁸ Health Insurance Coverage in California under the Affordable Care Act, California Simulation of Insurance Models (CalSIM) Version 1.7, June 2012

¹⁹Jost, Timothy Stoltzfus, Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues, The Commonwealth Fund, July 2010.