March 26, 2013

Recommendations of the Working Group on Employer and Employee Choice to the District of Columbia Health Benefit Exchange Authority

This report is submitted by the Employer and Employee Choice Working Group, chaired by Kevin Lucia and Billy MacCartee (Vice Chair). Its purpose is to present recommendations which either were unanimously endorsed or endorsed by such a vast majority of participants as to carry considerable weight, to identify issues on which the working group could not achieve consensus, and to summarize the arguments for and against such positions.

Background

In the current small-group health insurance market, employees who are offered health insurance typically have limited (or no) choice of plans. One intention of the Affordable Care Act (ACA) is to give employers the ability to offer their employees a wider range of health plan choices. The law requires that the SHOP Exchange give employers the option to allow employees to choose among all qualified health plans (QHPs) on one actuarial value metal tier level, although this requirement has been pushed back until 2015. The SHOP Exchange is permitted to give employers additional models of employee choice, including one qualified health plan (QHP).

The Board asked the working group to sort through employer and employee choice issues: "Recommended approach for small businesses (e.g. employee choice) for choosing plans, issuers, and contribution to coverage for workers; including consideration of age rating".

The working group clarified that the charge has three primary components:

1. **Employee Choice Models** – which "models" of employee choice should the Exchange offer to employers?
2. **Minimum Contribution and Participation Requirements** – Should the Exchange require that employers contribute a minimum portion to their employee's premiums and should the Exchange require that at least a certain portion of a company's employees purchase coverage in order to participate in SHOP?
3. **Premium Rating and Employer Contribution Approaches** – What premium rating and contribution approach should the Exchange pursue?

Members of the working group proposed the following fourteen criteria be considered when evaluating and making recommendations to the Board. These criteria were "nominated" and never fully discussed and agreed upon, but provide some insight into the thinking of working group members in making decisions. Please note that there may be some overlap among these criteria.

Preserve / Enhance Group Insurance

1. Increase or maintain employer offer
2. Maintain employer contribution
3. Increase employee take-up

Simplify Administration

4. Simplify administration for employers
5. Simplify administration for employees
6. Accommodate Exchange administrative burden

Control Costs

7. Affordability for employers and employees
8. Minimize impact of adverse selection

Increase Choice

9. Increase meaningful choice
10. Adequate choice to meet diverse health needs
11. Maximize employee portability

Other

12. Protect older employees
13. Encourage younger employees to take-up
14. Minimize disruption/harm to existing market

The working group was very well attended. About 15 people in person and on the phone attended all five meetings, which lasted about 3 hours each. To determine how close to unanimity the working group could come, it took "straw votes" after lengthy discussion of each issue on proposals that were shaped by, and seemed to garner significant support in, the group's discussion. Working group members represented several different stakeholder groups, but not necessarily in equal or appropriate numbers. Members requested that the Board evaluate votes based on whether a unanimous recommendation was reached and not based on the absolute number of votes.

The body of this report focuses on recommendations to the Board. Where a unanimous consensus was not reached, supporting and opposing viewpoints are presented. Wakely Consulting facilitated working group meetings and provided the group with supporting information. Lengthy discussions were held on each of the three major employer and employee choice topics listed on the first page, and are summarized in an appendix. Five appendices are included in this report:

Appendix A	Working group membership by stakeholder affiliation
Appendix B	Employee choice models background report
Appendix C	Premium rating and employer contribution briefing paper
Appendix D	Reviews of working group meetings
Appendix E	Individual working group members' submitted statements

Employee Choice Models

Question 1: Which "package" (or set) of employee choice models listed below should the Exchange offer to employers? After substantial discussion, the working group discarded two models of employee choice and focused on three others. Employers would be able to select one model from the package to offer its employees.

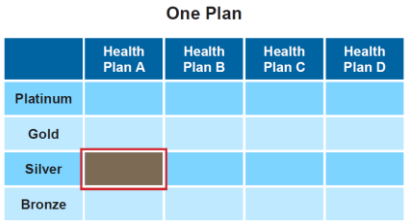
Package	Employee Choice Models in Package
Package #1	a. **All Issuers & QHPs / One Tier** – all issuers and all QHPs on one AV metal tier level b. **One-Issuer / Two AVs** – all the QHPs that one issuer offers on any two contiguous AV metal tiers c. **One-QHP** – a single QHP offered by one issuer
Package #2	(same choice models as Package #1, except for 2016 the Exchange is required to conduct studies and reassess the impact of the One-Plan model on the DC market, and determine if the One-Plan option should be removed from the package)
Package #3	a. **All Issuers & QHPs / One Tier** – all issuers and all QHPs on one AV metal tier level b. **One-Issuer / Two AVs** – all the QHPs that one issuer offers on any two contiguous AV metal tiers

Recommendation:
A clear consensus could not be reached, so the Board may want to refer this question to committee to determine the exact "package" of employee choice models that the Exchange should offer employers. There was consensus among working group members that the Exchange should include the "All Issuers & QHPs / One Tier" and "One-Issuer / Two AVs" employee choice models in the package. The committee should determine whether the "One-QHP" model should be included in the package as well, and, if so, whether the Exchange should be required to reassess this model for future years.

Background information on employee choice models:
Please refer to Appendix B for a more detailed explanation of employee choice models. Below is a summary of five employee choice models members considered during discussion. Note that working group members decided to modify the "One-Issuer / Multi-Tier" model so that employers and employees can choose from only two contiguous AV metal tier levels. This decision is explained further in the commentary section below.

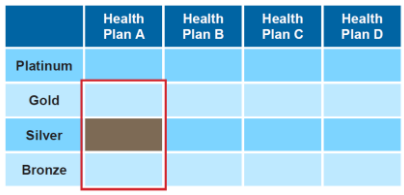
One-QHP

Employers choose one QHP from one issuer, and employees will have to select that plan if they wish to enroll



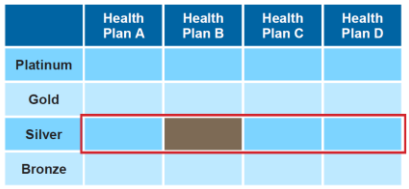
One-Issuer / Multi-Tier

Employers choose one issuer and employees can choose from all the plans the issuer offers across multiple AV metal tiers



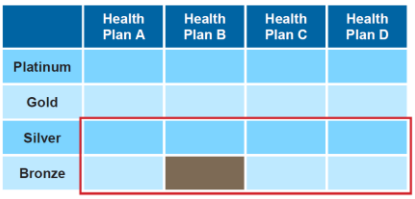
Multi-Issuer / One-Tier

Employers choose one AV metal tier and employees can choose from all issuer and all plans offered at that metal level. The Exchange is required by the ACA to offer this choice model for 2015.



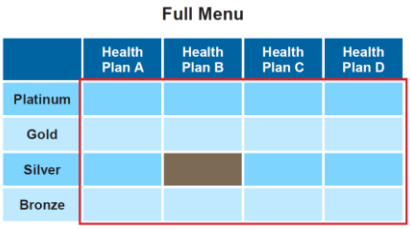
Multi-Issuer / Multi-Tier

Employers choose multiple issuers and multiple AV metal tiers levels and employees can choose any plan offered within the specified metal levels and issuers.



Full Menu

Employees can choose any plan from any issuer offered on the SHOP Exchange.



Voting Results:

At the end of the third meeting the working group took a vote on whether that the Exchange should offer Package #1 or Package #3 to employers. After the meeting one or members expressed concern that the vote was rushed and/or it was difficult to understand the questions posed to the group. After additional meetings were added to the working group, members decided to revisit the vote during the fifth meeting. The results of the initial vote taken during the third meeting are presented below, as they may prove useful to the Board in understanding the level of consensus among members.

During the third meeting, members were asked the following two questions:

- Would you make a recommendation to the Board that the Exchange should offer employers the ability to choose any one of the choice models in Package #1 (described above)?
- Would you make a recommendation to the Board that the Exchange should offer employers the ability to choose any one of the choice models in Package #3 (described above)?

Responses of the 14 members present are as follows:

	Yes	No	Abstain
Package #1 – all three models	11	1	2
Package #3 – two of the models, not One-QHP	6	8	0

During the fifth meeting, an additional vote was taken, but in a different manner. The member who initially voted "No" for Package 1 was from the Consumer stakeholder group and noted that their vote may change to "Yes" considering the working group had a better understanding of premium rating methodologies and had just unanimously voted. However, an Insurer member who abstained during the vote noted that they would likely vote "No" if a re-vote was taken. In an effort to reach a consensus, the group decided to include "Package 2" in the vote, which contains the same models as Package 1 with the caveat that the Exchange must reassess the One-QHP model for 2016.

Members were asked to rank their first, second, and third preference for the three Packages. Results of the vote are shown below:

Preference	Package 1	Package 2	Package 3
1st Preference	8	1	2
2nd Preference	0	9	1
3rd Preference	4	0	5

(note that some members did not place a vote for all three of their preferences and therefore the total votes for each Package are not equal)

Commentary:

The working group spent a considerable amount of time discussing and deliberating five employee choice models. (These are described in a paper on employee choice supplied to the working group and appended to this report.) Members discussed the potential impacts of adverse selection on increases in premium prices, and concluded it is an important factor when considering employee choice models. As a result, the working group decided to eliminate two of the models presented by Wakely--the "Full Menu" and "Multi-Issuer/Multi-tier" employee choice models. However, the group agreed that employers should be able to offer employees some choice across multiple AV metal tiers, and that this should be available from a single issuer. In order to constrain the premium-raising impact of adverse selection, the group decided to restrict the "One-Issuer/Multi-Tier" model to two contiguous AV metal tier levels. The

employer would choose which two contiguous AV tiers to offer employees. Members believed a package which includes both the "All QHPs/One Tier" and "One-Issuer/Two AVs" models provides employers the opportunity to offer employees substantial choice, while minimizing the premium-raising impact of adverse selection.

Although CMS is no longer requiring that SHOP offers the Multi-Issuer/One Tier model for 2014, members believe that the Exchange should offer this model because it will be required to do so in 2015 anyway and there is real value in offering employees a choice of different issuers. Exchange staff indicated that the Exchange plans to continue pursuing IT system development for premium aggregation and will be able to support choice models.

Although a clear consensus could not be reached, members unanimously agreed that the "All Issuers & QHPs / One Tier" (required in 2015 by ACA) and "One-Issuer / Two AVs" employee choice models should be included in the "package" the Exchange offers to employers. Consensus could not be reached on whether the "One-QHP" choice model should be included in the package, but there did seem to be majority support among members for including this model. Of the Insurer members in the working group, Kaiser Permanente was against including "One-QHP", while Care First and United Healthcare supported its inclusion in the "package". Members from the Consumer stakeholder group were also split in their decision as to whether "One-QHP" should be included. Voting results for Package #3 reveal that working group members were split on whether to offer employers a "package" that did not include "One-QHP".

Supporters of "One-QHP" indicated that this model is the dominant choice option employers and employees currently have in the DC small-group market. Members believed that Exchange should encourage employers to participate in the Exchange and employers should be able to continue offering this model as a choice option as they transition into the Exchange. Additionally, "One-QHP" may be easier to understand and administer for both employers and employees. Members also noted that "One-QHP" has zero premium-raising adverse selection.

Members who opposed including "One-QHP" in the package believed that one intention of the ACA is to increase choice for small-group employees and therefore employers should not even have the option to limit employee choice. Additionally, inclusion of the "One-QHP" model may limit competition among insurers. Member(s) who expressed these concerns seemed to show support for including "One-QHP" in the package of employee choice models if the Exchange was required to reassess the impacts of this model on the DC market and decide for 2016 if "One-QHP" should remain as an option. However, after the working group included "Package 2" in the vote, unanimous consensus could still not be reached.

Minimum Contribution and Participation Requirements

Question 2: Which of the following minimum employer contribution and employee participation rates should the Exchange require?

	Min Employer Contribution	Min Employee Participation
Option 1	50%	75%
Option 2	50%	0%
Option 3	50%	50%

Follow – up question: In an effort to reach consensus, would you recommend to the Board that the Exchange require a 70% minimum participation, which will be the requirement for the federally facilitated exchange?

Recommendation:
A clear consensus could not be reached, so the Board may want to refer this question to committee. There was unanimous agreement among members that a minimum employer contribution of 50% should be required, and as a result this was the only minimum contribution rate members voted on. The Board may wish to refer to committee to determine the minimum employee participation rate that SHOP should require.

Voting Results:
Members were initially asked to vote on "Question 2", described above, and results are as follows:

	Min Employer Contribution	Min Employee Participation	Number of members who voted for option
Option 1	50%	75%	**3**
Option 2	50%	0%	**1**
Option 3	50%	50%	**12**

In an effort to reach consensus, an additional vote was taken on the "follow-up question" – would you recommend to the Board that the Exchange require a 50% minimum contribution and 70% minimum participation? Results of the vote are as follows:

Vote Response	Member tally
Yes	8
No	4
Abstained	1

(note that three members either had to leave the meeting early or were unable to vote)

Commentary:
A consensus could not be reached and members expressed notably different viewpoints. All three members who voted for option 1 were Insurer members. They stated that the 50%/75% requirements is the standard in today's DC small-group market, and any reduction in the participation requirement would increase adverse selection and thus premium prices would have to increase. The one member who voted for option 2 was from the consumer stakeholder group and strongly believes that employees of a small-group company should not be disadvantaged if their co-workers choose not to enroll in the plan(s) offered by their employer. This member was especially concerned that a participation requirement greatly affects micro-group companies – i.e. if two employees in a company of three total employees choose not to enroll, then a 50% or 75% participation rate is not met, and the one remaining employee would not be able to purchase the employer's offered insurance. Members who favored option 3 also expressed similar concerns that companies with few employees may be disadvantaged by a high participation requirement rate, however they were also concerned about adverse selection potentially increasing premium prices. They believed a 50% participation requirement was a good middle-ground, which would limit adverse selection and also decrease burden on small-group employees.

As noted, all Insurer members of the working group voted for 50%/75% and a majority of members from other stakeholder groups voted for 50%/50%. In an effort to provide the Board with a unanimous consensus recommendation, members discussed whether a participation rate between 50% and 75% could be agreed upon. Insurer members believed the participation rate could not be decreased by much because adverse selection is an important consideration. The group also noted that the Federal Exchanges plan to administer a 50% minimum contribution rate and a 70% minimum participation rate. One member from the broker stakeholder group strongly believed that the minimum participation rate should not exceed 66% because the average size of small companies that currently offer coverage in the DC market is six employees. Therefore, if only two employees chose not to enroll, even a 70% minimum participation requirement would not be met. The working group ultimately decided to vote on a 50% minimum contribution and 70% minimum participation requirement – 8 members voted "yes", 4 voted "no", and 1 member abstained. All three Insurer members voted "yes" and members who previously voted for option 3 were split in their decision.

The following list includes additional PROs and CONs discussed by the group:

	PROs	CONs
Min Contribution Requirement	• By increasing participation of (healthy) employees, the employer contribution limits adverse selection and associated premium increases • It provides a significant subsidy to employees, shielding them from the full cost of coverage • Without a minimum level, employers could offer zero contribution, which is	• May dissuade some employers from participating in the Exchange because the minimum contribution would be too expensive

	just a way around non-group coverage	
Min Participation Requirement	• Insurers face increased uncertainty i.e., upward pressure on premiums, with multi-issuer options, and retaining the existing minimum participation requirement at least cushions that uncertainty	• This is enforced after open enrollment, so can result in a group not qualifying and being left uncovered

The group also discussed newly published guidance from CMS that waives minimum contribution and minimum participation requirements during a special enrollment period from November 15 to December 15. As a result, small groups who did not meet the requirements would at least be able to enroll during this special enrollment period. However, CMS guidance was not clear whether the first special enrollment period would begin in 2013 or 2014, and there was still concern that minimum requirements may still disadvantage employees for the 2014 plan year.

Premium Rating and Employer Contribution Approaches

Question 3: Which premium rating and employer contribution approach, of the five listed below, should the Exchange implement?

1. List bill with percent employer contribution
2. Composite rates with risk adjustment
3. Reallocated composite premium, with employee delta in list billing rates
4. Reallocated composite premium, with employee delta in composite rates
5. List bill with age stratified employer contribution

Recommendation:
Five approaches were considered, and there was unanimous support for a recommendation that the DC Exchange adopt the third among five models described by Wakely (2.3), and referred to as "Reallocated Composite Premium, with employees paying the difference in list billing between the reference plan and the plan they select."

Commentary:
Initially members were not certain whether it was within the working group's scope to make a recommendation to the Board regarding premium rating and employer contribution approaches. The group decided that it should in fact make a recommendation and additional meetings were held to further educate and inform members on this complex topic. Wakely provided a supplemental report detailing five potential premium rating and employer contribution models and an actuary from Wakely joined by phone to thoroughly explain each model. As noted, premium rate development is a complex

topic and Wakely's supplemental report should be referred to for an explanation of each option (Appendix C; 2.3 refers to the third of five models described in the supplemental report.)

Working group members discussed several criteria for evaluating premium rating and employer contribution approaches. These are outlined below. One of these, making insurers "whole" for the age-based selection they receive, creates other challenges in a market accustomed to composite rating (as D.C.'s small-group market is). Principal among these challenges are allowing employers to fix their contributions at the start of a plan year and not prejudicing employers against hiring older workers. But the health plans made a compelling case for rating in the context of employee choice that generates age-rated premiums for their enrollees. Meeting this requirement eliminated two of the five models (2.2 and 2.4).

How much age-rating should be transparent to employers and should effect employee contributions was intensely discussed. In the end, a majority of members did not believe that making transparent the difference in premiums by age is a major problem, They thought that employers already understand that they contribute more to an older employee's premium, and older employees would understand why their premiums may be *somewhat* more expensive than a younger employee's. However, the general sentiment was that older employees should not be made to contribute three times as much as young employees i.e. that the full effect of age rating when applied to employee contributions ought to be "muted," if it could not be eliminated.

Additional criteria discussed by the working group included:

- Insurer should be made "whole"
- Employers should be able to easily understand their contribution level – "defined contribution" in the ACA
- Employees should be able to easily understand their premium liability
- Younger employees should be encouraged to enroll

The group discussed the pros and cons of each model and evaluated them based on the criteria listed above. The working group was able to eliminate three of the five options fairly quickly because they either failed to make issuers whole or failed to fix costs and mute age-rating's impact on employee contributions. As noted in the recommendation, members voted unanimously for an approach described as "Reallocated Composite Premium, with employees paying the difference in list billing between the reference plan and the plan they select." Under this approach, issuers receive age-adjusted rates for their enrollees, employers make a fixed contribution for each enrollee (based on number of dependents), and employees of different ages pay the same toward the reference plan and only somewhat more/less by age for selecting a more/less expensive alternative to the reference plan. That is, the difference in employee contribution across ages is "muted" by comparison with pure list billing. Additionally, this model allows employers and brokers to continue using composite rates for the employer's reference plan, (Please see Appendix C for a more detailed description of how this model (2.3) works, how it differs from the other options, and the advantages and disadvantages of each model.)

Some members showed considerable interest in another model - list bill will age stratified contribution – (2.5 in the paper). However, those who supported the fifth model agreed that none is perfect, and model 2.3 seems to be at least equally beneficial, so the working group decided to unanimously recommend that the Exchange implement the third model.

The Exchange will have to determine how to make adjustments for discrepancies between the census of employees submitted prior to enrollment and the count of employees who actually enroll as well as for changes in the enrollment census throughout the year. Under the approach adopted, these will impact the employer's contribution, unless a special rule somehow distributes the premium impact of these changes across issuers. The working group discussed these concerns, and recognized that the recommended approach adds some uncertainty for employers, but decided that it did not have time to make a recommendation addressing them.

Appendix A: Working Group Members by Stakeholder Affiliation

DC HBX Employer & Employee Choice Working Group members

Stakeholder Group	Member Name	Organization
Insurer	John Fleig	United Healthcare
	Larry Gross	Kaiser Permanente
	Laurie Kuiper	Kaiser Permanente
	Chris Culotta	Care First
Broker	Hannah Turner	Keller Benefit Services
	Marilyn Koss	Koss Benefits
	Stephanie Cohen	Golden & Cohen NFP
Employer	Peter Rosenstein	AAOP
	Julie Gallon	Non-profit HR rep
	Katherine Stocks	Goldblatt Martin Pozen
	Dan Bradenburg	Saul Ewing LLP
Consumer	Christine Monahan	Georgetown HPI
	Dave Chandra	CBPP
	Susan Walker	Consumer Advocate

Chair: Kevin Lucia
Co-Chair: Billy MacCartee

Appendix B: Employee Choice Models Background Report

State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
December 2012

Design Considerations in Structuring Employee Choice for SHOP Exchange

Prepared by: Wakely Consulting Group

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT WAKELY CONSULTING GROUP
Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage. For more information, visit www.wakely.com.

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For more information, please contact Jon Kingsdale at jonk@wakely.com or (617) 939-2008.

Robert Wood Johnson Foundation

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Introduction & Executive Summary

In addition to small business tax credits, the primary value proposition for the Small Business Health Options Program ("SHOP") is to facilitate employee choice. Employee choice is an important component of a defined contribution ("DC") approach to health benefits that seems appealing in concept to many small employers. Under DC, the employer's main responsibility is a financial contribution toward employees' health insurance premiums, which the employee can put toward the purchase of the coverage that he/she chooses. Because the employee selects the coverage, insurer and premium that he/she will pay, net of the employer's flat dollar contribution,* the employee makes the trade-offs between cost-sharing for covered services, differences in provider networks and referral requirements, monthly premium contributions and other features of each health plan. In theory, the employee, rather than the employer, becomes the insurer's primary customer. His/her ongoing relationship in matters of coverage, service, claims payment, etc. should be directly with the health plan.

DC can be contrasted with defined benefits, the predominant form of group insurance for small employers today. Typically, the small employer selects one health plan for his/her group.** With defined benefits, year-to-year changes in premium, plan design and employees' costs—as well as day-to-day service issues—are generally viewed as the employer's responsibility. Hence, the appeal of DC for many employers is to fix their costs i.e., their premium contribution, reduce the administrative burden, and generally take them "out of the middle" between the employee and his/her health plan.

DC can be defined on a spectrum from least employer involvement—e.g., the employer simply contributes toward individual coverage for his/her employees — to most employer involvement—e.g., the employer selects a carrier and contributes a fixed amount toward a limited choice of plan designs from that carrier. For purposes of designing employee choice in SHOP, only group insurance, with the applicable tax, federal and state regulatory framework, would qualify under the ACA. Within SHOP, a state may consider a spectrum of employee choice, ranging from:

1. "Full Menu": group insurance whereby an employer makes a fixed dollar contribution, and employees can apply that contribution toward any of the full array of health plans in SHOP; to

2. "Structured Choice": group insurance whereby an employer makes a minimum contribution toward a benchmark plan, and employees can apply that contribution toward a limited set of health plan options (e.g., one QHP on the same actuarial value ["AV"] level from each issuer in SHOP).

There are several important and inter-related SHOP design decisions, which Exchanges will confront in determining how much employee choice is productive and how closely SHOP will approximate "pure" DC. This paper first describes the different employee choice models commonly being considered by state Exchanges. We then describe two distinct types of risk selection impacts, and how each can be addressed—one by risk adjustment and the other by SHOP design decisions. Finally, we review the design decisions that SHOP Exchanges can make to maximize choice, while minimizing consumer confusion and adverse risk selection.

The range of premium impact that Wakely has estimated for several states varies considerably by the degree and type of employee choice model in SHOP. While the premium impact is minimal for CMS' required model of giving employees the choice of all QHPs on only one actuarial value tier, it can range as high as 8-10 percent premium increase for states with pure community rating and a "full menu" of employee choice (any QHP on any actuarial level). These estimates are sensitive to state-specific market circumstances and regulations, and can be considerably lower than eight percent for many states.

Wakely has identified five design variables that an Exchange might consider in order to minimize consumer confusion and the premium-raising impact of adverse selection:

1. How much employee choice to offer in SHOP?
2. How many actuarial tiers in addition to Silver and Gold will the SHOP Exchange "populate" with QHPs?
3. How many QHPs per actuarial value tier should SHOP solicit from each issuer, and should those QHPs be "standardized"?
4. How and whether to set a minimum employer contribution or participation level?
5. What restrictions should the Exchange place on employees buying actuarial values up or down from the benchmark plan?

* When providing a choice of plans, some employers contribute a percentage of the premium for any plan selected, rather than the same dollar amount, but doing so defeats one of the principal aims of DC—to fix the employer's cost.

** Because of carriers' minimum participation requirements for small employer groups and employers' reluctance to deal with premium billing from multiple carriers, small employers generally offer only one carrier. In some markets, however, individual carriers do offer small employers a suite of two or three different health plans, either directly or through a private exchange. Since the enactment of the ACA, the trend toward choice of plans from a single carrier has accelerated in some markets.

Employee Choice Models

Federal regulations require the Exchange to offer a model of employee choice whereby the employer picks the AV level (Bronze, Silver, etc.) and employees can choose any issuer on that AV level. The regulations allow Exchanges to offer additional models of employee choice, such as the choice of QHPs at various AV levels from a single issuer, employee choice of any plan on any AV tier, or even the conventional small-group offering of just one QHP from one issuer, so long as the option of all participating issuers on an AV tier is made available as a choice for the employer.

There are many different ways to structure employee choice other than the CMS required model. Five models of employee choice that have been considered by some SHOP Exchanges are illustrated in the figures to the right, and other combinations of plan choice are possible.

One QHP. Offering one health plan to employees is the conventional model in a small group, so will likely be simpler for most employers and employees to understand and enroll in. Especially for employers who simply want to take advantage of the Small Business Tax Credit, offering a single QHP model may be attractive. The primary advantage of this model is that it is simple to understand, it mirrors the conventional market, and it accommodates those small employers who want to remain in full control of their employee benefits.

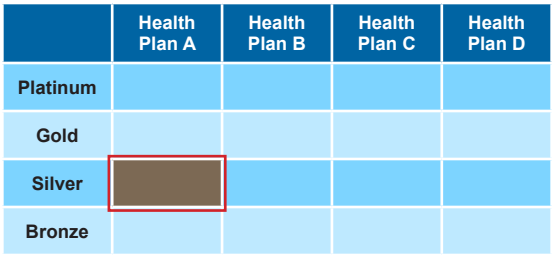
One Issuer/Multi-Tier. This model does represent a significant increase in employee choice over the one above, while keeping the group's risk with a single carrier. (It can include a choice of QHPs from one issuer at all four AV levels, or fewer than all four levels, e.g. three AV levels shown above.) Some carriers already offer this model in some parts of the country. In regions where differentiated provider networks are not offered by competing carriers, giving employees a choice of QHPs from one issuer at different actuarial values may be more "meaningful" than giving them the choice of issuers offering similar benefit packages at one AV level. Allowing employers to select one carrier, define their premium contribution, and give their employees a choice of different levels of coverage also preserves the conventional group relationship with a single carrier.

Multi-Issuer/One-Tier. Federal regulations require Exchanges to offer qualified small employers the (restricted) choice of all issuers on the same actuarial tier. The theory behind this requirement is that it offers the employee choice and encourages competition among carriers. The primary appeal of this model is to engage provider networks and carriers in market competition over costs, efficiency, quality and patient volume. In the context of competing carriers that offer different provider networks, this model allows individual employees to keep the savings from selecting more efficient or lower-priced provider networks, including integrated systems of care.

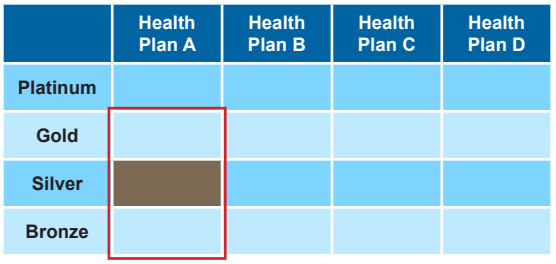
Multi-Issuer/Multi-Tier. This model represents a compromise between the one above and the one below. More than one issuer and more than one AV level are offered to employees, but not all issuers and AV levels. As will be discussed in the next section, it is designed specifically to broaden employee choice while limiting the impact of adverse selection resulting from unlimited choice of all QHPs. By limiting choice to fewer than all AV levels and QHPs, it may also reduce the consumer confusion that can result from unlimited choice.

Full Menu. In market research conducted for two states, this model has proven the most popular among employers and employees. The very broad choice of health plans offered to employees is sometimes seen as a "no-brainer"—why wouldn't purchasers (employers and employees) want as broad a choice of health plans as possible! However, none of this research has been conducted in a simulation of a real purchasing decision, where the complexities, even confusion, of broad choice may appear more concrete and challenging. Even in a "theoretical" context, some employers voiced concern about too much choice creating employee confusion, while many prefer to give their employees broad choice of plans and get out of the business of picking a group plan.

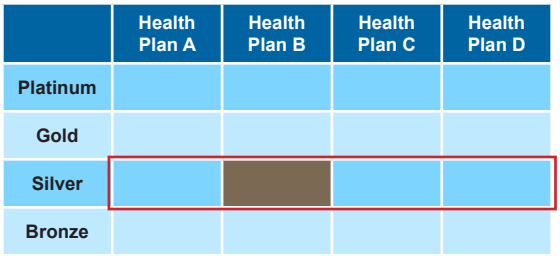
One Plan



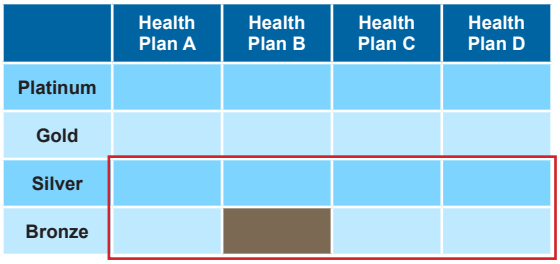
One-Issuer/Multi-Tier



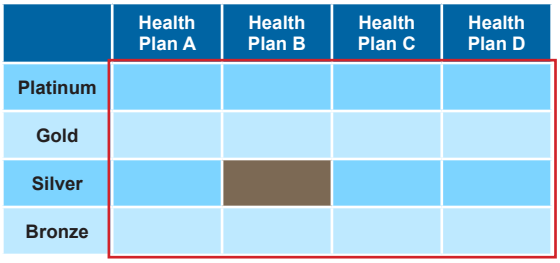
Multi-Issuer/One-Tier



Multi-Issuer/Multi-Tier



Full Menu



Finally, we note that the number of different employee-choice models offered also has implications for the operations of an Exchange. Employee choice of health plans adds complexity, and multiple models of employee choice will be more challenging to administer and explain to employers. This can add to the operational costs of the Exchange and to employer confusion. State discussions with federal officials suggest that Full Menu or some forms of Multi-Issuer/Multi-Tier can encompass the required Multi-Issuer/One-Tier, so a state could decide to offer either of the broader choice models instead of Multi-Issuer/One-Tier. However, states should confirm model choices with CMS before making this decision.

Adverse Selection

Adverse selection generally refers to individuals' propensity to make decisions that benefit themselves, to the detriment of the insurance market in general or to a specific health insurer. It is important to distinguish the following two types of adverse selection, as they relate to offering employee choice in the SHOP Exchange:

- Adverse selection against a given insurer ("Insurer Adverse Selection"). This generally refers to sick people disproportionately purchasing coverage through one or more insurers, and healthy people disproportionately purchasing coverage through other insurers.
- Adverse selection against the market in total ("Market Adverse Selection"). This generally refers to healthy people deciding not to purchase insurance or purchasing minimum coverage and sick people purchasing maximum coverage when they need it.

Both types of adverse selection can result from employees choosing options that benefit their own circumstances. Insurer Adverse Selection is a significant concern, especially where there are major differences between QHPs in cost-sharing, provider networks, coverage of benefits outside a contracted network or with and without referrals, and even brand reputation for more generous or reliable coverage.

Risk Mitigation: The ACA includes three risk mitigating programs intended to create a more level playing field for carriers who attract higher-cost members. Only the individual market can cede claims to the reinsurance program, so that program will not help adverse selection in the SHOP. For issuers in SHOP, the primary risk mitigating program is risk adjustment. Effective in 2014, plans that enroll low-risk members will have to pay money into the risk adjustment program, and plans who enroll high-risk members will receive money from the risk adjustment program.

In the absence of risk adjustment, plans with low-risk enrollees can afford to charge less and/or earn higher margins than those with high-risk enrollees. With the advent of risk adjustment, carriers with low-risk members will need to factor payments into the risk adjustment program as an added cost when setting their premium rates. Conversely, in the absence of risk adjustment, plans with high-risk enrollees must charge higher premiums to cover higher claims and/or suffer losses. With the advent of risk adjustment, carriers with high-risk members would be encouraged to lower their premiums, all else being equal, because of the payment they will receive from the risk adjustment program. For pricing products the same in and out of the Exchange, as required by the ACA, carriers must consider estimated risk scores across their entire small group enrollment.

In addition, the risk corridor program may assist with mitigating adverse selection to the extent that a carrier's small group expenses exceed the target after risk adjustment transfers. For the first two years of ACA, issuers in the small group market whose underwriting gains/losses exceed +/- 3 percent will share some of the gains/losses in excess of those corridors. To the extent that gains/losses beyond the corridor result from inadequate risk adjustment, carriers will be cushioned against selection bias (favorable or unfavorable) by the corridor program.

By contrast, none of the ACA's risk adjustment programs aim to protect against Market Adverse Selection in the SHOP Exchange. Offering employee choice, particularly the choice of different AV levels, will increase the potential for adverse selection against the entire market. The healthier members (with low service needs) will gravitate toward leaner plans, resulting in a loss of premium dollars relative to their utilized medical services. The sicker members (with high service needs) will gravitate toward richer plans, resulting in a gain of premium dollars that is not adequate relative to the increased use of medical services.

To see how this works, consider the following example. Many healthy employees have very few claims, but if their employer chooses one plan for the group, everyone in the group has a plan with average "richness" equivalent, for example, to a Silver plan. However, when given a choice of different AV levels of coverage, those employees who expect to have no or few claims would likely choose less rich coverage with a lower premium i.e., Bronze plans. In the example below, claims for employee A stay the same ($0), while premium revenues are lost as A moves from Silver to Bronze. If this dynamic is replicated across many employee groups, the market on average would incur a loss when compared to an environment without choice of plans. This impact on pricing would occur even within a single carrier offering plans at different AV levels.

One Silver Plan Offered to 2-Person Group:

Employee A:	Claims =	$0	Premium =	$5,000	
Employee B:	Claims =	$9,000	Premium =	$5,000	
Total:		$9,000		$10,000	MLR = 90%

In a Choice Situation, Employee A Selects Bronze:

Employee A:	Claims =	$0	Premium =	$4,286	
Employee B:	Claims =	$9,000	Premium =	$5,000	
Total:		$9,000		$9,286	MLR = 97%

The result is upward pressure on small-group premiums to recoup this revenue loss. As of 2014, differences among base premium rates for a carrier in a given geographic area should be based on differences in the benefit design, except as otherwise permitted under the ACA. (In our example, the carrier cannot simply charge more for Silver because healthier employees are expected to buy down to Bronze.) Therefore, we believe that the adverse selection resulting from the employee choice model will not only increase premiums for "richer" plans, but will increase premiums somewhat across an issuer's entire array of QHPs.

Under the ACA's community rating rules, such premium impact in SHOP must be spread across a carrier's entire book of small group business, in and out of the SHOP Exchange. Therefore, it can be quite diluted. For example, if Market Adverse Selection pushes premiums up by five percent in the SHOP, but only one-tenth of the carrier's small group enrollment is in SHOP, the impact on all of its small employer rates would be one-half of one percent.

While the half percent in this example seems relatively small, this is only because the carrier's entire small-group book of business is effectively subsidizing its SHOP accounts. The primary way that a carrier can avoid such premium-increasing impact across its entire small-group book would be to decide *not to participate in SHOP*. If enough carriers decide not to participate and avoid Market Adverse Selection, their decisions could force competing carriers to do the same to avoid a price disadvantage outside the Exchange. Therefore, Exchanges should consider how to mitigate Market Adverse Selection attributable to more employee choice inside than outside the SHOP Exchange.

Mitigating Market Adverse Selection in SHOP

The impact of employee choice on premiums will vary with local market circumstances and with design decisions made by the Exchange. Circumstances such as the range of premium differences among issuers, network differences among QHPs, the actual distribution of membership among QHPs and issuers, and the proportion of a state's total small group market that is in SHOP will influence Market Adverse Selection, but these are beyond the Exchange's direct control. The principal design decisions within the Exchange's control relate to:

1. **The range of employee choice of QHPs**. While the choice of QHPs at one AV level will have very modest adverse selection impact on overall premiums, broad choice of QHPs across multiple AV levels will generate more premium impact; and

2. **The level of employer contributions**. Higher contribution levels mitigate adverse selection by insulating the employee from the cost-consequences of his/her choices. At the extreme, were an employer to contribute 100 percent of the premium of the "richest" QHP available, all employees would be expected to select that coverage. As the percentage of premiums covered by the employer decreases, risk segmentation between different AV levels should increase.

Employee Choice

The ACA provides considerable discretion to state-based Exchanges to determine the extent of employee choice available in SHOP. Compared with the outside small group market— in which there are generally one or two plans per group from one carrier—CMS' requirement that all issuers on at least one AV tier (Multi-Issuer/One-Tier) be made available to employers in SHOP actually generates very modest Market Adverse Selection. Working with market-specific data for several states, Wakely has estimated this impact to range from .1 percent to one percent of premiums. Were a state to decide that only this model would be offered in SHOP, that restriction, plus risk adjustment for Insurer Adverse Selection, should largely address concerns about adverse selection in most markets. With "dilution" across an issuer's entire small-group book, in and out of the Exchange, the premium impact should be virtually undetectable—unless there are huge network and price differences among QHPs on the same AV tier.

The ACA allows Exchanges to offer employers this model plus other models of employee choice. As noted previously, a Full Menu model under which employees have the choice of any QHP on all AV levels also incorporates and satisfies CMS' choice requirements. The Full Menu model has a number of advantages: if the QHPs offered in SHOP mirror those offered in the non-group Exchange, then employees and individuals moving between the two Exchanges enjoy portability of coverage; Full Menu also takes the employer out of the selection process altogether; and of course, Full Menu gives employees full control over their own choice of plans.

On the other hand, full choice of AV levels, either within one issuer (One-Issuer/Multi-Tier) or across all issuers and AV tiers (Full Menu), can produce considerable Market Adverse Selection impact on premiums. Working with market-specific data for several states, Wakely estimated that this impact on premiums ranges from a low of one percent to a high of 8-10 percent of premiums. (Offering only One-Issuer/Multi-Tier would not meet the requirements of the ACA, but Full Menu would.)

In order to offer employees considerable choice — of both issuers and AV levels—but moderate the Market Adverse Impact of Full Menu, some states are considering several variants of Multi-Issuer/Multi-Tier models. One is that the SHOP Exchange require employers to make a minimum contribution toward a benchmark QHP on a particular AV level—50 percent is required to qualify for the Small Business Tax Credit; another is to restrict employees' choice of QHPs to the AV levels at or below the benchmark plan, or to allow employees to choose only one AV above the benchmark QHP.

Another variant of Multi-Issuer/Multi-Tier is to restrict the choice of QHPs to two issuers—typically a restricted network plan, such as Kaiser Permanente, and a broad network plan—and two AV tiers. Or the SHOP Exchange might allow only one standardized cost-sharing design from each issuer to be offered on the AV tiers made available to a group of employees.

Yet another option that some states are considering is to eliminate Platinum in SHOP. The ACA only requires issuers to offer Silver and Gold level plans. It is expected that many employers would also want to consider Bronze, and that most issuers would be interested in offering Bronze. Depending on the range of coverage typically offered in a state's small-group market today, there may be relatively little employer interest in Platinum to begin with, in which case not offering Platinum should not deter employers from SHOP, but would reduce Market Adverse Selection from employee "buy-up."

The various employee choice models discussed above are not mutually exclusive. In fact, if a SHOP Exchange offers small employers the choice of all five models, or a subset of the five, the Exchange can expect individual employers in SHOP to select different models. The selection by some employers of either One Plan or Multi-Issuer/One-Tier would modulate the Market Adverse Selection impact of multi-AV level models. For example, were a SHOP Exchange to offer employers the choice of One Plan, Multi-Plan/One-Tier or Full Menu, and were 25 percent of employees in SHOP to be offered One Plan, 35 percent to be offered Multi-Issuer/One-Tier, and 40 percent to be offered Full Menu, the Market Adverse Selection impact of Full Menu would be substantially diluted. In this example, Full Menu alone carries a Market Adverse impact of 4.5 percent (premium increase), but as illustrated below, offering other employee choice models dilutes the impact to 2.2 percent:

Choice Model	Premium Impact*	Portion of Employees	Diluted Impact
One Plan	1.00	.25	.25
Multi-Plan/One-Tier	1.005	.35	.352
Full Menu	1.045	.40	.42
TOTAL			1.022

* Mid-points of the ranges in Wakely's market-specific analyses of several states

Again, this impact would be spread across all community-rated small-groups in an issuer's book of business, in and out of the Exchange. If 20 percent of employees in a state's small-group market enroll in SHOP, and 80 percent are outside SHOP, then the 2.2 percent premium impact would be further diluted [2.2% x .2 = .0044%] to less than a half a percentage point. In effect, the outside market would subsidize the inside market, but the subsidy by any one group would be very small.

Standardization

Finally, the Exchange can decide to limit the variety of plans in SHOP. Based on market research and consultation with carriers, the Exchange should consider which product types (HMO, PPO, HDHP, other) it prefers to offer. The Exchange may also decide to "standardize" cost-sharing across QHPs, within a given AV level. Such standardization has a number of advantages and disadvantages, beyond reducing both Market and Insurer Adverse Selection.

Too much choice can overwhelm consumers. Extensive research into consumer choice of health plans,[1] the experience with various Medicare options,[2] and the Massachusetts Health Connector[3] suggest the need to simplify choice for consumers. Otherwise, in the face of complex choices, consumers can be overwhelmed and tend to resort to familiar concepts that make the decision easier, often sacrificing thoroughness and ending up with a plan that may not really understand or may not be in their best interest.

A second problem occurs when people struggle to discern "meaningful" differences across the available choices. Benefits and cost-sharing may vary in ways that are hard to decipher, and differences may be relatively inconsequential, even if promoted as substantial. A lot of similar choices also present the illusion of choice. Just as too much choice can overwhelm consumers and undermine the quality of the decision-making process, options that are too limited can cause a consumer to feel stuck in a plan that may not suit their needs. Consumers place a high value on the availability of choice, but can be overwhelmed by too much or "meaningless" choice.

Whether each issuer should offer its own unique plan designs on a SHOP Exchange or be required to align the key cost-sharing features

across issuers is another important design question facing state Exchanges. Private insurance exchanges are being designed both ways. Alignment of plan designs around the most popular designs in a state's small group market (adjusted for essential health benefits), should offer "good" choices, facilitate comparison shopping, and minimize consumer confusion. For example, Exchanges might use the key cost-sharing features of the most popular one or two small-group plans—using 2012 market data—approximating each AV level to standardize cost-sharing across issuers, i.e., the same maximum out-of-pocket, annual deductibles, and copayments or coinsurance for inpatient, outpatient, ER, office visits, day-surgery and prescription drugs. By simplifying the comparison of coverage, this sort of benefit alignment makes it easier for consumers to compare plans on other variables, such as price, network and service. It would also reduce competition among carriers to design cost-sharing features to attract better risks.

However, several considerations argue against "standardization." First, if carriers must be encouraged to participate, "dictating" their offerings is not an inducement. Second, prescribing cost-sharing, even if based on "popular" designs, discourages innovation. Third, reducing employers' choice of plans can make the SHOP Exchange less attractive than the outside market. Small employers will be looking in 2014 to match their renewal options against their current plan benefits and premiums, so their starting points for shopping will vary considerably from one employer to the next. Standardizing and limiting their options in SHOP could create a significant disadvantage compared with the outside market.

Therefore, the degree of plan standardization across issuers should be carefully considered, including the possibility of offering a mix of some standard and some unique cost-sharing designs from each carrier. For example, by requiring one standardized plan design per actuarial tier from all issuers, in addition to unique designs, the Exchange can offer employers a broad set of QHP options, and allow employers the ability to give their employees an "apples-to-apples" comparison of QHPs.

Minimum Employer Contribution

In today's small group market, carriers typically require minimum employer contributions, minimum employee participation, or both. These requirements are designed to minimize Market Adverse Selection that would result if only the sicker employees in groups enrolled for coverage. CMS has made it clear that minimum participation requirements in SHOP apply to the group, not the issuer, and so the SHOP must count as participating all enrollees from an employee group, regardless of which QHP they choose.

In addition, an employer contribution of 50 percent toward the premiums for the group's benchmark plan is required to qualify the employer for the Small Business Tax Credits, available as of 2014 only in SHOP. Fifty percent contribution is a common, though not universal, minimum set by carriers (or by regulation) in many markets.

Where such minima are not set by regulation, but left to the underwriting discretion of each carrier, the issuers in SHOP will need to abide by a common set of group underwriting rules. If issuer A requires 70 percent participation, and issuer B requires 80 percent, what happens to a group of four employees, in which only three enroll—two in issuer A and one in issuer B? Does issuer B drop the group because the employer did not meet its 80% minimum? Then what happens to its one enrollee?

It is generally advisable for SHOP Exchanges to use the local market standard to set their own minimum participation and/or contribution levels. Waiving these minimums or setting them below the outside market will increase Market Adverse Selection, and setting them above the market standard will discourage small employers from using SHOP. (Where these requirements vary by carrier within a state, the Exchange will have to impose a common standard.) Given the Market Adverse Selection impact of employee choice, states should consider using the high end of the market range prevalent in their small group markets.

As noted previously, the higher the average employer contribution in SHOP, the lower the Market Adverse Selection will be. (The minimum contribution level is one variable that influences averages, but the average prevailing contribution level is even more important.) Setting a minimum contribution level against the employer's benchmark plan, and restricting the employees' ability to "buy-up" to higher AV levels from the benchmark should reduce the Market Adverse Selection impact on premiums. This approach offers the substantial advantage over setting a minimum participation level of being administered prospectively, without waiting to see how the group's enrollment turns out.

Summary

SHOP Exchanges should consider how best to balance the advantages of broad employee choice against the consumer confusion that can result from overwhelming choice and the premium-raising impact of Market Adverse Selection. An unstructured choice of dozens of different QHPs—some with relatively minor differences on key features, such as annual maximum out-of-pocket spending caps that most consumers do not understand, or on a host of services carrying modest financial impact—can confuse consumers. In turn, such confusion may end up imposing a burden on employers and driving them away from SHOP.

Substantial Market Adverse Selection will raise premiums for participating issuers across their entire small group enrollment, in and out of the Exchange. Therefore, the premium impact of SHOP design requirements on a participating issuer will be diluted considerably by its non-SHOP small group enrollment. In effect, the outside market subsidizes SHOP, so that the total impact as a percentage of small group premiums can be modest. However, the prospect of substantial Market Adverse Selection *in SHOP* could dissuade carriers from participating in SHOP.

The range of premium impact that Wakely has estimated for several states varies considerably by the degree and type of employee choice model in SHOP. It is *de minimus* for CMS' required model of giving employees the choice of all QHPs on only one actuarial value tier. By contrast, if all employees in SHOP are given the choice of all QHPs on all four AV tiers ("Full Menu"), the Market Adverse Selection impact on premiums ranges from a low of one percent to a high of 8-10 percent for different states. As these estimates are sensitive to state-specific market circumstances and regulations—which vary considerably among the several states for which Wakely has projected Market Adverse Selection—each state may want to conduct its own estimate of Market Adverse Selection.

Wakely has identified five design variables that an Exchange should consider in its effort to balance the advantages of offering broad employee choice in SHOP against the premium-raising impact of Market Adverse Selection and the confusion attendant on "too much" unstructured choice:

1. Which of the five employee choice models to offer in SHOP?
2. How many actuarial tiers in addition to Silver and Gold will the SHOP Exchange "populate" with QHPs?
3. How many QHPs per actuarial value tier should SHOP solicit from each issuer, and whether those QHPs should be "standardized"?
4. How and whether to set a minimum employer contribution toward premiums?
5. If "Full Menu" or "Multi-Issuer/Multi-Tier" models are offered in SHOP, what restrictions on employee choice should the Exchange place on buying up or down from the benchmark plan?

As discussed above, factors other than balancing the advantages of broad employee choice against the disadvantage of adverse selection also enter into consideration of SHOP design decisions. The simplicity of offering just one model, be it Full Menu or another, has some appeal; portability of coverage under Full Menu between SHOP and the non-group Exchange has some appeal; and the number of different QHP designs offered on each AV level will affect the ability of consumers to sort through and select the "right" plan for themselves.

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2 See, for example, Jonathan Gruber. *"Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?"*. Henry J. Kaiser Foundation, March 2009;
Damico, A.; Gold, M.; Jacobson, G.; Neuman, T. "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums". (Kaiser Family Foundation, October 2010), http://www.kff.org/medicare/upload/8117.pdf;
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Jennifer M Polinski et al. "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present". *Journal of the American Geriatrics Society* 58, no. 5 (May 2010): 950–966;
YanivHanoch et al. "How Much Choice is Too Much? The Case of the Medicare Prescription Drug Benefit". Health Services Research 44, no. 4 (August 1, 2009): 1157-1168;
Barnes, A.; Bhattacharya C.; Cummings, J.; Hanoch, Y.; Rice, T.; Wood, S. "Numeracy and Medicare Part D: the importance of choice and literacy for numbers in optimizing decision making for Medicare's prescription drug program". *Psychol Aging*. 2011; 26(2): 295-307.
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3 Rosemarie Day & Pamela Nadash; "New State Insurance Exchanges Should Follow The Example Of Massachusetts By Simplifying Choices Among Health Plans". *Health Affairs* May 2012 31:5982-989.

Appendix C:

Methods for Premium Allocation among SHOP Issuers & Employer Premium Contribution

(DRAFT FOR DISCUSSION)

March 18, 2013

1 Introduction

Federal regulations require that, as of 2015, the Small Employer Health Options Program (SHOP) give employers the option to allow employees to choose among all qualified health plans (QHPs) on one actuarial value tier. Several states are contemplating SHOP models that offer more choice to employees than the mandated approach. Even under the mandated approach, there are important decisions to be made regarding composite rates, list bill premiums, or variations of either.

Composite rates generally refer to premium rates that are group-specific and allow for the same premium for all employees, regardless of age. Composite premiums differ by family structure such as employee plus spouse, employee plus child/children, and family. In states that allow rating variation on age, one group's employee-only composite rate will differ from another group's employee-only rate if the groups have employees of different ages. (Similarly, family rates will differ in these states from group to group with the ages of employees and dependents, and the number of enrolled dependents per family.) But, under composite rating, the employer pays the same amount for each employee (for employee-only coverage), regardless of the employees' ages. Composite rates are also broadly thought of as averages. (CMS regulations refer to them as "average rates.") When a group is provided composite rates as a new quote or at renewal, the composite rates in total for the group's census are equal to the sum of the list rates for the group's census, because composite rates essentially represent the average of the list bill rates. In most states, composite rates are the norm rather than the exception for rating groups, although micro-groups are often restricted to list bill rating.

Composite Invoice from Carrier

GROUP NUMBER	GROUP NAME	INVOICE PERIOD	PAGE NO
			1

SUB NO.	SUBSCRIBER NAME	TYPE CHG	DATE	RATE	COVERAGE TOTAL	TOTAL AMOUNT DUE
	PRIOR AMOUNT BILLED:					$ 7,067.53
	PAYMENTS RECEIVED:					$ 7,000.00
	ADJUSTMENTS / INTEREST:					$ -
	BALANCE FORWARD:					$ 67.53
	COVERAGE TYPE: **HMO BLUE NE DEDUCTIBLE**					
	CHARGES BASED ON RATES AND ENROLLMENT THRU 7/16/12					
123	SMITH, ANN				$ 532.86	
456	DOE, JOHN				$ 1,404.66	
789	DOE, JANE				$ 532.86	
321	JONES, BOB				$ 1,404.66	
654	RAMSEY, OSCAR				$ 532.86	
987	MICHAELS, RICHARD				$ 532.86	
369	JOHNSON, BARRY				$ 1,404.66	

MESSAGE:	**CUSTOMER INFORMATION:**
CHANGE RATE EFFECTIVE 7/10/12	**Please see reverse side of invoice for customer service contacts.**

CURRENT DUE:	**$**	**6,345.42**
TOTAL DUE:	**$**	**6,412.95**

List bill rates generally refer to group premium rates that are employee-specific i.e., are calculated individually for each employee using applicable rating factors (in 2014, age, geography and possibly tobacco use). The list bill literally shows these individually calculated premium rates to the employer for each employee. List billing makes transparent to the employer what they generally know, but may tend to forget—that older employees cost more and younger employees less for coverage. Also, list billing automatically adjusts premiums mid-year for mid-year changes in the census e.g., when a 64-year-old employee retires and a 25-year-old is newly hired.

List Invoice from Exchange

GROUP NUMBER	GROUP NAME	INVOICE PERIOD	PAGE NO 1

SUB NO.	SUBSCRIBER NAME	TYPE CHG	DATE	RATE	COVERAGE TOTAL	TOTAL AMOUNT DUE
	PRIOR AMOUNT BILLED:					$ 7,067.53
	PAYMENTS RECEIVED:					$ 7,000.00
	ADJUSTMENTS / INTEREST:					$ -
	BALANCE FORWARD:					$ 67.53
	BENCHMARK PLAN: **HMO BLUE NE SILVER**					
	CHARGES BASED ON RATES AND ENROLLMENT THRU 7/16/12					
123	SMITH, ANN				$ 558.98	
456	DOE, JOHN				$ 1,454.66	
789	DOE, JANE				$ 456.74	
321	JONES, BOB				$ 1,605.33	
654	RAMSEY, OSCAR				$ 608.98	
987	MICHAELS, RICHARD				$ 456.74	
369	JOHNSON, BARRY				$ 1,203.99	

MESSAGE:	**CUSTOMER INFORMATION:**
CHANGE RATE EFFECTIVE 8/1/12	**Please see reverse side of invoice for customer service contacts.**

CURRENT DUE:	**$**	**6,345.42**
TOTAL DUE:	**$**	**6,412.95**

Employers generally contribute toward employee premiums by one of two methods: a fixed-dollar amount or a percentage of premium. While many employers decide each year to contribute a certain percentage toward premiums e.g., 75% for the employee and 25% for her dependents, in composite rating this percentage translates into a fixed amount toward the average premium for employees. We refer to this approach as "fixed-dollar amount." In a multi-plan, employee choice offering, the same fixed-dollar amount typically applies to whichever plan the employee selects. By contrast, under list billing, employers generally contribute a fixed percentage e.g., 75% for employees, 25% for dependents, but because the premiums for each employee vary by allowable rating factors, so do their premiums and therefore so does the employer's contribution amount.

While it has been possible under list billing for employers to contribute the same fixed dollar amount, rather than percentage of premium, the ACA will apply new non-discrimination rules to employer contributions. Contributing a fixed-dollar amount toward list bills is thought to

violate non-discrimination rules under the ACA because older workers' premiums will be higher than younger workers', but all will get the same dollar contribution by the employer. As a result, the employer would contribute a smaller percentage toward an older worker's than a younger worker's premium. As a result of the new non-discrimination rules, for which regulations are still not available, there is now a tie between allowable forms of (a) employer contribution (fixed-dollar vs. percentage of premium) and (b) allowable rating methods (composite vs. list billing). As indicated in the table below, a fixed-dollar contribution under list billing will likely not pass the non-discrimination test under ACA rules.

Employer Contribution	Composite Rating	List Billing
Fixed-Dollar	X	Not Allowed
Percentage of Premium	X	X

This section of the report addresses how premium revenue should be billed and distributed among issuers participating in SHOP, particularly when premium rates need to be provided to employees to help inform their decision, and issuers will not know exactly who within a group will select their plans. In developing proposed approaches we considered the following objectives:

- Optimizing equity among SHOP issuers
- Allowing employers budget certainty through fixed contributions
- Operational simplicity
- Incorporation of billing techniques familiar to employers and brokers
- Complying with the ACA's non-discrimination rules

The following section of the report will address allowable contribution approaches under each of the premium rating and distribution methods discussed in this section.

For states that will allow some rating variation by age in 2014 and beyond, the following is a list of possible operational methodologies for distributing premium revenue among issuers.

1. List Bill (age rating)
2. Risk-Adjusted Composite (average rating)

3. Reallocated Composite Premium, with the member's buy-up/down premium calculated on the member's list-bill premiums
4. Reallocated Composite Premium, with the member's buy-up/down premium calculated on the member's composite rates
5. List Bill with Age-Stratified Contribution

Each of these approaches is described below, along with their advantages and disadvantages. All the examples displayed reflect a three-life group consisting of employees with ages <25, 45-49, and over 60. All employees select a Silver plan from three different issuers, A, B, and C, respectively.

2 Approaches

2.1 List Bill

- Components of approach:
  - The premium charged for each member would be calculated based on each employee's age (assuming variation of rating based on age is allowed in the state).
  - To avoid age discrimination, the list bill methodology would require employers to contribute a percentage of each member's premium for the plan selected by the employer, rather than contributing a set dollar amount.
  - The following table provides an example of premiums distributed between three issuers.

List Bill Premiums in a Multi-Issuer Environment

Employee	Age	Issuer	Plan (AV)	List Bill Premium
1	<25	**A**	Silver	$119
2	45-49	**B**	Silver	$300
3	60+	**C**	Silver	$430
Total				$849

- Advantages:
  - All issuers are "made whole," meaning that each issuer will receive premiums according to the age of the employees who enroll in their products. Issuers are made whole even if there is a mid-year census change.
- Disadvantages:

- Older employees pay more than younger employees for the same plan.
- Composite premiums are typical in most states. Changing to list billing could present an operational challenge for issuers and significant change to how employers and brokers consider premium rates.
- Employers would need to be careful in establishing contributions in order to pass non-discrimination rules under this approach. For example, many employers are accustomed to paying the same amount per employee (toward employee-only coverage). However, our understanding is that doing so in 2014 in conjunction with a pure list bill premium methodology would be discriminatory since older employees would pay more than younger employees for coverage (more as a dollar amount and as a percentage).

2.2 Composite with Risk Adjustment

- Components of approach:
  - Composite rates are calculated for all plans that employees of a group could select e.g., all QHPs on the Silver tier. Rates for any one plan are calculated based on the assumption that all employees of a group enroll in that plan.
  - Premiums are paid by employees and employers according to the contribution schedule i.e., fixed-dollar or percentage of premium. Issuers receive composite rated premiums for each member enrolled in their plans.
  - Risk adjustment incorporates the demographic differences between who enrolled (member-specific) and who was incorporated in the rating (group in total).
    - In risk adjustment, the concept is that risks beyond what can be used to vary premium rates should be calculated and spread retroactively through cash transfers. Therefore, in "standard" risk adjustment techniques, the demographic variation of employees, limited to 3:1, should be removed from the net risk score for an issuer (in states that allow age rating variation of 3:1). In this Composite with Risk Adjustment approach, since issuers rate based on the demographics of the group rather than the individual member who selects their plans, the demographic variation of the group would be removed from each risk score of the members enrolled in their plans.

- CMS' requirement to use standard demographic (age) factors in rating, just as the federal risk adjustment model uses standard coefficients for demographics, simplifies this approach.

Multi-Issuer Composite Rates: the Risk Adjustment Solution

Step 1: Calculation of Composite Rates Assuming 100% of Group Enrolls in Plan

Employee-only	
Issuer	**Silver**
A	$250
B	$275
C	$300

Step 2: Employee Selections

Employee	Age	Issuer	Plan (AV)	Premium	Ee Age Factor
1	<25	A	Silver	$250	0.50
2	45-49	B	Silver	$275	1.14
3	60+	C	Silver	$300	1.50
Average				$275	1.05

Step 3: Risk Adjustment ("Correction")

Issuer	Premium (A)	EE Age Factor (B)	Age Factor in Rates (C) = Average (B)	Risk Score Adjustment (D) = (B) - (C)	**Risk Adjustment (E) = (D) * Average (A)**	**Net Revenue (F) = (A)+(E)**
A	$250	0.50	1.05	(0.55)	**-$151**	**$99**
B	$275	1.14	1.05	0.10	**$26**	**$301**
C	$300	1.50	1.05	0.45	**$124**	**$424**
Total	$825	1.05	1.05	-	**$0**	**$825**

- Advantages:
  - All employees would pay the same amount for the same plan, regardless of age or plan selected.
  - For states already planning on administering risk adjustment, this is an easy "fix" to a potentially complex issue.
  - For states where composite rates are prevalent, the Composite with Risk Adjustment methodology allows employers and brokers to keep composite rates, something to which they are accustomed.
  - A defined contribution approach is possible. This means that an employer could choose a set dollar amount, and employees could select a plan. All employees purchasing the same plans would pay the same amount (for employee-only

coverage), regardless of age. The employer contribution would be a fixed dollar amount per employee, regardless of employee age. This could possibly mean that employers would not need to select a reference plan, depending on how the state-specific SHOP operates.
    - Issuers' ultimate revenue is adjusted to reflect their actual SHOP enrollment (but revenue will not equal list bill premiums).
- Disadvantages:
    - Issuers are not "made whole" with respect to the list bill premiums for the employees who enroll in their products.
    - For states which have HHS administer risk adjustment, the reconciling calculations would need to be performed by the SHOP which collects demographic information for groups as part of SHOP enrollment.

2.3 Reallocated Composite with Buy-up/down Equal to Difference in List Bill Rates

- Components of approach:
    - Issuers receive list bill premiums. The only exception to this may be with regard to mid-year census changes.
    - Composite rates are calculated for all plans that employees of a group could select. Rates for any one plan are calculated based on the assumption that all qualified employees of a group enroll in that plan.
    - A reference QHP and contribution amount is selected by the employer.
    - The employer pays the same dollar amount for each employee, regardless of age or plan selected by the employee.
    - For employees who select the reference plan, their premium payments are the same dollar amount, regardless of age.
    - In addition to the employee contribution for the reference plan, if an employee selects a plan other than the reference plan, the employee pays (or receives) the difference between the list bill of the selected plan and the list bill of the reference plan.

Multi-Issuer Composite Rates: Reallocated Composite

Buy-up and Buy-down is based on the difference in List Bill premiums

Step 1: Calculation of Composite Rates Assuming 100% of Group Enrolls in Plan

Employee-only	
Issuer	**Silver**
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	**A**
Metal Tier	**Silver**
% Contribution	**70%**

Step 3: Employee Selections

Employee	Age	Ee Age Factor	Issuer	Plan (AV)	List Bill Premium
1	<25	0.50	A	Silver	$119
2	45-49	1.14	B	Silver	$300
3	60+	1.50	C	Silver	$430
Average		1.05			$849

Step 4:Calculate Premiums and Reallocate Revenue

	Benchmark Plan				Selected Plan			
Selected Issuer	**Composite Rates (A)**	**List Bill (B)**	**Paid by Employer (C) = 70% * (A)**	**Paid by Employee (D) = (A) - (C)**	**List Bill (E)**	**Additional Amt Paid by EE (F) = (E) - (B)**	**Total Premium Collected (G) = (C)+(D)+(F)**	**Total Reallocated Premium (H) = (E)**
A	$250	$119	$175	$75	$119	$0	$250	$119
B	$250	$273	$175	$75	$300	$27	$277	$300
C	$250	$358	$175	$75	$430	$72	$322	$430
Total	$750	$750	$525	$225	$849	$99	$849	$849

- Advantages:
  - All issuers are “made whole,” meaning that each issuer will receive premiums according to the ages of the employees who enroll in their products. The only exception to this could be mid-year changes in the census.
  - Employers pay the same amount for each employee (for employee-only coverage), regardless of age or plan selected by the employee.
  - This methodology allows employers and brokers to keep composite rates, something to which they are accustomed in many states.
- Disadvantages:
  - Older employees pay more than younger employees for more expensive plans (and save more than younger employees for less expensive plans) than the reference QHP.

- This approach may not pass non-discrimination rules. There certainly is compliance with non-discrimination rules when the reference plan is selected by employees. However, older employees who select a plan richer than the benchmark will pay more than younger employees who select the same plan.

2.4 Reallocated Composite with Buy-up/down Equal to Difference in Composite Rates

- Components of approach:
  - Composite rates are calculated for all plans that employees of a group could select. Rates for any one plan are calculated based on the assumption that all qualified employees of a group enroll in that plan.
  - A reference QHP and contribution amount is selected by the employer, which determines the employees' contribution to the reference plan.
  - In addition to the employee's contribution for the reference plan, if an employee selects another plan, the employee pays (or receives) the difference between the composite rates of the reference plan and of the selected plan.
  - Issuers receive adjusted list bill premiums. Premiums are composite rated for purposes of employee choice, but revenues are allocated to issuers on an age-adjusted basis.
  - The total of the composite rates collected from the employer will not equal the list bill premiums calculated. The difference between those two totals, is the percentage adjustment applied to each issuer's list bill collections.

Multi-Issuer Composite Rates: Reallocated Composite

Buy-up and Buy-down is based on the difference in Composite Rates

Step 1: Calculation of Composite Rates Assuming 100% of Group Enrolls in Plan

Employee-only	
Issuer	**Silver**
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	**A**
Metal Tier	**Silver**
% Contribution	**70%**

Step 3: Employee Selections

Employee	Age	Ee Age Factor	Issuer	Plan (AV)	List Bill Premium	Composite Premiums
1	<25	0.50	A	Silver	$119	$250
2	45-49	1.14	B	Silver	$300	$275
3	60+	1.50	C	Silver	$430	$300
Average		1.05			$849	$825

Step 4: Calculate Premiums and Reallocate Revenue

	Benchmark Plan			Selected Plan					
Selected Issuer	**Composite Rates (A)**	**Paid by Employer (B)= 70%*(A)**	**Paid by Employee (C) = (A) - (B)**	**Composite Rates (D)**	**Additional Amt Paid by EE (E) = (D) - (A)**	**Total Premium Collected (F) = (D)**	**Total List Bill Premium (G)**	**Adjustment to List Bill (H) = Total (F) / Total (G) - 1**	**Total Reallocated Premium (I) = (G) * (1+(H))**
A	$250	$175	$75	$250	$0	$250	$119	-2.8%	$116
B	$250	$175	$75	$275	$25	$275	$300	-2.8%	$292
C	$250	$175	$75	$300	$50	$300	$430	-2.8%	$417
Total	$750	$525	$225	$825	$75	$825	$849	-2.8%	$825

- Advantages:
  - All employers would pay the same amount for all employees, regardless of age or plan selected.
  - Employees would pay more (or less) for more (or less) expensive plans than the reference plan, but all employees would pay the same amount for the same plan, regardless of age.
  - Employers and brokers, who are accustomed to composite rates in many states, would continue to see composite rating.
  - A defined contribution approach is possible. This means that an employer could choose a set dollar amount, and employees could select a plan. This could possibly mean that employers would not even need to select a reference plan, depending on how the state-specific SHOP operates. Employees would pay the difference between the composite rate of the plan selected and the defined contribution paid by the employer.

- Issuers' ultimate revenue is adjusted to reflect their actual SHOP enrollment (but revenue will not equal list bill premiums).
- This approach optimizes the equity of payment among issuers. All issuers would have the same percentage adjustment to list bill rates.

- Disadvantages:
  - Issuers are not "made whole" with respect to the list bill premiums for the employees who enroll in their products i.e., their ultimate adjusted revenue will not equal their list bill premiums.
  - Issuers will not be able to calculate their revenue with only the information they have. The SHOP will need to perform these calculations and provide support of the premium transfers to issuers.

2.5 List Bill with Age-Stratified Contribution

- Components of approach:
  - The employer chooses the reference plan. Composite rates are calculated for the reference plan, and the employer determines her percentage contributions (X%) toward the composite rates.
  - All employees who choose the reference plan pay the same amount [(1-X%) x composite rate], regardless of age (for employee-only coverage).
  - The employer actually contributes the difference between each employee's *list bill* premium and the employees' contribution toward the reference plan. This methodology results in employers making an age-stratified contribution -- higher percentage of list bill premiums for older members and lower percentage for younger employees.
  - As employees buy-up or buy-down to other QHPs, rather than selecting the reference plan, their employer contributions stays constant (a fixed allowance). Therefore, the employee pays the difference between list bill of the selected QHP and the fixed allowance paid by the employer.

List Bill with Age-Stratified Contribution

Step 1: Calculation of Composite Rates Assuming 100% of Group Enrolls in Plan

Employee-only	
Issuer	**Silver**
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	**A**
Metal Tier	**Silver**
% Contribution	**70%**

Step 3: Employee Selections

Employee	Age	Ee Age Factor	Issuer	Plan (AV)	List Bill Premium
1	<25	0.50	A	Silver	$119
2	45-49	1.14	B	Silver	$300
3	60+	1.50	C	Silver	$430
Average		1.05			$849

Step 4: Calculate Premiums

	Benchmark Plan				Selected Plan		
Selected Issuer	**Composite Rates (A)**	**List Bill (B)**	**Paid by Employee (C) = 30% * (A)**	**Paid by Employer (D) = (B) - (C)**	**List Bill (E)**	**Additional Amt Paid by EE (F) = (E) - (B)**	**Total Premium Collected (G) = (C)+(D)+(F)**
A	$250	$119	$75	$44	$119	$0	$119
B	$250	$273	$75	$198	$300	$27	$300
C	$250	$358	$75	$283	$430	$72	$430
Total	$750	$750	$225	$525	$849	$99	$849

- Advantages:
  - All issuers are “made whole,” meaning that each issuer will receive premiums according to the age of the employees who enroll in their products.
  - All employees selecting the reference plan pay the same amount, regardless of age.
  - The employer makes a fixed dollar contribution for each enrollee i.e. her contribution is fixed, so long as the

- Disadvantages:
    - If employees select a higher cost plan than the reference plan, older employees pay more than younger employees for the same plan. (As in methods 2.1 and 2.3, this "inequality" is symmetrical i.e., older employees also save more than younger employees for selecting a less expensive plan than the reference plan.)
    - The employer's contribution will change throughout the year with changes in the enrollee census
    - Composite premiums are typical in most states. Changing to list billing could be an operational challenge for issuers, and a significant change to how employers and brokers consider premium rates.
    - The complexity and newness of age-adjusted employer contributions is hard to explain to employers and employees alike.

3 Conclusion

There are many things for a state to consider when selecting an approach, and there are many things for issuers to consider when pricing products offered within each of these approaches. The main differentiations among approaches are:

- Issuers generally prefer methods that result in obtaining list bill, or age-specific revenue in accordance with the members who actually enroll in their plans. Of the methods listed in this report, the ones that meet this objective are:
    - List Bill
    - Reallocated Composite Premium, with the buy-up or buy-down premium calculated as the difference between the member's list-bill premium for the reference plan and the selected plan
    - List Bill – Age-Stratified Contribution
- Some stakeholders think that having a methodology in which employees of all ages pay the same amount, for each plan, is important. Of the methods listed in this report, the ones that meet this objective are:
    - Composite with Risk Adjustment
    - Reallocated Composite Premium, with the buy-up or buy-down premium calculated as the difference between the composite rates of the benchmark plan and the selected plan
- Appeal to employers (and possibly brokers) is paramount to creation of a thriving SHOP. Based on the concept that employers generally prefer paying a set dollar amount for

each employee (for employee-only coverage), the following methods meet this criteria best:

  - Either of the Reallocated Composite Premium methodologies
  - Composite with Risk Adjustment

- Minimizing the operational complexity is an important consideration in selection of an approach. It is important to consider the operational complexity and transparency of each approach from the perspective of the SHOP and the issuers. Of all considerations, this criterion is the most subjective and is heavily influenced by other related decisions, such as: Will the state administer risk adjustment? Will an issuer who currently bills on a composite basis operationalize a list bill system regardless of one state's decision?

Appendix D: Reviews of Working Group Meetings

In addition to supplemental materials, after each meeting working group members were provided with a review of the previous meeting (note that a review of the last meeting was not provided to members and is represented in the body of the report). The review documents are attached below to provide the Board with further details of the working group's discussions.

DC HBX Employer & Employee Choice Working Group
Review of Meeting #1 Held on 2/22/13

The Working Group's Charge

The Exchange Board has proposed the following charge for the Employer and Employee Working Group:

"Recommend approach for small business (e.g. employee choice) for choosing plans, issuers, and contribution to coverage for workers; includes consideration of age rating."

The working group clarified that the charge has two primary components; (1) Which "models" of employee choice should the exchange offer to employers? (2) What options and requirements should small employers have in contributing toward their group health benefit plans? – i.e. a fixed dollar contribution, a percent of premium contribution, and any minimum contribution levels?

Criteria for Framing Recommendations

Members of the working group proposed the following criteria be considered when evaluating and making recommendations. These criteria were "nominated" and never fully discussed and agreed upon, and may be refined as the working group progresses. Moreover, there may be some overlap among these criteria. Wakely has grouped the proposed criteria into several categories to facilitate discussion and evaluation.

Preserve / enhance group insurance

1. Increase or maintain employer offer
2. Maintain employer contribution
3. Increase employee take-up

Simplify Administration

4. Simplify administration for employers
5. Simplify administration for employees
6. Accommodate Exchange administrative burden

Control Costs

7. Affordability for employers and employees
8. Minimize impact of adverse selection

Increase Choice

9. Increase meaningful choice
10. Adequate choice to meet diverse health needs
11. Maximize employee portability

Other

12. Protect older employees
13. Encourage younger employees to take-up
14. Minimize disruption/harm to existing market

Minimum Contribution & Participation Levels

The work group discussed requiring employers to make a minimum contribution and to reach minimum participation levels on the part of employees. Based on input at the meeting from agents and health plans, it appears that 50% minimum contribution toward the premium for employee-only coverage and 75% participation by employees who do not have a "legitimate waiver" (e.g. covered through spouse) is a standard underwriting requirement for small group insurance by the largest health plans in D.C. As minimums of this sort help protect against adverse selection, and adverse selection will be greater with employee choice, the work group should consider requiring of issuers the same (or higher?) contribution and participation requirements as the carriers currently apply to small employers.

Next Steps

For the next meeting, the working group has decided to rank the five different employee choice models for each criteria. This exercise will assist the working group in making recommendations for each employee choice model and will help the group tackle the Charge. Five employee choice models were discussed at the first meeting. Please refer to the background analysis report for further clarification on employee choice models. Wakely will prepare a matrix of choice models and criteria to use in evaluating the choice models.

Wakely was also asked to provide some information on the premium impact of adverse selection. We have estimates done for other markets, so they will not be precise fits for D.C., but can shed some light on the likely range of premium impact from adverse selection. Wakely will provide these for the next meeting. Wakely will also look at what other states are doing, Maryland in particular.

DC HBX Employer & Employee Choice Working Group
Review of Meeting #2 Held on 2/27/13

Impacts of Adverse Selection

The working group reviewed adverse selection and its impact on premium price increases. An extensive actuarial analysis is required to determine specific impacts on the DC market. Wakely provided expected impacts of adverse selection on premium price increases for two states. Although these figures are not DC specific, they provide the group with a sense of adverse selection impacts for employee choice model. Note that these percentage increases are a one-time increase and are not annual increases.

Increases in Premium Prices due to Adverse Selection

Employee Choice Model	State 1	State 2
Full Menu	1 – 6 %	4 – 8 %
One-Issuer / Multi-Tier	1 – 5 %	4 – 8 %
2 AV Tiers / Multiple QHPs	NA	1 – 4 %
1 AV Tier / Multiple QHPs	0 – 1 %	0 – 1 %
1 QHP	0 %	NA

The group discussed that the ACA is already expected to cause premium prices to increase by 20 – 50% (high level estimates discussed, group did not discuss sources), and therefore in deciding employee choice models, the additional impact of adverse selection should be an important consideration.

Employee Choice Models of Other States

The working group reviewed employee choice model considerations of other State-based Exchanges, as shown in the table below. With exception to "Multi-Issuer / Multi-Tier", States have chosen to implement a wide range of employee choice models. Note that the ACA requires SHOP exchanges to offer employers the "Multi-Issuer / One-Tier" option.

	Employee Choice Model				
State-based Exchange	One Plan	One-Issuer / Multi-Tier	Multi-Issuer / One - Tier	Multi-Issuer / Multi-Tier	Full Menu
Maryland		X	X		
Oregon	X	X	X		X
Connecticut	X	X	X		
California*			X		
Colorado**	X		X		
Minnesota	X		X		X
Massachusetts	X	X	X		

Vermont***			X		X
New York***			X		X

* Recommended to the Board

**More models were recommended to Board, models known to be approved shown

***Leaning towards this choice decision, but may have not made an official policy decision yet

Narrowing Options for Employee Choice Models

After general discussion of the pros and cons of each model, and reviewing the employer choice matrix provided by Wakely, as a next step the working group discussed whether the working group should narrow its options for employee choice models by removing some models from consideration. While this decision to narrow model options would not be final, the working group thought it would be helpful to get a sense of members' viewpoints to facilitate future deliberations.

Many members were against the Full-Menu option, primarily because of potential premium price increases due to adverse selection. Additional reasoning against Full-menu included that this model may cause administrative difficulties for Employers (although one could argue that Full Menu removes decision requirements for Employers) and may create difficulties for brokers to explain and administer plan options for clients.

One member expressed concern with discarding Full-Menu because it may be a good option for smaller employers (i.e. less than 10 employees) and administrative difficulties for these smaller groups would not be as great. As a summary, the following is the pros and cons discussed by the group.

Full-Menu pros and cons discussed by the working group:

PROs	CONs
• Provides the most choice to employees • May not create admin difficulties for very small groups	• Premium price increases due to adverse selection • Possible employer administrative difficulties related to many carriers • Employee confusion • Difficulties for brokers to explain and administer

During discussion it became evident that many members supported the One-Issuer / Multi-Tier model. Members noted that it minimized the confusion and administrative difficulties associated with Full-Menu, but also provides substantial choice (in combination with Multi-Issuer / One – Tier as required by ACA).

One-Issuer / Multi-Tier pros and cons discussed by the working group:

PROs	CONs
• Similar to today's market • In combination with ACA required model, it provides employers/employees substantial choice ○ MD is taking this approach	• Premium price increases due to adverse selection

Overall, the group did not support Full-Menu, but did support One-Issuer / Multi-Tier and did not want to take it off the table as an option. The group discussed that as a potential "middle-ground", to minimize adverse selection impacts while also providing substantial choice, the working group could also consider a "boxed-in" model of multiple issuers (but not necessarily all issuers) and multiple AV tier levels (but not all tier levels).

DC HBX Employer & Employee Choice Working Group
Review of Meeting #3 Held on 3/12/13

Employee Choice Models

The working group re-visited employee choice models discussed previously. CMS had released regulations that pushed back to 2015 the requirement for State-based Exchanges to offer an employee choice model and preform premium aggregation. (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04952.pdf) As a result, exchanges have the option to implement choice models and premium aggregation in 2014, but will not be required to do so until 2015. In response to a question, staff indicated that the DC Exchange still plans to pursue functionality for choice models and premium aggregation for 2014, and the working group decided to recommend employee choice models to the Board for implementation in 2014.

Based on previous discussion, the working group focused on three employee choice models; (1) One-Issuer/Multi-Tier, (2) Multi-Issuer/One-Tier, and (3) One Plan.

One-Issuer/Two-Tier

There was unanimous support from the members of the working group for a version of the One-Issuer/Multi-Tier model in which employers may choose to offer QHPs from on issuer at only two contiguous AV metal levels. This model had received general support at the second meeting, including

the choice of QHPs from one issuer at any AV level; the primary reason to reconsider and constrain the spread of AV tiers to just two levels is to reduce the impact of adverse selection on premiums. To reduce the impact of adverse selection on premiums, the working group decided that the metal tiers employers may offer their employees must be "contiguous". The majority of members preferred two contiguous metal tiers. Some members preferred three contiguous metal tiers, but health plans indicated that a narrower spread in actuarial value than three metal levels is far more common in today's DC market. Therefore, members were able to come to a unanimous decision that the working group's recommendation would include a modified version of the One-Issuer/Multi-Tier model in which employers choose two contiguous metal tiers.

Multi-Issuer/One-Tier

The Multi-Issuer/One Tier employee choice model is required by the ACA. Members decided that although this model is not required until 2015, the working group's recommendation should include it because there is no reason to not include this model for only one year, and the choice among delivery systems, narrow and broad networks, HMOs and PPOs, etc. from different issuers is an important element of market reform.

One Plan

There was an overwhelming majority support that the working group's recommendation should include the One Plan model, because this is the primary choice option in today's market. One or more members expressed concern that the One Plan model gives employers the ability to limit employee choice and one intention of the ACA to expand employee's choice in the small group market.

At the end of the meeting, in an effort to reach consensus clarify opposing viewpoints, the group took a "straw vote" on two different recommendations involving the three employee choice models discussed above.

Recommendation 1: Would you make a recommendation to the Board that the Exchange should offer employers the ability to choose any one of the three employee-choice models described above? or

Recommendation 2: Would you make a recommendation to the Board that the Exchange should offer employers the ability to choose only two of the employee-choice models described above – Multi-Issuer/One Tier and One-Issuer/Two-Tier? (Employers would not be able to offer the One-Plan model to their employees?)

Responses of the 14 members present are as follows:

	Yes	No	Abstain
Question 1 – all three models	11	1	2
Question 2 – two of the models, not One-Plan	6	8	0

Minimum Contribution and Participation Rate

Members again discussed that in today's DC market insurers generally require a minimum employer contribution of 50% and minimum employee participation rate of 75%. Members deliberated the pros and cons of minimum contribution and participation rate requirements. Below are the pros and cons discussed by members.

Pros for Minimum Contribution Requirement:

- By increasing participation of (healthy) employees, the employer contribution limits adverse selection and associated premium increases
- It provides a significant subsidy to employees, shielding them from the full cost of coverage
- Without a minimum level, employers could offer zero contribution, which is just a way around non-group coverage

Cons for Minimum Contribution Requirement:

- May dissuade some employers from participating in the Exchange because the minimum contribution would be too expensive

Pros for Minimum Participation Rate Requirement:

- Insurers face increased uncertainty i.e., upward pressure on premiums, with multi-issuer options, and retaining the existing minimum participation requirement at least cushions that uncertainty

Cons for Minimum Participation Rate Requirement:

- This is enforced after open enrollment, so can result in a group not qualifying and being left uncovered

Overall there seemed to be significant support for a minimum contribution and participation requirements, but members were confused by newly published guidance from CMS on waiving these minimum requirements during special enrollment periods. A consensus could not be reached and no vote was taken. Members were invited to submit their own statement regarding this issue, and it was noted that the pros and cons would be included in the report to the Board. (This issue will be addressed again during the two meetings added by the Chairs.)

Premium Rate Development

Members began to discuss the complex subject of premium rate development, the pros and cons of composite billing vs. list billing, and their effects on employer contribution strategies. Composite billing is the norm in the DC market, but list billing can be more easily applied in SHOP. Insurer members of the working group seemed to prefer list billing, but doubts were expressed as to whether DC should move to list billing or could do so in time for 2014. Some members preferred composite billing and expressed their decision for recommended employee choice models may be affected by the group's decision on premium rate development.

The working group ended the meeting without addressing premium rate development. After the meeting, the Chairs decided to add two additional meetings to ensure that the working group fulfills its charge to consider recommendations on premium rate development and other open issues. To assist the group in understanding this complex topic, Wakely will develop briefing materials for premium rate development. The working group plans to review Wakely's paper and discuss potential premium rate development model options and determine if a recommendation can be made to the Board.

Employer & Employee Choice Working Group
Overview and Preparation for 3/22 Meeting

Set forth below are the sets of options that Jon summarized at the conclusion of today's meeting (3/21), for each of these three topics:

1. Rating and Employer Contribution Approaches
2. Minimum Contribution & Participation Requirements
3. Employee Choice Models

We will be joined tomorrow on the phone by Mary Hegemann, an actuary who can do a much better job than Jon did today of explaining the Rating method 2.3. I apologize for being unclear about it, but now can at least clarify that it offers the following advantages:

a. The employer contributes a fixed amount toward the composite rate of the benchmark (or "reference") plan
b. The issuer gets their true list bill amount for enrollee
c. Older employees do pay more than younger employees for more expensive plans, and less than younger employees for less expensive plans, BUT as Chris stated today, and I misunderstood, this age-related delta is "muted." That is, the older employee would not pay "full freight" for buying up and the younger employee might not enjoy a discount for buying down. I believe this "muted" incentive for employee choice is in line with preferences expressed by many folks today.

Here are the sets of alternatives we have discussed to date, which will be voted/decided on during Friday's meeting :

Rating and Employer Contribution Approaches

1. List bill with % contribution
2. Reallocated composite premium, with employee delta in list billing rates (model 2.3)
3. Reallocated composite premium, with employee delta in composite rates (model 2.4)
4. List bill with age stratified employer contribution (model 2.5)

Minimum Contribution & Participation Requirements

	Min Contribution Rate	Min Participation Rate
1.	50 %	75 %
2.	50 %	50 %
3.	0 %	0 %

Employee Choice Models

The working group plans to revisit its employee choice votes from meeting #3. Members voted on the following two questions:

1. Would you make a recommendation to the Board that the Exchange should allow employers to choose any one model from the three below:
    a. All Issuers & QHPs/One Tier – all issuers and all QHPs on one AV metal tier level
    b. One-Issuer/ Two AVs – all the QHPs that one issuer offers at any two contiguous AV metal tiers
    c. One-QHP – a single QHP offered by one issuer

2. Would you make a recommendation to the Board that the Exchange should allow employers to choose any one model from the two below:

    a. All Issuers & QHPs/One Tier – all issuers and all QHPs on one AV metal tier level
    b. One-Issuer/ Two AVs – all the QHPs that one issuer offers at any two contiguous AV metal tiers

Members voted as follows:

	Yes	No	Abstain
Question 1 – all three models	11	1	2
Question 2 – just models “a” and “b”	6	8	0

Appendix E: Individual Working Group Members' Submitted Statements

Working group members were invited to submit a one-page statement to the Board. The purpose of this statement is to allow members to express their views on non-unanimous issues, which may have not been fully captured in the body of the report. Individual statements submitted by members are attached below (one statement was submitted).

Statement #1

Additional Comments on Minimum Contribution and Participation Requirements

A slight modification to permit the use of an exception is offered to the recommendation that the Exchange require a 50% minimum contribution and 70% minimum participation.

While a high participation requirement may lessen adverse selection and reduce pressure to increase premiums, it also can result in a small employer's inability to provide important tax qualified health benefits to his or her employees, despite that employer's voluntary support. At the same time, employee access to employer-sponsored coverage can become contingent on and subordinated to the choice of other workers. In today's marketplace, this problem is sometimes resolved on a case-by-case basis where an exception is granted to the participation requirement.

Therefore, it is suggested that waivers be made available to accommodate those groups which can satisfy the two-thirds participation (i.e., 66%) requirement, but may fail the slightly higher test, as is similar to today's circumstance. Given that the average small group size in today's marketplace is only six employees, this small modification could enable significantly more employers to offer coverage to their groups without substantial change to the requirement.

This recommendation is qualified by the assumption that the availability of this waiver provision (for which approval could be regulated in scope) will not result in additional cost concerns.

Marilyn Koss

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