



# **Study of SHOP Exchange**

**FINAL REPORT**

## ***Analysis of Key Maryland SHOP-Related Policy Options***

Submitted to:

**Maryland Health Benefit Exchange**

Submitted by:

**INSTITUTE FOR HEALTH POLICY SOLUTIONS, INC.**

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## **INTRODUCTION**

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### **Purpose and Structure of this Report**

#### ***Purpose***

The federal Affordable Care Act (ACA) aims to greatly improve ready access to and informed consumer choice of competing plans in the individual and small-group insurance markets. A key part of its design is the establishment of insurance Exchanges to serve these markets. Aside from the experience in Massachusetts, previous efforts to establish Exchange-like entities have often proved unsuccessful because of adverse selection caused by inadequate market rules, insufficient numbers of enrollees, and reluctance of health plans to participate. To mitigate these problems, the ACA limits rate variation, standardizes “essential” benefits and cost-sharing “levels,” requires risk adjustment, mandates coverage, and makes tax subsidies available only for coverage bought through the Exchange.

While Maryland’s small-employer market rules and administrative roles are in many respects similar to those called for in ACA provisions, small employers do not now have a way to allow their workers to make their own choice among health plans offered by competing carriers. (The present market *does* accommodate an employer option to allow workers to choose between different benefit plans offered by the same carrier.) And the ACA’s individual market reform rules and sliding-scale tax subsidies will dramatically alter the size and characteristics of the insured population.

How successful these reforms are in Maryland will depend crucially on decisions that Maryland makes about the relationship of these markets and associated Exchange structure and operations. The purpose of this study is to identify alternative approaches and analyze their advantages and disadvantages in light of Maryland’s context, in order to inform the Board of the Maryland Health Benefit Exchange (MHBE) and its recommendations in its report to the Maryland General Assembly.

### **Study Questions and Structure of this Report**

This report addresses the three key policy questions identified by the MHBE:<sup>1</sup>

1. Should the individual and small group markets be merged?

This question is addressed in the first chapter, “Merge Markets?”

2. Should the small-group market be expanded to include employers with 51 to 100 employees prior to 2016 (that is, effective January 1, 2014)?

This question is addressed in the second chapter, “Small-Employer Market Definition.”

3. What are the advantages and disadvantages of the various options the SHOP may choose from to offer workers a choice of qualified health plans (QHPs)?

More specifically, what are the relative merits of the worker-choice model (allowing for a defined employer contribution) that proposed federal regulations require SHOPS to provide, compared to other choice options the SHOP might also provide, including one that would allow employers to specify a single QHP for their workers.

This question is addressed in the third chapter, “Worker-Employer Choice.”

The MHBE also identified a fourth key question:

4. To what extent is there existing Maryland infrastructure that could support various informational and business operations of the SHOP exchange?

This study question differs in character from the three addressed in this report. The issues addressed here require making a choice among two or more policy options. The fourth question involves determining whether there exist within Maryland the kinds of capacity that will be needed to support key administrative tasks and functions that the SHOP Exchange must perform that differ from those that the individual-market Exchange will carry out.

Therefore, the fourth question is addressed in a separate report, “Technical Assessment of Private-Sector Capacity.”

The MHBE also asked that we identify any other study questions that we believe, in our professional judgment, are necessary for the Exchange Board to consider in order to make its recommendations on the design and function of the SHOP exchange. We identified one sub-question, relating to standardization of benefit designs and cost-sharing structures, which is discussed at the end of the third chapter on Worker-Employer Choice.

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<sup>1</sup> For clarity of presentation, this report discusses the study questions in an order different from the order in which they were originally asked. Also, in consultation with MHBE staff, two of the questions have been modified in light of ACA provisions and proposed federal regulations.

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## MERGE MARKETS?

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This chapter addresses the question: Should the individual and small group markets be merged?

The ACA gives states the option of merging the individual and small-group markets. In essence, this means that the same carriers (“issuers”) would serve both markets. Moreover, carriers would have to make the same products (plans) at the same age-rated premiums available to any individual or small-employer group—that is, all the people purchasing coverage from a carrier would be combined into a single risk pool for the purpose of determining premium rates.

### Background

#### *Relative Size of the Two Markets*

It is useful to begin by comparing the relative size of the two markets.

The individual (non-group) market

In 2010, about 165,000 Marylanders had coverage in the individual market.<sup>2</sup> But another 450,000 or so are uninsured and would not qualify for Medicaid or CHIP under reform.<sup>3</sup> Some of the currently uninsured will be able to get coverage through their employer, but most will have to purchase coverage in the individual market, either inside or outside the Exchange. And some with employer coverage will move to the individual Exchange.

Each health plan will be required to create a single risk pool for individuals who purchase individual coverage, regardless of whether they do so inside or outside the Exchange, so precisely where people choose to buy individual coverage is not relevant to the present question.<sup>4</sup>

Hence, a reasonable upper-bound estimate for the post-reform individual market in Maryland is slightly over 600,000 enrollees, while a reasonable lower-bound estimate is

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<sup>2</sup> Maryland Insurance Administration, November 29, 2010.

<sup>3</sup> IHPS calculations using the U.S. Census Bureau’s online tabulator for the Current Population Survey (combining the samples surveyed in 2010 and 2011).

<sup>4</sup> People who choose to stay with their pre-reform, “grandfathered” individual coverage will *not* be part of this single risk pool, but by January 2014, very few people will still be enrolled in such plans, due to the relatively short average length of enrollment in individual coverage. “Grandfathering” only applies to the plans people were enrolled in as of the date the ACA was enacted, March 2010.

around 400,000 enrollees.<sup>5</sup>

### The Small-Group Market

The small-group market is more than twice as large as the individual market at present. In 2010, about 365,000 Marylanders were covered by insured small-group products.<sup>6</sup> An additional unknown number were covered by employers who were self-insured.

It is difficult to predict whether the implementation of ACA will cause this number to grow or decrease. In fact, estimates based on credible simulation models vary substantially, depending on varying assumptions about how small employers will react to the incentives and alternatives under health reform.

Unlike larger employers, employers with fewer than 50 full-time-equivalent employees face no federal penalty if they do not provide health insurance. Some small businesses that currently offer coverage may decide to drop it—especially if they have many modest-income workers who could qualify for tax credits as individuals buying through the Exchange. (These individual tax credits are not available for SHOP or other employer-sponsored coverage, nor for workers eligible for such employer coverage [with limited exceptions]).

On the other hand, some employers that do not now offer coverage may decide to begin doing so to enable their workers to comply with the individual mandate. This is especially likely for firms that employ a number of workers whose incomes are too high to make them eligible for tax credits. Such workers would realize a tax advantage because some or all of the premium contributions to employer-sponsored plans are not subject to federal income and employment taxes, whereas if these workers had to use their after-tax income to buy coverage to meet the mandate requirement, their net cost of coverage would be substantially higher. Another factor that may cause a few lower-wage small employers to newly offer coverage is the federal small-business tax credit (which increases in 2014 but is then limited to two years for each employer).

Another small-group market enrollment boost will come from workers who currently decline coverage offered by their employers but decide to accept the coverage to comply with the individual mandate requirement. (Workers who have the option of accepting employer-sponsored coverage cannot qualify for tax credits in the Exchange unless the employer coverage meets the “unaffordable” definition under the ACA.)

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<sup>5</sup> This rough, order-of-magnitude estimate is *not* based on any formal simulation model. The lower bound implies an overall participation rate of about 65 percent among people without options other than individual coverage. It is generally consistent with estimates from the Urban Institute that project 405,000 participants in the individual Exchange, once health reform is full phased in. (This estimate does not include enrollees in the individual market outside the Exchange.) M. Buettgens, J. Holahan and C. Carroll, “Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid,” The Urban Institute, March 2011, Table 3. <<http://www.urban.org/url.cfm?ID=412310>>.

<sup>6</sup> Maryland Health Care Commission, “Maryland’s Small Group Market: Summary of Carrier Experience for the year ending December 31, 2010,” (slide presentation) June 16, 2011.

## Size of Markets after Reform

If the predictions above are reasonably correct, the new post-reform individual market of at least 400,000 people would exceed the size of the present small-group market of 365,000. It is difficult to know whether and by how much market enrollment will grow but, as explained, it is reasonable to assume that Maryland's small-employer group enrollment will be much more stable than will the individual market—that is, growth (if any) in small-group enrollment, and any associated change in the risk profile of those enrolled, will be much less than growth in individual enrollment. And it is likely that both markets will be large enough to be sustainable even if they were not merged.

## Implications of Market Size for the Merger Question

One reason to consider merging the individual and small-group markets would be the need for “critical mass”—a risk pool that is large enough to spread risk broadly and be stable over time. The pool has to be large enough to ensure that shocks to the system—an influx of a number of higher-risk people or the exodus of a significant number of low-risk people—do not cause large and destabilizing changes in the average premiums.

If either the individual market or the small-group market, on its own, were not large enough to meet this criterion, that fact alone would be a compelling argument in favor of merging the markets. However, it appears that both the small-group market (as currently defined) and the individual market are sufficiently large on their own and do not need to be merged to attain critical mass.

(Note that the Maryland circumstance is very different from that in Massachusetts before the state reformed and merged its markets. In Massachusetts, the individual market was only about 5 per cent as large as the small-employer market, and it was much more expensive because the combination of community rating with no individual mandate and no subsidies produced adverse selection; that is, many lower-risk people chose not to buy coverage because of the high cost while high-risk people did participate. Given the inconsequential size of its individual market, the much larger small-group market could absorb the merger with only minimal effects on small-employer premiums.)

## ***What Market Merger Does and Does Not Entail***

As noted earlier, if the individual and small-group markets were merged, carriers would be required to serve both markets, to offer the same coverage options to individuals and to small employers, and to create a single risk pool for people buying as individuals and as employees so that the age-adjusted premiums would be the same for a person of a given age in either category.

Even if the two markets were merged, however, distinctions would remain between individual and small-group coverage. Coverage sold to individuals would still be individual coverage, and coverage issued through an employer group (or through the SHOP) would still be employer coverage. The distinctions are significant for tax purposes and for plan administration. The SHOP and the individual Exchange would each retain some differentially unique functions that the other does not need to perform:

The individual Exchange . . .

- must determine eligibility for individual tax credits and display after-tax-credit prices for individual purchasers;
- must give each individual the option to pay premiums to the health plan directly rather than through the Exchange (the Exchange may opt not to collect any private premiums at all); and
- cannot administer the advanced federal tax-credit portion of the premium (which is paid directly to the plan by the U.S. Treasury.)

The SHOP Exchange . . .

- must determine that the employer is qualified and meets any contribution and participation requirements that the SHOP or Maryland market rules establish (the SHOP does *not* review or determine income eligibility of individuals);
- must bill and collect from the employer for the total premium payable with respect to all enrolled workers and transmit the appropriate premium to each Qualified Health Plan (QHP) in which the employer's workers are enrolled; and
- would provide a bill to the employer listing each workers plan choice and associated premium. It would ideally also list each worker's contribution amount for the worker's chosen plan.

### **Adverse Selection**

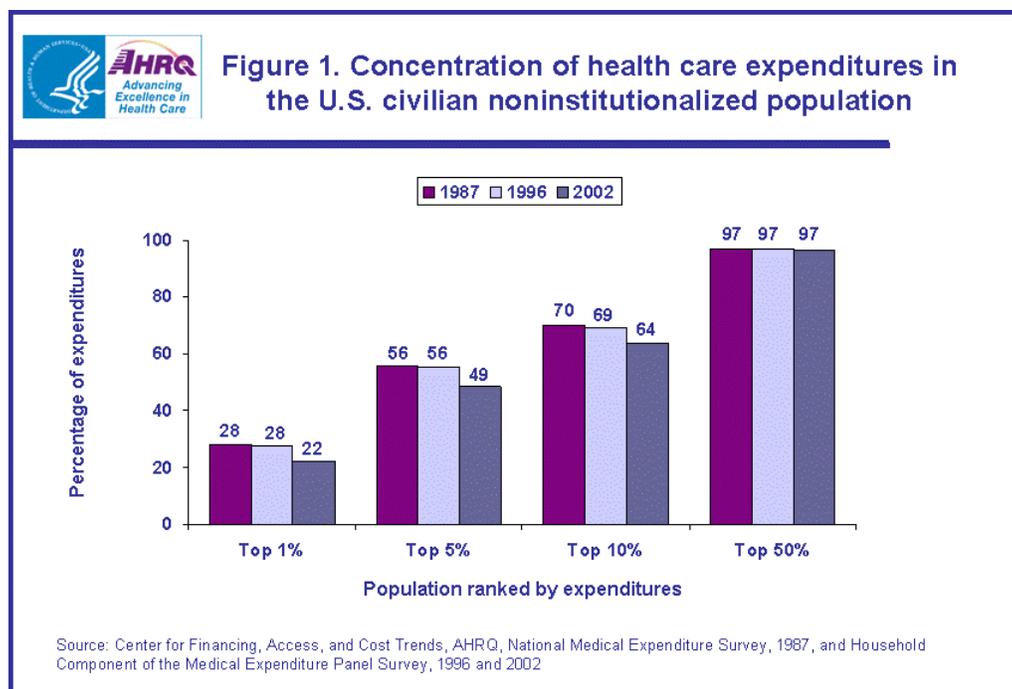
One of the issues that arises in almost all considerations of reforming health markets is the possibility of adverse selection. Adverse selection occurs when some markets or some insurers enroll a disproportionate share of high-risk enrollees, with the result that the higher costs of the medical claims incurred by the people in that risk pool put that market or that insurer at a competitive disadvantage. If such adverse selection is not remedied or offset, the result can be failure for the entity that is the victim of adverse selection.

An adverse distribution of risks can have devastating consequences because in any given period, a high proportion of medical costs are incurred by a small proportion of the insured population. For example, over the course of a year, half the population incurs essentially *no* medical care costs (that is, only 3 percent of total health care expenditures), while the other half incurs 97 percent of total expenditures. And only about 5 percent of the population accounts for essentially half of total health expenditures (see chart on top of next page<sup>7</sup>). Of course, neither insurers nor enrollees can accurately predict all persons who will be most or least expensive. But if one insuring entity enrolls more than its share of these high-risk individuals, the entity's costs can be dramatically higher than the rest of the market.

Although adverse selection is commonly viewed as a potential problem when considering the distribution of risk among health plans, it can also be a problem within and across

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<sup>7</sup> Although the data in this chart is relatively old, newer data from the same source confirm that the percentages in 2007-2008 remained the same ( $\pm 1$  percent) as in 2002.



markets. In this context, the concern is about the extent to which adverse selection, resulting from individual decisions to buy or not to buy individual coverage, will increase average premium levels in the individual market. (It should be noted, however, that federal premiums tax credits will shield eligible individuals under 400 percent of the poverty level from the impact of higher average premium levels. Tax-credit recipients are expected to constitute a majority of individual market enrollment.) If the individual and small-group markets were merged, the effects of such adverse selection would also raise average premiums, though to a lesser extent, for small employer groups.

The ACA recognizes the dangers of adverse selection and includes a number of provisions to mitigate the dangers, including reinsurance for the reformed individual market, “risk corridors,” and risk adjustment, but they may not be sufficient to compensate for all of the resulting cost differences.

## The Options Regarding the Decision to Merge Markets and the Advantages and Disadvantages of Each

There are basically three options available to states with regard to merging the individual and small-group markets: (1) merge the markets on January 1, 2014, at the time the Exchange becomes operational; (2) leave the markets as they are; or (3) defer a decision until there is more experience with the effects of reform.

We consider these in turn, but it is important to preface this discussion by highlighting a key point related to the risk effect of one key group: the people who are currently uninsured because they were medically underwritten and denied coverage because of their perceived high medical risk—the so-called uninsurables. The ACA prohibits insurers from

denying coverage for health status, past or present illness, or, in fact, any personal characteristic, thereby guaranteeing that the individuals who have been denied coverage can now get it. And many of these individuals have modest incomes and will qualify for federal premium tax credits that will make the newly accessible coverage also affordable. They are likely to be among the first entrants to the new “guaranteed-issue” individual market. (Early entrants will include people currently enrolled in Maryland’s high-risk-pool programs, unless arrangements are made to phase them into the reformed individual market more gradually.) The medical claims incurred by these people are almost certain to be high initially and perhaps for a longer period as well. Whether the transitional reinsurance and risk-corridor programs that are included in ACA will be sufficient to compensate for this effect is uncertain. Under the reinsurance program, which is effective only from 2014 to 2016, payments will be made to (non-grandfathered plans) individual market plans (both inside and outside the Exchange) that enroll a disproportionate share of higher-risk enrollees. All health insurers—group, individual, and self-insured—will contribute to the fund from which payments are made.

Temporary risk corridors are also designed to protect individual or small-group insurers from an initial influx of high-risk individuals. In essence, if plan costs are higher than expected, the federal government will pay a portion of the excess (within a corridor) to the insurer, and if the costs are below an expected amount, the plan will pay the government.

We now turn to a discussion of the options related to possible merger of the two markets.

### **Option 1: Merge the Markets on January 1, 2014**

There are, of course, both advantages and disadvantages to a policy of merging the individual and small-group markets at the time the Exchange becomes operational in January of 2104.

#### **Uncertain Impact of Merging Markets on Premium Rates**

The implementation of health reform seems certain to raise premium rates in the individual market. In the current individual market, medical underwriting is permitted. That is, carriers can and do deny coverage to applicants based on their health status.<sup>8</sup> In the reformed individual market, “guaranteed issue” will be required. That is, carriers will not be permitted to refuse to cover applicants based on their health status.

With the implementation of guaranteed issue, people who previously had been denied coverage because of their high risk will be considerably more likely to buy coverage than people without identified health risks. Low-risk people in the individual market who are not eligible for tax credits would have to pay the full premium costs themselves; and a significant number can be expected to decline coverage and instead pay the (less expensive) tax penalty for not conforming to the mandate. As a result, average medical

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<sup>8</sup> People turned down by regular insurers can buy coverage through the Maryland Health Insurance Plan (MHIP), at greater cost.

costs in the individual market will be higher than they are now, probably considerably higher.

Another reason premiums will increase in the individual market as a result of health reform is the minimum actuarial-value requirements under the ACA. A not-inconsequential share of current enrollees in the individual market have coverage that does not meet those requirements. When health reform takes effect in January 2014, they will have to buy coverage that meets the new ACA requirements—unless they have been enrolled in their current plan continuously since the ACA was enacted in March 2010 and choose to remain in that “grandfathered” plan.

While health reform is certain to raise premiums in the individual market, what we need to know for purposes of this policy issue is different. We want to understand how average medical costs of enrollees in the *post-reform* individual market will compare to average medical costs of enrollees in the small-employer market (which we expect will not change significantly).

If the two markets remain separate pools, insurance premiums will reflect that underlying difference in average medical costs.<sup>9, 10</sup> If the two markets were merged, on the other hand, both individual purchasers and small-group purchasers would be part of the same pool, and average medical costs in that combined pool would be lower than in one of the separate pools and higher than in the other pool.

What is uncertain is which of the post-reform pools will have higher average medical costs. The problem is that no one can predict with any degree of confidence the risk distribution of actual purchasers in the post-reform individual market. If the individual mandate is very effective so that many now-uninsured low-risk people buy individual coverage, then there is little reason to expect that average medical costs in the reformed individual market will be higher than in the small-group market (which should not be significantly affected by reform).

On the other hand, if many low-risk people decide that paying the penalty for not conforming to the mandate is a better deal for them than buying individual insurance, then average medical costs in the reformed individual market would likely be higher than in the small-group market. (In the group market, the employer’s contribution reduces the worker-paid cost of insurance for all workers in the group, regardless of their income. Thus it could be argued that the ratio of high-risk/high-cost people to low-risk/low-cost people can

Currently, premium rates in Maryland’s individual market are lower than in the small-group market. This is due primarily to the fact that carriers must guarantee issue in the small-group market, while they can “medically underwrite” and deny coverage to high-risk people in the individual market. Also, the level of patient cost-sharing (deductibles and co-insurance) typical in the individual market may be greater than in the small-group market.

<sup>9</sup> In addition to other factors such as different administrative costs, different choices about coverage levels, etc.

<sup>10</sup> The more effective the individual mandate is, the less difference there should be in average medical costs between the (reformed) individual and small-group markets.

be expected to be greater among higher-income people who purchase as individuals than among higher-income workers who purchase as members of a small-employer group.)

If the two markets were merged, whichever market has the lower average medical costs would pay higher average premiums as a result of the merger. Conversely, the market that has higher average medical costs would benefit from the merger.

Note that, if merging the markets were to result in lower premiums for individuals, those lower prices for individuals would be of benefit primarily to higher-income people. People buying as individuals with incomes at or below 400 percent of the poverty level are protected by tax credits from higher market-wide prices.

### Advantages

An advantage of merging the markets is that there would be greater continuity of coverage and provider relationships as people move between employer-based and individual coverage. In a non-merged market, the same health plans may not be available in both markets, so when people have to change from group to individual coverage or vice versa, they will often have to choose a new health plan and may have to terminate a relationship with one or more of their providers. In a merged market, all health plans are available to everyone.

### Disadvantages

If small-group premiums did rise as a result of merging the markets—or even if small employers expected them to do so—some small employers might either switch to self-insured coverage or drop coverage entirely. The result would be higher net insurance costs for their workers because they would lose the tax benefits of having employer-sponsored coverage. Also, since employers with low-risk workforces would be most likely to exit the fully insured market, average medical costs and, therefore, premiums, would likely increase further in the fully insured market.

Merging markets initially would add another potentially destabilizing effect at the very time when many other major changes with somewhat uncertain consequences will be occurring. It might be prudent, therefore, to wait until the effects of the other changes have reached some degree of stability before adding another major change to the system.

Merging markets would require some carriers to offer coverage in a market they do not now serve. Many small-group carriers, for example, do not offer individual coverage. Entering a new market, whether the small-group or individual market—would require new administrative procedures, marketing approaches, billing systems, and other kinds of realignment, which could be costly and difficult to implement, especially at a time when carriers are being required to change so many other aspects of their business. Affected carriers might decide to leave the market entirely.

Finally, as noted earlier, both the individual and small-group markets appear to be sufficiently large that merging them is not necessary to attain the critical mass necessary for stability.

## Other Uncertain Impact

There is concern that some carriers may be reluctant to participate in a SHOP Exchange that offers workers choice among competing carriers (as discussed in a later chapter), since carriers generally are unenthusiastic about individual choice because of concerns about adverse selection and “churning” as workers switch health plans from year to year. Therefore, some carriers serving the small-group market could elect to offer coverage only outside the SHOP and not through the SHOP.

The individual Exchange, on the other hand, will offer carriers serving the individual market the opportunity to reach a large new population of tax-credit recipients, who *must* buy coverage through the Exchange. Therefore, it is expected that many carriers currently serving the individual market will want to participate in the individual Exchange.

If the individual and small-group markets were merged, carriers wanting to offer coverage through the individual Exchange would also have to offer coverage through the SHOP Exchange. Thus, it could be argued that more carriers would offer coverage through the SHOP Exchange if the markets were merged than if they were not.

However, members of the SHOP Advisory Committee with experience in the small-group market felt that merging the markets was more likely to cause some carriers to withdraw entirely, because of the difficulties (noted above) associated with serving a market (the individual market) that they are not now set up to serve. So the end result could be fewer carriers participating in the SHOP Exchange, rather than more.

If carriers did withdraw from Maryland’s small-group market (only eight serve it now<sup>11</sup>), continuity of existing employer group plan arrangements would be compromised.

### **Option 2: Take No Action With Regard to Merging the Markets—Retain the Status Quo**

This option is straightforward: The individual and small-group markets would not be merged, and no study would be planned regarding the desirability and feasibility of doing so at a later date. That is, no firm date for re-visiting this decision would be established.

The advantages and disadvantages of this approach are, for the most part, just the opposite of those detailed above regarding a merged market, so we provide only a brief explanation of each.

#### Advantages

If markets are not merged, premiums for small employers buying coverage at the time reform begins would be more predictable and probably more stable because the size and composition of the market would be changed to a smaller degree; it would be affected only by the change in the number of small employers buying coverage and not by the inclusion of people buying as individuals. Rates would also probably be lower because the risk pool

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<sup>11</sup> Maryland Health Care Commission, *op.cit.*

would not include the high-risk individuals who had previously been denied coverage because of their high-risk health status and who will now be guaranteed access to coverage.

The small-group market would also be more stable than if markets were merged—at a time when other major unsettling market changes will be occurring as reform is implemented. A merger would add another element of unpredictability and complication.

### Disadvantages

If the two markets remain separate, premium costs for people buying as individuals are likely to be higher than they would be if markets were merged (except for individuals eligible for tax credits). Because of the guaranteed issue requirement under ACA, individuals who were previously denied coverage because of poor health status will be able to buy coverage, and probably most will do so because they know they will likely need costly medical services. Their inclusion in the risk pool will raise average claims costs. This could be somewhat or fully offset by the influx of the many low-risk young people who do not now buy coverage, but some of them may choose to pay the tax penalty rather than conform to the mandate to acquire coverage. Assuming the net result is an increase in average claims costs as a result of the influx of newly insured individuals, the amount of the resulting premium increase would be less if these higher costs were spread over everyone buying coverage in a merged market rather than over just those buying as individuals. It is important to note, however, that individuals who are eligible for tax credits (those with income at or below 400 percent of the poverty level and who buy through the Exchange) would be protected against higher costs because their net costs for coverage are limited to a specified percentage of income.

A second disadvantage of retaining separate markets for groups and individuals is that continuity of coverage and provider relationships would be adversely affected. People who move back and forth from buying as individuals and as employees of small groups would often find that the health plan or the particular benefit structure they currently have would not be available in the new market. When that happens, people who have PPO, HMO, or other provider network coverage will often have to change providers as well as plans, because the same providers will not be in the network of the new coverage arrangement. In a merged market this would happen less often because, at least in the Exchange, the same plans would be available to all.

Finally, if markets remain separate and no action is undertaken to plan a formal actuarial study for the purpose of considering a merger at a later time, key data from the early years of reform operation might not be retrievable, which would make any subsequent study more difficult and perhaps less reliable.

### **Option 3: Defer a Decision to Merge the Individual and Small-Group Markets**

If this option were chosen, the individual and small-group markets would not be merged on January 1, 2014, but the issue would be reconsidered at a later time, and an actuarial study

would be conducted based on experience in the two separate markets during at least 2016 (but not during the start-up year of 2014, and perhaps not during 2015 as well). Based on that study, the issue of whether or not to merge the two markets could be revisited with better information.

The advantages and disadvantage of this approach would be the same as those outlined above for retaining separate markets, with two exceptions. On the positive side, planning a formal actuarial study could help ensure that key needed data is captured during the early years of reform operation. On the negative side, some might consider it a disadvantage that uncertainty would remain regarding the possibility of a merger of the two markets. Such uncertainty might have an effect on carriers' decisions about which markets to enter and when and what products to offer, as well as some employers' decisions about whether and how to offer coverage. It could be argued that it would be better to make all the changes at once so that stakeholders would not need to try to guess what the future is going to look like and then face the challenge of again having to adapt to another significant market change.

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## SMALL-EMPLOYER MARKET DEFINITION

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This chapter addresses the question: Should the state expand the definition of the small-group market to include employers with 51 to 100 employees effective January 1, 2014, or wait to do so until 2016?<sup>12</sup>

The ACA specifies that effective January 1, 2016, the small-group market will be composed of employers with from 1 to 100 employees. Currently in Maryland, the small-group market is defined as the market serving employers with up to 50 employees. The policy decision the state must make is whether to expand the definition of the small-group market immediately (effective January 1, 2014) at the time the other major reforms become operational or to do so two years later when required by federal law.

Before laying out the advantages and disadvantages of making one choice or the other, we discuss a number of related issues to provide a background for making that decision.

### Market Size

In 2010, just under 45,000 small-employer groups (those with 50 or fewer employees) had coverage through insured small-group products.<sup>13</sup> These plans provided coverage for about 365,000 Maryland employees and dependents.

Only a minority of small employers—estimated at between 35 percent and 47 percent—offer coverage.<sup>14</sup> The proportion offering coverage increases with firm size. Even when the employer offers coverage, however, not all workers are eligible, and some of those who are eligible decline to enroll. Overall, only about 37 percent of Maryland small-business workers are enrolled in coverage offered by their own employer.<sup>15</sup>

If the small-group market had been defined to include employers with 1 to 100 workers in 2010, the larger market would have covered between roughly 20 percent and 25 percent

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<sup>12</sup> The MHBE originally phrased this question as: “whether the SHOP Exchange should be made available to employers with 50 to 100 employees prior to 2016, as allowed by the ACA.” Under the ACA, however, the issue is the definition of the entire small-group market. The SHOP is available only to small employers (unless the state elects to expand it to large employers beginning in or after 2017). If (and only if) the small-group market definition is expanded to include employers with up to 100 employees, then the SHOP Exchange becomes available to the entire expanded market.

<sup>13</sup> Maryland Health Care Commission (MHCC), *op.cit.*

<sup>14</sup> MHCC estimates 35 percent of small businesses offer coverage. MEPS employer survey for Maryland estimates 47 percent.

<sup>15</sup> MEPS employer survey for Maryland, 2010.

more lives than the 1-to-50-worker market did—approximately between 438,000 and 456,000 people in total.<sup>16</sup> Maryland firms with 51 to 100 employees offer coverage more frequently than smaller firms—89 percent versus 47 percent according to the MEPS survey. But even so, only 44 percent of workers employed in these larger firms are actually enrolled in coverage offered through their own employer. (Of course, some substantial number are covered through a spouse or other source.)

### Implications of Market Size for the Expansion Question

As noted above under the “Merge Markets?” question, one compelling argument in favor of expanding the small-group market would be if, at its current size, it was not large enough to have the “critical mass” necessary to spread risk broadly and maintain stability over time. However, it appears that the small-group market as currently defined is sufficiently large on its own to meet this test.

## **Regulatory Differences**

Small groups as currently defined (up to 50 employees per firm) are regulated differently from larger groups, and these regulations will, of course, apply to firms with 51 to 100 employees when they are included within the small-group designation in either 2014 or 2016, depending on the date the state chooses.

Current small groups have access to guaranteed-issue coverage; that is, they cannot be denied coverage because of health status or any other characteristics of members of the group. Larger groups can be medically underwritten: carriers can decline to cover the entire employer group if they deem the group to be too high risk.

Carriers currently serving the small-group market in Maryland must use adjusted community rating in setting premiums. This means that premiums cannot be based on actual or expected claims experience of a particular employer group (with exceptions for new entrants to the market<sup>17</sup>). Premiums can vary based on the age of a firm’s employees and its geographic location, but the total variation for the two factors in combination cannot exceed plus or minus 50 percent. These rating rules are consistent with but slightly more restrictive than the ACA requirements that go into effect in 2014. The ACA allows premiums to vary by plus or minus 50 percent for age and also allows variation by geographic location and up to a 50 percent additional charge for tobacco use. It appears Maryland will not have to change its small-group rating rules to comply with the ACA.<sup>18</sup> But, even if Maryland chooses to do so, the effect of both the current rating and the future rating rules that apply to small firms in Maryland is that small groups with the same average age in the same geographic area, buying the same insured product from the same carrier, pay the same premium.

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<sup>16</sup> IHPS estimate based on the MEPS employer survey for Maryland, 2010.

<sup>17</sup> Effective July 1, 2010, Maryland law now allows carriers to adjust rates for health status for new groups entering the small-group market during each group’s first three years of participation. The allowable rate variation declines from  $\pm 10$  percent in year 1 to  $\pm 5$  percent in year 2 and  $\pm 2$  percent in year 3.

<sup>18</sup> A change will be needed to eliminate the time-limited health rating for new market entrants referenced in the previous note.

The rating rules that currently apply to Maryland firms with 51 or more employees are quite different from those for smaller firms. Insurers can “experience rate” such firms, setting premiums to reflect the actual or expected claims experience of each particular employer group. The consequence is that high-risk groups, with less healthy workers and dependents, pay substantially more than low-risk groups with healthier enrollees.

## **Self-Insurance**

Small employers have the option to self-insure their workers’ health expenses, taking on the risk themselves, rather than buying insurance protection from a carrier and thereby transferring the risk to the carrier. This possibility has important implications for the success or failure of a variety of market reforms. The issue is thus worth some attention.

### ***What is Self-Insurance***

“Buying insurance” means that the employer pays a set premium for a set period, and the insurer agrees to pay all covered medical expenses incurred by all covered workers during that period. By doing so, the employer has transferred the total risk for covered services to the insurer: even if total expenses exceed the total premium paid, the insurer, not the employer, has to bear the total cost. Conversely, if total expenses for the coverage period are less than the total premium paid, the insurer, not the employer, pockets the difference. What happens to an employer’s premiums for the following coverage period, however, depends on whether the employer group is “community rated” (as with current small employers in Maryland) or “experience-rated” (as with employers with more than 50 employees). For community rated groups, a particular group’s new rate will depend on the claims costs of all insured groups in the aggregate, not those of the particular group. For an experience-rated employer, in contrast, the new rate will reflect actual or expected claims for that particular employer’s enrollees, based in whole or part on the past experience of that group.

Employers who want to provide health coverage for their workers do not have to “buy” insurance from a carrier. They can instead “self insure.” They can decide what medical expenses they are willing to cover and then directly pay the expenses for those services for their enrolled workers. (Usually a self-insured employer hires an insurer or a third-party administrator to pay its claims, but that administrator is not at risk for the claims.)

Only the largest companies are in a position to take on the entire risk of health coverage for their workers, because their large enrollment permits them to “spread the risk” so that the amount of the total claims cost is quite predictable. For small employers, the risk/cost is not predictable; for example, the cost of one premature baby could be catastrophic. Small employers thus cannot safely self insure.

But employers’ options are not limited to either passing all the risk on by being fully insured or taking on all the risk themselves by being completely self-insured. Insurers often offer employers “reinsurance” or “stop-loss insurance” that transfers some (but not all) of the risk to an insurer and thereby reduces the employer’s risk and makes “self-insurance” feasible even for relatively small employers. In essence, the employer pays for

costs up to the amount predicted but also for some portion of the costs beyond that point; then the insurer assumes some or all of the excess.

There are different forms of reinsurance. Some types pay claims that exceed a specified dollar amount for any particular covered employee or dependent. Others cap the employer's liability, in total, at some percentage (greater than 100 percent) of expected total expenditures for the employer's group.

### ***Why Is Self-Insurance Attractive to Some Employers?***

Self insurance can be especially attractive to relatively low-risk firms because it may be cheaper for them to cover risks internally by self-insuring rather than buying coverage if their insurance premiums would be based on a risk pool composed of firms with higher average risk. In Maryland now, employer groups with 50 or fewer employees are community rated. After reform is implemented, adjusted community rating will apply at some point (no later than 2016) to firms with up to 100 employees. This situation creates incentives for firms with relatively healthy work forces to self-insure.

In a (modified) community-rated pool, every employer group, regardless of its workforce's health risk profile, pays a premium rate that varies only by differences in age, geographic location, and whether or not dependents are covered—but *not by differences in health status, which is the most important determinant of claims costs*. So, if a particular employer's workers (and their covered dependents) are relatively healthy, that employer will pay an insurance premium that is more (perhaps considerably more) than the actual cost of their workers' medical expenses. For this kind of employer, self-insurance (with appropriate stop-loss protection) becomes very attractive because the cost is likely to be substantially lower than for insured coverage.

In markets where experience rating is permitted, as in Maryland for firms with more than 50 employees, the incentives for self insurance would seem to be less because firms can be experience rated so that each group's premiums reflect the health status of just that group's enrollees. But Advisory Committee members report that interest in self-insured arrangements is growing among groups with 51 to 100 employees. One broker reported that one (unspecified) carrier now provides *only* self-insured quotes in that market.

Self insurance is also attractive to some firms for other cost-related reasons. Self-insurance can be attractive to avoid state premium taxes and "risk premiums" and other expenses charged by carriers for insured plans. It also provides a way to avoid state benefit mandates and to simplify administration of multi-state employer plans by not having to meet a host of different state requirements regarding benefits and other matters.

Under ERISA, states cannot prescribe what medical expenses an *employer* does or does not cover. But states can prescribe what services *insurers* must cover. So an employer that buys insurance is in effect subject to the state's benefit mandates indirectly. But a self-insured employer is not, because self-insurance is deemed not to be insurance for purposes of regulation. (Self-insured and larger employer plans also will *not* be required to cover federal essential health benefits under the ACA.)

### **Why Self-Insurance Is a Problem for the Small-Group Market?**

The bulk of small-group market reforms, both those already in place in Maryland and those that are required by ACA, are designed to spread risk by increasing the size of the risk pool to ensure that it includes a cross section of higher- and lower-risk enrollees, thereby ensuring both that higher-risk groups do not pay excessively high premiums and that the risk pool will be stable over time. Self-insurance threatens the attainment of these goals.

Under ACA health reforms, insurers must treat all their (insured) small-group business (both inside and outside the SHOP Exchange) as one “pool.” Within that pool, premium rates can vary only by the age of the covered person (with a maximum variation of 3:1 from highest to lowest—the equivalent of  $\pm 50$  percent) and by geographic location, tobacco use, and whether or not dependents are covered. Risk corridors and risk adjustment, which also applies across the entire insured small-group market, help to ensure that risks are pooled across that entire market. *But* if the lowest-cost (small) employer groups choose self-insurance, then they are *not* part of the insured small-group market. With the lowest cost groups out of the insured pool, the average premium for the groups remaining in the pool will be higher, which could lead to a downward spiral of ever-higher rates and the exodus of more and more relatively low-risk employers.

States can limit self-insurance only indirectly, by regulating medical stop-loss insurance.<sup>19</sup> Like a number of other states, Maryland prohibits the sale of stop-loss insurance with a specific attachment point<sup>20</sup> of less than \$10,000 or an aggregate attachment point<sup>21</sup> of less than 115 percent of expected claims.<sup>22</sup> However, this kind of state regulation does not seem to have significantly inhibited the use of self-insurance.

Although state options in this area are limited, the federal government should be able to take administrative action to address issues involving the effects of self-insurance on the goals of health reform. It seems they would be more likely to do so by 2016 than by 2014.

We now turn to the options available to the state with regard to the definition of the small-group market.

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<sup>19</sup> The federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from directly regulating employer-provided employee benefits, but allows states to regulate the business of insurance.

<sup>20</sup> “Specific attachment point” means the dollar amount in losses attributable to a single individual in a policy year beyond which the medical stop-loss insurer assumes all or part of the liability for losses incurred by the insured.

<sup>21</sup> “Aggregate attachment point” means the percentage of expected claims in a policy year above which the medical stop-loss insurer assumes all or part of the liability for losses incurred by the insured.

<sup>22</sup> Maryland Statutes, Article – Insurance, §15-129.

**Option 1: Expand the small-group market to include employers with 51 to 100 employees effective January 1, 2014, rather than wait until 2016**

***Advantages***

The ACA requires that, by January 1, 2016, the small-group market must include all employers with a workforce of 100 or fewer employees. The only question facing the state is whether to redefine the small-group market beginning two years earlier, when other reforms are implemented.

The principal reason to expand the small-group market to include firms with up to 100 employees is to increase the size of the risk pool—to ensure that risks are widely spread so that premiums do not vary excessively and to ensure that the risk pool is stable over time. As noted above, however, the current small-group markets is sufficiently large that expanding it is not necessary to attain the critical mass necessary for stability.

A closely related reason is to guarantee access to affordable coverage for higher-risk firms with 51 to 100 employees, firms that must now pay premiums reflecting their higher-risk enrollees. If they were pooled with all other firms in the now expanded small-group market, their premiums would be lower and they could not be denied coverage. Access to coverage does not seem to be a problem for these employers in the current Maryland market, however, so guaranteeing access does not seem to be a reason to rush to redefine the market.

Another possible advantage to expanding the market is that such an expansion would increase both the overall size of the small-group market and the average size of the groups in that market, thereby possibly bringing down average administrative costs for the entire market through economies of scale. The costs of underwriting would be eliminated for employers in the 51 to 100 worker category. Insurers and the SHOP Exchange would be spreading fixed costs over a larger base, and per-enrollee administrative costs are somewhat lower when employers are larger. Members of the Advisory Committee, however, did not think such administrative savings would be significant.

If employers with 51 to 100 employees chose to go to the SHOP Exchange for coverage, they could offer individual workers the option of choosing from any of the health plans the SHOP offers rather than channeling them into a single employer-chosen plan. Workers could be expected to look favorably on having such a range of choices, especially since they would be less likely to have to change health plans when moving from job to job, with the attendant likely loss of continuity of coverage and provider relationships.

It can also be argued that it would be advantageous to redefine the small-group market to include larger employers immediately when most of the major changes take place in 2014 and “get it all over with.” The alternative is to have another possibly disruptive change occur in 2016, with uncertain results, just as stability is being achieved after the other reforms have been in place for two years. The change has to be made in any case, and any ill effects are likely to be no easier to cope with in 2016 than in 2014.

### ***Disadvantages***

Expanding the market definition to include larger employers could possibly raise premiums for the insured small-group market. There is no reason to believe that the average risk profile of these larger firms is any worse than that of the smaller firms. So if they all stayed in the insured market, there should be no adverse selection or significant change in rates. But the larger firms are in a better position to self-insure, combined with good stop-loss coverage or reinsurance. The firms with particularly low-risk workers would have the strongest incentives to do so, and their exodus from the insured pool would raise rates for everyone left in the pool. The process could escalate as more and more lower-risk firms switch to self-insurance because of rising rates—the dreaded downward spiral of adverse selection. But, of course, if this bad result were to occur, it would occur in 2016 as well as in 2014. The appropriate response would appear to be to find a way to prevent inappropriate use of self insurance to thwart the intent of a broader spreading of risk.

It could be argued that it would be better to wait until 2016 to add larger employers because to do so earlier would add one additional level of uncertainty and complication at a time of potentially confusing and destabilizing major change. Since this segment of the market does not seem to be experiencing major problems right now, there seems to be no urgency about making the change.

To put the larger employers into the small-group market reduces their flexibility in choosing plan design, since the plan design in the small-group market is fairly tightly prescribed under the ACA. But, of course, any such flexibility will disappear in any case in 2016.

### **Option 2: Defer expanding the small-group market until the federally required date of January 1, 2016**

The advantages and disadvantages of this approach are that it would postpone any benefits or possible downside effects described above for two years.

### ***Advantages***

Deferring expansion of the small-group market postpones any potentially significant premium increases for currently insured employer groups that could be caused by low-risk employers with 51 to 100 employees choosing to self-insure. It also postpones any destabilizing effects that such a change might cause, which could be harder to manage along with all the other major changes occurring in 2014. Finally, it also allows additional time for the federal government to consider what administrative actions it could take to limit the possible impact of self-insurance on the insured small-group market.

### ***Disadvantages***

On the other hand, deferring expansion postpones any premium reduction that higher-risk larger employers might otherwise see. It also postpones the option for these employers to

offer their employees a choice of health plans through the Exchange, which would, if adopted, make it easier for employees to maintain relationships with health plans and providers when they switch jobs.

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## **WORKER-EMPLOYER CHOICE**

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This chapter addresses the question: What are the advantages and disadvantages of the various options the SHOP may choose from to offer workers a choice of qualified health plans (QHPs)? More specifically, what are the relative merits of the worker-choice model (allowing for a defined employer contribution) that proposed federal regulations require SHOPS to provide compared to other choice options the SHOP might also provide, including one that would allow employers to specify a single QHP for their workers.<sup>23</sup>

The MHBE wishes to understand the advantages and disadvantages of a worker-choice model, under which the employer could make a defined contribution, compared to the more traditional model, under which the small employer chooses the plan (or multiple plans from a single carrier) that it will offer to its workers.

The discussion in this chapter is intended to provide the MHBE with a full analysis of the advantages and disadvantages of the alternative approaches of interest, while recognizing the recently issued proposed federal regulations that clarify requirements for SHOP Exchanges.<sup>24</sup> Those proposed regulations interpret the ACA to say that a SHOP must offer employers at least the following option:

The employer chooses the level of coverage it wishes to support (that is, the bronze, silver, gold, or platinum level of cost-sharing) and the employer's workers may then choose the QHP offering coverage at that level in which they wish to enroll. (Note that choosing among QHPs at a specified level of coverage implies choosing among competing carriers [called "issuers" in the ACA].)

This proposed rule does not mean that *employers* must use this approach if they purchase coverage through a SHOP Exchange. It simply means that a SHOP must make this option available to employers. The proposed rule makes clear that a SHOP may choose additional ways to allow employers to offer coverage to their workers.

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<sup>23</sup> This question was originally posed by MHBE in the following form: "Whether the SHOP Exchange should be a defined contribution/employee choice model or whether employers should choose the qualified health plan to offer their employees." Subsequently, however, proposed federal regulations clarified requirements for SHOP Exchanges, as described in the text, and we were directed by MHBE staff to conduct our analysis following that regulatory interpretation of the ACA.

<sup>24</sup> *Federal Register*, Vol. 76, No. 136, Friday, July 15, 2011, pp. 41886 ff. The worker-employer choice requirements for the SHOP are at proposed 45 CFR 155.705(b)(2) and (3).

We also note that, if the employer selects the federally specified option, the proposed federal rules require that *all* QHPs within the coverage level selected by the employer are to be made available to its workers. In this regard, the proposed rules represent an interpretation of vaguer language in the ACA, which does not use the word “all” and says only that each worker “may choose to enroll in a qualified health plan that offers coverage at that level” (that is, the coverage level chosen by the employer). We will refer to this distinction later in this discussion.

## **Overview of Options**

There are a multitude of alternative plan-choice structures a SHOP could potentially offer to employers and their workers, and it will be difficult to predict in advance how the market will respond to the alternative(s) initially adopted or what variations or refinements might be needed in light of experience or desired by small employers and their workers. Therefore, flexibility will likely be important for success, and the MHBE Board may wish to have the flexibility to adapt, refine or change the plan-choice structures it offers through the SHOP as operational experience is gained.

For purposes of the present discussion, the following four alternative plan-choice structures were selected to illustrate the range of available options and to permit a thorough discussion of relative advantages and disadvantages. (Note that we are discussing here the options that the *SHOP* must provide and can choose to provide, not the options the *employer* must provide. The employer can choose any of the options the SHOP provides.)

(It is important to understand that, under the ACA, the term “qualified health plan” [QHP] is not synonymous with “issuer.” The term “QHP” means one specific health plan / product / benefit design from one issuer at one coverage level. Thus, an issuer [that is, a carrier or insurer] may offer a variety of QHPs, for example, one or more at each of the bronze, silver, gold, and platinum coverage levels.)

1. Employer chooses *one issuer*; worker enrolls in a QHP offered by that issuer.
2. Employer chooses one coverage level; worker chooses (any) QHP at that level. (Proposed federal regulations require SHOPS, but not employers, to provide this option.)
3. Employer chooses two coverage levels; worker chooses among QHPs at those levels, but with some restrictions.
4. Worker can choose any QHP at any level.

We discuss the four illustrative options in the order shown, which represents increasing degree of choice available to individual workers. The reader will want to keep in mind, however, that proposed federal regulations would require the SHOP to offer employers at least the second option, which has already been outlined above.

First, however, we discuss two topics that will be important to understand for purposes of the broader discussion of choice alternatives.

### ***A Preliminary Note About Cost Containment and Choice***

Reducing the cost of health care is a critical goal. The ACA addresses cost containment using the concept that, if health plans have to compete for individual enrollment, they will strive to find ways to keep their premiums as low as possible. In the individual Exchange, this concept is implemented by basing individual premium tax-credits on the cost of the second-lowest-cost plan available at the silver coverage level. A tax-credit recipient who chooses a more expensive silver plan, or a plan at a higher coverage level, must pay the entire premium difference out of their own pocket. (Conversely, if they choose a lower-cost plan, they would realize the savings.) Similarly, in the SHOP Exchange, the ACA contemplates a structure under which workers choose among several available health plans and permits their employers to make a defined contribution so that, again, a worker choosing a more expensive plan would pay the entire premium difference out of pocket. And a worker choosing a less expensive plan would receive the savings.

By making buyers price conscious, the ACA aims to create a strong incentive for carriers to compete on the basis of value, to improve quality and service levels, and to be more efficient.

In the current marketplace, small employers *are* price-conscious purchasers, and carriers *do* compete for employers' business on the basis of price and value. But employers also want to keep their workers happy and, in health care, that means making sure that the coverage network includes the physicians and other providers their workers want to use. When an employer must deal with a single carrier, as is the case in the current small-group market, that in turn means that carriers offering broad provider networks have a substantial competitive advantage over integrated-delivery-system-based plans or carriers offering narrower, more selective provider networks.

Unfortunately, competition among carriers offering broad provider networks has not resulted in slowing the growth of health care costs and health insurance premiums. The perverse incentives of third-party, fee-for-service reimbursement are well known. An alternative path is needed. One possible alternative path is to encourage the creation of narrower networks of providers that compete to provide the best care to patients, not simply the most care, and are rewarded financially when they provide good care efficiently and keep people well. Such narrower networks could be provider-organized integrated delivery systems and similar arrangements. Or they could be carrier-selected networks of efficient providers that are paid under alternative methods that incorporate incentives for good quality, efficient care. But neither of these potentially promising alternatives can develop when employers have to choose a single carrier that is acceptable to all their workers. They can only grow and develop when individual workers have the opportunity to choose among competing provider networks and themselves benefit financially when they choose a more efficient provider network.

In the following discussion of choice options, the potential cost-containment benefit of allowing individual workers to choose among health plans is often cited as an advantage. The foregoing reasoning is the basis for those statements.

### ***A Preliminary Note about Worker Choice, Composite Rates and Age-Rating of Premiums***

Currently, small-employer plans in Maryland charge the same premium amounts for both young and old workers within a small-employer group. These are referred to as “composite rate” premiums and are required by law. In practice, the premiums a Maryland health insurer charges for a given small-employer group are based the average age of workers participating in coverage.

A benefit of composite rates is that, when an employer requires its workers to pay a portion of the premium for health insurance, all workers, regardless of age, pay the same amount for the same level of coverage.

In the SHOP, employers can elect to give individual workers choice among plans from competing carriers (assuming the final federal regulations follow the proposed regulations). In this situation, the age profile of the workers who choose and enroll in respective plans will differ. And the SHOP will need to assure that the total premium collected from the employer group equals the premiums owed to each health plan based on the respective (individual) ages of that health plan’s own enrollees. That is, the SHOP will need to pay its participating health plans premium rates that are individually age-rated.

If the worker’s share of the premium was a percentage of those individually age-rated premiums, however, the oldest workers would have to pay up to three times as much as the youngest workers. This would be inconsistent with prior Maryland policy decisions, as embodied in current law. Therefore, the SHOP will need legal authority to use a different approach.

Another important consideration for the SHOP in a worker-choice environment is how to assure that a participating employer can set and know its premium contribution in advance. This is straightforward when all of an employer’s workers are covered by the same plan. But it requires more careful design when the workers can choose plans offered by competing carriers.

A final consideration for the SHOP is making sure that employers offering worker choice among health plans can qualify for the federal small-employer premium tax credits.

A detailed technical explanation would be out of place at this point in the discussion, but it is important to note here that there are ways to solve this apparent conundrum and meet the following three important criteria:

- Older workers do not have to contribute much more than younger workers;
- The employer can set and know its premium contribution in advance; and
- Employers can readily establish contribution policies that qualify for the federal small-employer premium tax credits.

In Appendix A, we offer a brief explanation of one possible approach that is consistent with guidance the Internal Revenue Service has issued laying out employer contribution structures that qualify for the federal small-business health insurance credit when the

employer offers its workers choice among different health plans.<sup>25</sup> If that IRS guidance is subsequently updated, the approach outlined in Appendix A might need to be revised. Therefore, Maryland may wish not to lock in any specific approach, but rather maintain flexibility to adopt approaches that are consistent with IRS small-business tax-credit guidelines.

Also, operating a worker-choice program essentially requires that employer group composite rates be calculated by adding up the individual age rates for participating workers and dividing by the number of workers, rather than by simply basing the composite rate on the average age of participating workers. If the SHOP used the new “add-up” approach while the outside small-group market used the average-age approach, the SHOP could be at a disadvantage in the marketplace. Maryland might wish to consider whether it would be appropriate to adopt rating rules that apply the “add-up” composite-rating approach for the entire small-group market.

### **Option 1: Employer chooses *one issuer*; worker enrolls in a QHP offered by that issuer**

This option offers small employers essentially the same choices they face in the current small-group market. The employer can choose to offer its workers just one qualified health plan (QHP), or the employer can choose to offer its workers a choice among two or more QHPs offered by a single issuer (carrier), at two or more employer-specified coverage levels. Maryland could decide to offer either one, or both, of these sub-options.

#### **Advantages**

Carriers serving the small-group market greatly prefer to enroll entire employer groups. They worry about risk fragmentation and fear experiencing adverse selection if workers in an employer group can choose between competing carriers. To compensate for this perceived increased risk, they will increase the “risk factor” or “risk charge” included in their premium when participating in a worker-choice environment. (The required risk adjustment should provide some protection against such risk, but carriers will have to believe that it will in fact do so before agreeing to reduce their risk charges.)

Because this option does *not* permit workers to choose among competing carriers, it presents carriers with the lowest risk of adverse selection (among the options discussed here) and therefore is least likely to raise premiums due to higher carrier risk charges. For the same reasons, it is also the option least likely to discourage current small-group-market carriers from participating in the SHOP.

Note, however, that if the final federal rules require the SHOP to offer any employer option that involves worker choice between competing carriers—as the proposed rules do—then carriers will presumably have to agree to have their QHPs offered under the worker-choice option in order to participate in the SHOP at all. And it seems likely that

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<sup>25</sup> Internal Revenue Bulletin: 2010-51, December 20, 2010, Notice 2010-82, *Tax Credit for Employee Health Insurance Expenses of Small Employers*. <[http://www.irs.gov/irb/2010-51\\_IRB/ar09.html](http://www.irs.gov/irb/2010-51_IRB/ar09.html)>

each QHP would have to be offered at the same premium rates, regardless of whether the employer or the worker is choosing. In this environment, it is unclear to what extent offering this Option 1 to employers in addition to a worker-choice option would encourage carriers to participate in the SHOP.

Because it is the option most similar to the existing small-employer market, this approach also presents the least need for new administrative systems, both for the SHOP and for employers. Employers could maintain their contribution policies as at present, and would not have to change their payroll-deduction processes for the worker's share of the premium.

This option also presents the least difficult choices for workers, because they do not have to choose between carriers and need (at most) to decide what level of coverage they wish to enroll in. This limitation on choice could, of course, be considered a disadvantage for workers.

### ***Disadvantages***

Simply because it is most similar to the current market, this option represents the least “value added” by the SHOP Exchange. It would offer little reason for any currently offering small employer to switch from their current arrangement to the SHOP Exchange, unless by doing so the employer could retain its federal small-business health insurance tax credit for another two years. (Beginning in 2014, that credit is available *only* for coverage purchased through a SHOP Exchange, but only for two tax years for any one employer.) But the maximum 50-percent credit is reserved for the smallest, lowest wage employers—those with 10 or fewer full-time-equivalent workers and average annual FTE wages of \$25,000 or less<sup>26</sup>—and anecdotal reports suggest that few currently offering Maryland small employers qualify.<sup>27</sup>

It was hoped that the small-business credit would encourage more low-wage small employers to begin offering coverage for the first time, but the reality of individual tax credits for low-income workers and the experience of Maryland's Health Insurance Partnership—a very similar program—suggest otherwise. In any event, once their eligibility for the federal small-business tax credit ends, employers using this option may be persuaded to drop out of the SHOP and purchase directly from their chosen carrier.

Another disadvantage of this option is that it does not permit each worker to choose the carrier that best fits the worker's particular situation and needs. This disadvantage would be most salient when the competing carriers offer different delivery systems or provider networks that do not overlap significantly. Similarly, this option does create a context in which the worker has an incentive to make a cost-conscious choice among carriers/provider networks/delivery systems, and it therefore undercuts the primary private-market

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<sup>26</sup> The credit is available for employers with less than 25 FTE workers and less than \$50,000 average annual FTE wages, but the credit percentage phases down as the number of workers and average annual wages increase.

<sup>27</sup> Low participation in the small-business tax credit was reported by the brokers and TPAs represented on the SHOP Advisory Committee.

cost-containment mechanism under the ACA. (This topic will be discussed further under the next option.)

Because this option does not afford workers a choice between carriers, it is most likely to require workers to change carriers, and potentially break established provider relationships, when they leave one job and move to another employer that also offers coverage.

The SHOP Exchange potentially could establish a structure under which workers with two (part-time) jobs could have each employer make a partial contribution toward coverage under a plan chosen by the worker from among the SHOP's offerings. But Option 1 would not allow for such a structure.

Offering this option alongside the federally required worker-choice option would require the SHOP Exchange to maintain both worker-choice and non-worker-choice administrative systems—although it is not clear to what extent additional resources would be required to do so.

### **Option 2: Employer chooses *one coverage level*, worker chooses a QHP at that level (federally required option)**

As discussed at the beginning of this chapter, proposed federal regulations require that the SHOP provide at least the following option for employers:

- The employer can pick a level of coverage (bronze, silver, etc.) it is willing to support.
- Each worker then gets to choose from among (all) the QHPs offered at that coverage level.

Under the proposed federal regulations, the SHOP could decide to offer only this option to employers, or it could be one of multiple options.

This approach requires the SHOP to have robust consumer information and decision support systems to help workers choose among QHPs, so that the employer does not have to play this role and so that agents can more readily service small groups in an individual-choice environment.

### **Advantages**

Several advantages of this approach are a consequence of the fact the workers have a choice among QHPs.

Most people would probably agree that giving workers a choice of QHPs (even without a choice of benefit levels) provides a significant benefit. People value choice—being able to select from a variety of carriers based on customers' perceptions of reputation, quality, service, value, and, perhaps most importantly, availability of particular providers and type of delivery system. Giving workers such choice frees the employer from the burden of having to impose a specific choice of one carrier on all workers, when they are likely to have different preferences and would make other choices if they had the option to do so.

Under this approach, the employer can make a defined contribution toward its workers' health insurance. A worker can choose a more expensive QHP than the one on which the employer's contribution is based,<sup>28</sup> but, if so, the worker, not the employer, bears the additional cost.

This approach encourages cost containment. Assuming the employer chooses to make a defined fixed contribution (or even, though to a lesser extent, if the employer pays a percentage of the premium cost for any plan), workers have a financial incentive to choose the most cost-effective carrier (at the selected coverage level). If they choose a carrier whose QHP's premium is greater than the one on which the employer's contribution is based, they have to pay the additional premium cost out of pocket. (Conversely, if the worker chose a lower-cost QHP, they would realize the savings.) Since buyers will be price conscious, the result should be to create a strong incentive for carriers to compete on the basis of value, to improve quality and service levels, and to be more efficient.

Because workers have a choice of carriers, if they move to a job with another small employer that offers the same or a similar option, they are more likely to be able to retain their relationship with the insurer and the providers in the insurer's network. Continuity of care and of provider relationships are highly valued by consumers and can have a positive effect on outcomes.

Compared to an approach that allows workers to choose both a carrier and the benefit level (Options 3 and 4), this approach poses less danger of adverse selection. When people have a choice of benefit levels (essentially the level of consumer cost sharing in this instance), the concern is that higher-risk people—those anticipating they will need expensive medical care—will choose more comprehensive coverage, while lower-risk people choose coverage with higher deductibles and co-pays. The result would be adverse selection against the more comprehensive benefit levels. Since, under this approach, workers can choose from only one benefit level, the adverse selection potential is less than under Option 3 or 4, though it still exists (as discussed under "Disadvantages").

If it is necessary to mitigate the effects of risk selection among plans, the risk adjustment mechanism is generally easiest to implement when all the issuers are offering the same benefit level. Determining the proper money transfers among plans becomes more difficult when the benefit levels are varied.

### ***Disadvantages***

In a sense, it is not particularly useful to detail some of the disadvantages of this approach as if there were a choice for the SHOP to choose another option *instead* of this one. Under the federal regulations, at least as currently proposed, there is no such choice: the SHOP is required to offer this option to employers. The SHOP will simply have to accept the disadvantages as a condition of doing business. On the other hand, if the potential

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<sup>28</sup> The SHOP may wish to establish some minimum employer contribution requirement as a condition of eligibility to purchase coverage through the SHOP—as is common in the traditional small-group market. Assuming so, that minimum contribution level would presumably be tied to one of the QHPs offered at the coverage level selected by the employer. This might be called the "employer reference plan."

disadvantages of this approach for *employers* could be avoided by having the SHOP offer other options as well, it is worth considering these disadvantages.

### Unavoidable Possible Disadvantages

Because this approach differs from that of the existing small-employer market, especially because it allows workers in one firm to choose from coverage offered by different carriers, it will require carriers to adopt new administrative structures.

Compared to approaches that do not allow workers to choose among carriers (Option 1), this approach could have the potential for greater adverse selection and higher premiums for the carriers that attract higher-risk enrollees. Carriers that offer broad, less tightly managed networks (for example, PPOs compared to closed-panel HMOs) could experience adverse selection because less healthy people are more likely to want broad freedom to choose from a wide selection of providers and to move to others if they become dissatisfied. And it is not certain how effective risk adjustment will be in offsetting such adverse selection effects.

### Disadvantages That May Not Be Present with Other Options

This approach gives workers a choice among a variety of carriers. Employers may find that workers seek advice from their employer about which plan to choose, which could place a burden on employers if they feel compelled to provide such advice and counsel rather than encourage workers to go the Exchange for such help.

Under this approach (or any other that allows workers a choice of health plans or benefit levels), the employer must deduct different amounts from each enrolled worker's paycheck. While this task is not substantively different from what employers already have to do when workers choose different coverage levels (from a single carrier) and do or do not cover dependents, the number of different possible payroll-deduction amounts would be considerably larger. To make this task as easy as possible for employers, the SHOP would provide the necessary information (see box).

Compared to options that offer workers even more choices of not only health plans but benefit levels, this approach can be seen as disadvantageous from the worker's perspective. For example,

#### ***SHOP Functions to Assist Employers:***

The SHOP would perform functions that would make worker-choice as easy as possible for small-employers. (Some are specifically required by proposed federal rules.)

- Handling enrollment functions using single standard enrollment form (single point of contact);
- Sending a single bill showing how much is due from the employer and listing each individual worker's plan choice and the associated premium amount;
  - » Ideally, the SHOP "list bill" should also show, if desired by the employer, how much is due from each worker and from the employer (given the employer's contribution policy), and
- Transmitting the proper payment to each of the QHPs/carriers.

a worker might wish to choose a lower level of coverage to avoid paying as much of the premium or, conversely, might prefer more comprehensive coverage than is offered at the benefit level chosen by the employer. Most people would agree that at least up to some point, having more choices is a benefit.

### ***A Possible Variation on the Federally Required Construct***

As discussed, a disadvantage of Option 2 is that the potential for adverse selection still exists. In particular, carriers that offer broad, less tightly managed networks (for example, PPOs compared to integrated-delivery-system-based HMOs or other tightly managed, closed network plans) could attract people with known health conditions, who are more likely to want broad freedom to choose from a wide selection of providers. As a result, broad-network plans might be reluctant to participate in the SHOP.

A modest modification of the (proposed) required federal construct could help to reduce adverse selection against and thus gain participation of broad-network plans. Under this alternative approach, workers would be allowed to choose among HMOs at one coverage level (chosen by employer) and PPOs from a lower coverage level. (By “HMO” in this context, we mean integrated delivery systems or other managed, closed network plans.)

This variation is potentially more attractive to carriers. The Exchange Board could elect to offer it in addition to the federally required option.

### **Option 3: Employer chooses *two* coverage levels, worker chooses among QHPs at those levels, but with some restrictions**

Under this approach, the employer would extend greater choice to workers by offering a choice of both benefit levels (selecting from the bronze, silver, gold, and platinum levels) and qualified health plans providing those benefits and thus also a choice of carriers. The employer would select two benefit levels (the number could be more), and then the workers would first choose a benefit level and then choose a QHP/carrier that provides that benefit level. The SHOP might place some limits on the choice—for example, not allowing the coverage levels offered to be the extremes of bronze and platinum. (Different limitations could be designed.)

### ***Advantages***

The workers who are offered this option would have greater flexibility (within some limitations) to choose a plan that best fits their needs and preferences. The greater the range of choices, the greater the potential for a good fit and greater consumer satisfaction—a benefit to workers, employers, and health plans.

Assuming the employer makes a defined contribution (or less optimally, pays a fixed percentage of the premium), this approach creates substantial incentives for workers to be price conscious when choosing a plan. Because they pay directly out-of-pocket for any excess beyond the employer contribution, workers have reason to carefully consider the cost-benefit tradeoffs when selecting a higher- or lower-benefit plan and a carrier and its

attendant provider network and delivery system. Workers can be expected to consider value in terms of quality, service levels, efficiency, etc., which creates strong incentives for health plans to compete to improve overall performance.

The approach allows employers to decide what amount they wish to contribute to health coverage for their workers (beyond some required minimum)—the defined contribution—and to have better control over their costs over time, because if premiums go up, at least their workers choosing more expensive plans will have the option to switch to more affordable plans. This could reduce the pressure on the employer to keep raising its contribution amount.<sup>29</sup>

The choices available to workers under this option are almost as extensive as those offered to people who purchase coverage through the Exchange as individuals. The greater the range of choice, the greater the likelihood that a person who switches jobs among employers or between employer-sponsored and individual coverage will be able to maintain a long-term relationship with a carrier, delivery system, and a selected set of health providers. Continuity is important for consumer satisfaction and quality of care.

By extending choice broadly, this approach moves quite far away from the highly restrictive system that now prevails in the small-group market, which means the Exchange adds considerable value compared to the status quo.

Because workers offered this option by their employers will presumably come to value being able to choose among carriers, and employers will value being able to make a defined contribution, this option improves the likelihood that the SHOP will be able to retain employers even after their eligibility for the federal small-business tax credit ends.

This option would impose only minimal additional administrative burden on the SHOP Exchange relative to the federally required option (because the basic operational architecture to support worker choice is essentially the same).

### ***Disadvantages***

While choice is generally deemed to be desirable, making good choices becomes more difficult when the range of choice becomes large. This approach involves weighing different carriers, delivery systems, cost-sharing benefit levels, and prices and then choosing the option that offers the best value for the worker and his or her dependents—which can be a daunting task. Workers make seek advice from employers, which, if they provide rather than sending the person to the Exchange for help, could be costly.

Because this approach differs markedly from the present small-group market, it would require carriers to adopt new administrative structures, but these are essentially the same as those required to adapt to the federally required option.

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<sup>29</sup> Assuming the employer's contribution level is based on one of the QHPs offered at one of the coverage levels selected by the employer (the "employer reference plan"), the employer could change its choice of "reference plan" if the cost of the plan originally selected grew faster than other plans. The employer could also reduce the percentage of premium it contributes toward the cost of the reference plan (subject, presumably, to some minimum contribution percentage).

Option 3 entails a risk of adverse selection against plans at the higher of the two coverage levels offered, particularly if they are broad-network plans. This risk is less than under Option 4 and probably worse than under Option 2. But judicious refinement of this option might reduce the risk of adverse selection under it. (See, for example, the discussion of a possible variation on the federally required construct, above.)

As with all approaches that offer worker choice, the employer must deduct a different amount from each worker's paycheck because the amount will depend on which option the worker chooses. Although the SHOP-provided information should make the task easy (as discussed under Option 2), members of the Advisory Committee expressed concern about employer resistance.

### ***A Possible Variation on Option 3***

To help overcome carrier fears about risk selection, the SHOP might be given sufficient latitude to pursue other variations. For example, it might offer "suites" of a limited number of competing QHPs at different coverage levels, rather than offering all QHPs available at the (two) coverage levels chosen by the employer. These suites would be made up of QHPs offered by carriers that have agreed to participate in this arrangement.

Such an approach might be a way to help carriers get experience with worker choice across carriers and benefit levels in a more controlled way. (And it is illustrative of the wide range of choice structures the SHOP could potentially develop.)

### **Option 4: Worker can choose *any* QHP at *any* level.**

Under this option, an employer would offer the worker the option to choose *any* QHPs offered by the SHOP at *any* coverage level. Presumably, an employer choosing this option would make a defined contribution, so that the worker would pay the full marginal cost of selecting a more expensive plan. The SHOP might wish to impose certain limits on switching among benefit levels to avoid selection problems as enrollees health status change. For example, the SHOP might decide that, after the initial selection of a benefit level at each worker's first open enrollment, the enrollee would be limited in how many levels could be "skipped" at the time of subsequent open enrollments.

### ***Advantages***

The advantages of this approach are essentially the same as those described for the previous option (Option 3), so we simply outline them here.

- Workers have even a broader range of choices, and thus the probability of having a "good fit" is maximized.
- When employers make a fixed contribution toward a premium, workers have strong financial incentives to choose the most cost-effective plan, which creates incentives for health plans to compete in terms of service, quality, and efficiency. And employers may be able to more easily control their contribution over time by not being tied to the cost of any particular health plan.

- Because choice is so broad, workers who change jobs or move from employer-sponsored coverage to individual coverage can keep their same health plan and maintain continuity of provider relationships.
- This option would impose only minimal, if any, additional administrative burden on the SHOP Exchange relative to federally required option.

### ***Disadvantages***

This approach probably creates the greatest potential threat of adverse selection, especially if there are no constraints on movement among benefit levels when people re-enroll. People tend to choose comprehensive coverage—that is, low consumer cost-sharing plans—when they anticipate needing expensive medical care and less expensive, less comprehensive coverage when they are healthy. If people can move from any benefit level to another with no restriction, they will tend to move toward the platinum plan when sicker and toward the bronze plan when healthy. The result could be adverse selection against the high-benefit-level plans. This potential problem could be mitigated by prohibiting anyone from jumping more than one or two benefit levels when re-enrolling. And, of course, to the extent that risk adjustment is effective, it will lessen the bad effects.

This approach requires workers to choose from the widest variety and number of possibilities. People certainly value having choices. But the evidence shows that when people have to weigh more than six or seven choices, they tend to turn to techniques to simplify the task that do not conform to the economist's model of a rational, all-knowing consumer. Of course, the Exchange is required to provide information to consumers in a form that makes valid comparison as easy as possible, but even with such help available, the task make prove difficult for many.

If the range of possible choices is very large, the potential advantage related to the financial incentives for workers to choose cost-effective plans could be offset by the difficulty of selecting from so many options. Given the complexity, people might make choices that do not reward the best-performing carriers with high enrollment.

The other disadvantages are essentially the same as those described for the previous option (Option 3).

- Carriers will have to implement new administrative structures but ones that are similar to those needed for the federally required SHOP option.
- Workers may ask employers for helping in choosing a plan, which could be a burden.
- Employers will have to deduct different amounts from each worker's paycheck depending the plan they choose (and the number of dependents covered). The Exchange will supply the information to make the task easy.
- This approach differs markedly from the present small-group market, so it would require carriers to adopt new administrative structures, but these are essentially the same as those required to adapt to the federally required option.

## Additional Issue Related to Worker Choice

### *Should Benefit Designs/Cost-Sharing Structures Be Standardized?*

Although ACA requires a certain degree of standardization of benefit design for QHPs offered in both the individual and small-group markets, there are important reasons to consider whether the state should go farther in requiring standardization. We turn to this important issue now.

Under ACA, all small-group plans must fit into one of the four federally specified cost-sharing or “actuarial value (AV)” levels. The actuarial value refers to the proportion of the cost of covered services that the insurer will pay for the average enrolled person. So a plan that has an actuarial value of 60 percent, will cover 60 percent of the cost of medical claims incurred by a typical person covered by the plan.<sup>30</sup> The federally defined plans correspond to the following actuarial values: “bronze” (60 percent AV), “silver” (70 percent AV), “gold” (80 percent AV), and “platinum” (90 percent AV).

But, particularly at the bronze and silver levels, there will be many ways that an issuer can design patient cost-sharing (that is, different combinations of deductibles, copayments and coinsurance rates) to achieve a particular AV level.

In the Maryland small-group market, carriers must all offer the same standardized plan, but riders are allowed. The federal concept of different AV levels would presumably replace the current Maryland small-group-market structure that allows carriers to sell riders that “buy down” patient cost-sharing levels from the levels specified in the CSHBP. This ACA structure could be seen as standardizing the actuarial value—though not the precise design—of those “buy down” riders.

The question of whether to require more standardization regarding what cost-sharing combinations will be permitted is important because *multiple cost-sharing designs at the same AV level could make comparison and choice of a QHP more difficult for workers*. This issue is closely related to the worker-employer choice issue.

To facilitate informed worker choice of plans, the MHBE Board may wish to consider alternative options for standardizing patient cost-sharing structures within AV levels.<sup>31</sup> The Board may already be considering such options with respect to the individual Exchange. Even if it is not, it may wish to do so for the SHOP, given the history of greater state involvement in benefit design in Maryland’s small-group market, compared to the individual market.

<sup>30</sup> Technically, the AV levels are to be based on the percent of costs for essential health benefits that would be covered for a standard-risk population.

<sup>31</sup> Note that the lower AV levels, particularly bronze, would more logically accommodate a large number of standardized plans, such as a high-deductible design and a low-deductible-with-higher-coinsurance design.

There appear to be three primary options:

1. The Exchange specifies one or a few standard cost-sharing designs per AV level. Participating issuers must offer *only* these standard designs.

- The Exchange might specify only one design at the platinum level but two or three at the bronze level. (For example, Massachusetts specifies one “gold” design and three designs at each of the “silver” and “bronze” levels.)

This approach simplifies choice for workers but could inhibit rapid adoption of improvements in benefit design over time. If implemented immediately, and the designs chosen by the SHOP were not attractive relative to newer designs in the outside market, it could severely impair successful implementation of the SHOP. (Note that the Massachusetts Connector did not specify its standard designs until it had gained some experience with what people were actually buying, both through the Connector and in the outside market.)

2. The Exchange specifies one or two standard cost-sharing designs per AV level. Participating issuers must offer these standard designs but may also offer a limited number (one to three) of additional cost-sharing designs of the issuer’s own choosing.

- The number of standardized or additional cost-sharing designs permitted might vary by AV level.

This approach establishes standard plan(s) workers can use to compare the relative cost of competing carriers at a particular AV level. Limiting the number of additional cost-sharing designs could keep the choice process from becoming overwhelming, while still allowing carriers to develop and offer innovative plan designs in the SHOP.

3. No standardization of cost-sharing levels. Participating issuers may offer any cost-sharing design that meets the criteria for the applicable AV level.

This approach makes it more difficult for consumers to compare health plans and creates more opportunities for risk selection.

## **A Final Note on Worker-Employer Choice Options**

As noted at the start of this discussion, there are a multitude of alternative plan-choice structures a SHOP could potentially offer to employers and their workers, and it will be difficult to predict in advance how the market will respond to the alternative(s) initially adopted, or what variations or refinements might be needed in light of experience or desired by small employers and their workers. Further, carriers may be more willing to participate in new worker-choice variations as they gain experience with worker choice or as they, as well as the SHOP, learn from innovations in other states or markets.

Therefore, flexibility will likely be important for success, and the MHBE Board may wish to have the flexibility to adapt, refine or change the plan-choice structures it offers through the SHOP as operational experience is gained.

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## APPENDIX A: AGE-RATING OF PREMIUMS AND COMPOSITE RATES

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Early in the discussion of Worker-Employer Choice issues, we noted that current Maryland rules require composite rates for small-employer groups, and the difficulties that could arise from the fact that worker choice essentially requires that the SHOP pay each health plan premiums that are individually age-rated for the workers who enroll in that plan. Here we outline one possible technical approach that could meet the three important criteria outlined earlier:

- Older workers do not have to contribute much more than younger workers;
- The employer can set and know its premium contribution in advance; and
- Employers can readily establish contribution policies that qualify for the federal small-employer premium tax credits.

First, it may be useful to illustrate some simple approaches that would *not* meet all three criteria. For example, an employer could simply decide to pay the same percentage of premium for whatever plan each worker chooses. This approach meets the IRS guidelines for the small-employer tax credits. But it does not allow the employer to know its total premium contribution in advance, because the total will depend on which plans the workers choose. And, because the premiums owed to the health plans now differ based on the age of each individual worker, older workers would have to contribute considerably more than younger workers—up to three times as much—even if they chose the same plan.

Alternatively, the employer could decide to simply contribute a flat dollar amount toward every worker's premium. This approach allows the employer to set and know its premium contribution in advance, but now older workers have to contribute an even larger multiple of what younger workers contribute, due to the necessity of individually age-rated plan payments by the SHOP. Importantly, this approach does *not* meet the IRS guidelines for the small-employer tax credit and may not meet other federal guidelines with respect to nondiscrimination in employee benefits.

The approach outlined below would overcome those difficulties and meet the three specified criteria. It would allow the employer to specify one plan (the employer “reference plan”) for which its workers' premium contributions would be the same regardless of age. Workers could choose alternative plans, and would pay (or save) the premium difference for that plan choice. This premium difference would be larger for older than for younger workers, but it would be far less than the difference in the full age-rated premium amount for older vs. younger workers. This approach is directly analogous to the approach taken in

the individual Exchange for federal tax-credit recipients. Under the ACA, individuals at a given income relative to the poverty level will pay the same amount for the benchmark second-lowest-cost silver plan, and will pay (or save) the premium difference for alternative plan choices, with older individuals paying or saving a larger amount than younger individuals.

Briefly described, a new approach to composite rating in the SHOP could work as follows:

- The employer would choose a reference plan, and would receive a composite rate quote for that plan (The composite rate would be simply based on the average of what each worker's age-rated premium would be for that plan).
- The employer would set its defined contribution based on that composite rate. Each worker in a given family category would, regardless of age, have the same remaining (composite) worker contribution amount for the reference plan.
  - » The employer contribution should be set high enough to assure that the (uniform) composite worker contribution for the reference plan is *no more than* the lowest age-rated premium for that plan. Doing so will assure that the youngest workers do not have to pay *more* than their respective full age-adjusted premium amount and that employer contribution amounts are sufficient to allow the SHOP to make employer contributions “portable.”
  - » The SHOP might also wish to establish an overall minimum employer contribution requirement, for example, 50 percent of the composite rate for the employer-designated reference plan (if higher than the preceding standard).
- Workers could choose other plans, based on seeing and paying the premium price difference associated with their choice. (That is, the SHOP would display for each worker the premium price difference for the plan choices available to them, based on the worker's age.)
- To make the employer contribution amounts “portable” (without burdening the employer with a more complicated employer role), the SHOP would “decompose” the total employer contribution into amounts for each worker. It would do that internally (“behind the scenes”) by subtracting each worker's composite contribution amount for the reference plan from the full age-rated premium that would pertain for that worker.
- The SHOP would send the employer a bill showing the total contribution required from the employer and the individual contribution required from each worker, based on the employer's chosen contribution level for the reference plan.
- The SHOP would thus bill and collect the full age-rated premium for each worker's plan choice, and would pay each plan accordingly.

### ***Dealing with Group Enrollment Changes***

The approach just described would assure that the employer would know its required contribution amount and the SHOP would receive payments from each group that equaled its payment obligations to plans for the workers and dependents *initially enrolled at the beginning of the year*. But the SHOP would also need to establish policies regarding

payments where workers and dependents are added or deleted from a group's enrollment over the contract year.

It is understood that conventional (single carrier) small-group plans in Maryland set an annual composite rate for each family category based on an employer group's initial demographic profile and guarantee that rate for 12 months. When qualifying new individuals are added to (or leave) the group plan, the employer's established composite rate for the applicable family category pertains, regardless of the age of individuals involved. The employer thus knows that his group premium rates are set for the contract year. The SHOP will presumably wish to make a similar guarantee when an employer elects to allow its workers to choose among plans offered by different carriers.

In the conventional market, the group health plan bears a risk for age-profile changes over the year.

The ages of workers and dependents who are added to (or leave) a given group are typically different from the average age reflected in the composite rate for that group. Thus, the composite rates the employer pays for them (or saves, when a worker leaves) are different than what the premium rates would be if the impact of their ages on the composite rate was taken into account.

Sometimes the employer's contract composite rate exceeds what this revised composite rate would be: for example, if a 25-year-old worker joins a group whose average age is 44. If, on the other hand, the 25-year-old were to leave rather than join the group, the employer's savings from no longer having to contribute for that worker would exceed the underlying reduction in expected health plan costs for the group as a whole. Other times, the employer's contract composite rate is less than a revised composite rate would be: for example if a 50-year-old parent with a teenage daughter joins a group where the average age of such parents was 26.

Where a carrier has the entire employer group in its enrollment, it can reasonably assume this risk, because its related losses and gains across all of its small-employer groups should approximately average out over the year.

However, this would not be true for health plans in the SHOP Exchange, where individual workers and dependents from groups with different age profiles and different employer contribution levels can join or leave different health plans having different premium levels. A given health plan might experience significant differences in the ages of its "new adds" compared to its age profile from initial group enrollments.

Therefore, if Maryland decides that SHOP employers' composite rates should remain fixed for the year (as in the conventional market), the SHOP will still need to pay each plan its applicable age-rated premium for each worker or family it enrolls. While it is reasonable to expect that the associated "wins" and "losses" across all SHOP enrollment should be about equal over a year, the SHOP would need a reserve fund to draw on in order to reliably make applicable premium payments to plans.

For example, the SHOP would need to draw on such funds in periods when the average age of workers who are added to existing SHOP groups mid-year exceeds the average age of workers already in those groups. It is also highly probable that at least some age-profile differences between initial and change enrollments would occur over an entire year.

In order to appropriately spread the risks for such changes across the entire SHOP Exchange enrollment, it would be reasonable to establish a small assessment on participating plans in order to capitalize what would hopefully be a rotating fund. An analysis of appropriate levels and alternative bases for such an assessment are beyond the scope of this paper, but it would seem that this could be a very small share of premiums, and an advisory group of participating plan actuaries might help determine a fair and simple formula for allocating costs.

### ***Concluding Notes***

The approach outlined here is consistent with guidance the Internal Revenue Service has issued laying out employer contribution structures that qualify for the federal small-business health insurance credit when the employer offers its workers choice among different health plans.<sup>32</sup> If that guidance is subsequently updated, the approach outlined here might need to be revised.

Also, the SHOP could be at a disadvantage in the marketplace if the new approach to calculating composite rates—by adding up the individual age rates for participating workers and dividing by the number of workers—was used by the SHOP while the outside small-group market calculated composite rates by simply using the average age of participating workers.

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<sup>32</sup> Internal Revenue Bulletin: 2010-51, December 20, 2010, Notice 2010-82, *Tax Credit for Employee Health Insurance Expenses of Small Employers*. <[http://www.irs.gov/irb/2010-51\\_IRB/ar09.html](http://www.irs.gov/irb/2010-51_IRB/ar09.html)>