District of Columbia Health Benefits Exchange

Employer Plan Selection Recommendations

HRIC Insurance Subcommittee

November 28, 2012

DC HBX SHOP Employer Plan Selection Draft Recommendations

Introduction

The District of Columbia's Health Benefit Exchange (DC HBX) Small Business Health Options (SHOP) exchange will provide more options to many small businesses and their employees by making multiple health plans available to all regardless of size. The method of health insurance plan selection available to employers and their employees will drive the experience of small businesses in the Exchange and will define the number and type of health plan options for employers and employees.

The Mayor's Health Reform Implementation Committee (HRIC) Insurance Subcommittee recently held two open comment periods for stakeholders to weigh in on the methods that should be adopted by the DC HBX Board with regards to how a small business employer makes health insurance plan(s) available to employees. Although few stakeholders responded, those who did provided thoughtful insights, research, and alternative plan selection methods that were all carefully considered by staff in preparing this recommendation.

In the request for public comment, the Insurance Subcommittee asked stakeholders to also comment on a proposed employer contribution method to be referred to as the Employer Reference Plan Contribution Model. A recommendation on this model is included below for DC HBX Board consideration. The Insurance Subcommittee urges the DC HBX Board to allow for additional stakeholder comment on both the recommended plan selection method and contribution methods presented in this report in anticipation of a final determination being made in December 2012.

The Insurance Subcommittee also notes that despite two comment periods no feedback was received by small employers themselves. We propose over the course of the next 2-3 weeks to convene at least two small business focus groups or working groups to discuss the recommended plan selection methods. We will work across District agencies to ensure this feedback is gained and reported to the DC HBX Executive Board in a timely manner.

Overview:

Final Exchange regulations for the Affordable Care Act (§155.705(b)(2)) require an Exchange to allow a small business employer (defined by the DC HBX Executive Board as 50 or fewer) to select any metal level tier (Bronze, Silver, Gold, Platinum) within which their employees can select any health plan offered by any health insurance carrier or COOP. In addition, the final rule provides that employees in a merged market (adopted by the DC HBX Executive Board) must still have a plan that meets the small group deductible limits and coverage levels set forth in 1302(c)(3) and (d) of the Affordable Care Act.

The final Exchange rule also provides (§155.705(b)(3)) Exchange with the flexibility to allow a small business employer to make one or more QHPs available to employees. In other words, the Affordable Care Act and Exchange rules do not limit a SHOP exchange's ability to offer additional options, including choice across cost-sharing levels or allowing employers to offer only one plan.

Stakeholder Feedback:

The Insurance Subcommittee solicited comment from stakeholders to determine any plan selection methods beyond the Affordable Care Act metal level tier mandate that would benefit both employees and employers while maintaining the overall integrity of the DC HBX insurance marketplace.

Stakeholder feedback generally argued for both "employer choice" and "employee choice." Employer choice allows for a small business employer to select a specific carrier and make available to employees either a discrete number of qualified health plans (QHPs) or all QHPs offered by that carrier, regardless of metal tier. Employee choice refers to the ACA-mandated selection method allowing for an employer to select a metal level tier and making all QHPs available to their employees.

The challenge presented in stakeholder feedback is maintaining a careful balance between expanding and improving health insurance options for the employees of small businesses while respecting and understanding the complexity and potential administrative burdens a small employer may face with plan selection options that are completely different from the method by which plans are selected today.

Research:

The work of other state-based exchanges has been key in staff analysis of this policy decision. States vary on employer plan selection approaches beyond the ACA mandate. Maryland's work on employer plan selection has been particularly useful and presents a viable path forward for additional plan selection methods that ensure both employer and employee choice while maintain consistency with a jurisdiction where many of the same health insurance carriers offer products and where many small employers and employees may reside.

Maryland's "employer choice" plan selection method gives a small business employer the ability to select one carrier or insurance holding company system from which their employees can select any QHP offered by that carrier or insurance holding company system on any tier. One stakeholder discussed a selection method similar to this whereby an employer would be able to select a particular carrier and a "discreet set of QHPs" to make available to his or her employee. While it does not provide for further plan selection beyond the carrier level, we feel the Maryland approach to employer plan selection addresses the need for additional employer choice.

Recommendation:

The Insurance Subcommittee – based on stakeholder feedback, staff analysis, and the work of other state-based exchanges – recommends that the DC HBX allow for both the Affordable Care Act mandated selection method in addition to the employer choice method adopted by Maryland that allows for an employer to select one carrier or insurance holding company system and make all available QHPs, regardless of metal tier, available to their employees.

Additional Actions:

Some stakeholders provided feedback on ways employer contributions could be made and calculated for an employee's health insurance coverage. The Insurance Subcommittee proposed an Employer Reference Model whereby an employer would select a "reference plan" to offer employees on the Exchange that would typically be a silver level plan and the employer would then set their contribution based on the reference plan.

After further review of guidance from HHS and the work of other states, the Insurance Subcommittee views ACA guidelines for minimum essential coverage and health insurance affordability requirements as appropriate guidance for employer contributions to employee health coverage.

We recommend that the DC HBX Executive Board not consider employer contribution methods at this time, instead deferring any action until the appropriate advisory committee can be convened. Defining employer contributions should not be a priority of the Board at this time as it will not impact implementation of ACA and the establishment of the DC HBX insurance marketplace.

Stakeholder Feedback

November 5, 2012

To: Brendan Rose
HBX Insurance Subcommittee- Insurance Market Working Group
Department of Insurance, Securities and Banking
810 First St, NE, Ste 701, Washington, DC 20002

RE: Comments on Employer Plan Selection and Employer Contributions in the SHOP

We represent the National Association of Insurance and Financial Advisors -- Greater Washington and the Greater Washington Association of Health Underwriters, respectively. These two local non-profit membership organizations represent the vast majority of agents and brokers providing professional health insurance services to individuals and employers in the District of Columbia.

We write to offer input on the proposed DC HBX Employer Plan Selection and Employer Contribution options.

Employer Plan Selection

Employer Flexibility: Employers face a myriad of changes to their employee health benefits in the coming years as the federal and District governments implement health care reform. In order to ensure a smooth transition into the DC HBX, it is crucial that small employers continue to have the flexibility to offer health benefits to their employees in a manner that meets the diversity of needs and budgets of a broad range of small businesses. While the DC HBX has the ability to offer new options that may appeal to some small employers, many small employers simply want to continue offering plans the way that they have been for years. The District should ensure that employers have adequate choices within the HBX that allows employers to mirror their existing benefit plans as closely as possible. This will allow for a smoother transition and level of understanding from both employers and their employees.

- **Employers Know Their Employees**: Small employers know their employee population better than anyone else. Employers use this knowledge to assist their employees by providing them with a manageable set of choices that are appropriate for their population. For example, a small financial services firm with college-educated, higher-income employees may have significant success offering consumer-directed HDHPs combined with Health Savings Accounts since their employees are more likely to understand the complex financial and tax implications as well as have the necessary cash flow to be able to cover the costs of the high deductible. Alternatively, a small employer with lower-income employees with less formal education would not want to offer a consumer-directed HDHP because even if the premiums are lower, their employees are less likely to have the financial ability to cover costs of services subject to the high deductible. Employers should be able to use their knowledge of their employees and their higher level of understanding of health benefits to offer their employees more manageable and appropriate choices.

- **Employers Want Employee Satisfaction:** Employers choose to offer health insurance for their employees for a variety of reasons, most importantly for employee recruiting and retention.

Given that benefits are often the second largest cost for small businesses after employee compensation, it is in the employer's best interest to maximize employee satisfaction to get the most value from such a high-cost item.

- **Employer Benefit Philosophy – Active Engagement**: Many employers want to be actively engaged in their benefits offerings as part of an overall philosophy of taking care of their employees. While some employers may prefer a hands-off approach and be happy to turnover health benefit-related functions to the HBX, many employers will want to continue an active role including answering employee questions about product options, provider networks, claims assistance, and covered services.

- **Inflexible HBX Could Cause Small Employers to Drop Coverage:** If the DC HBX is too rigid to accommodate their diverse needs and budgets, small employers not subject to the ACA's Employer Shared Responsibility provision may opt to stop offering employer-sponsored health insurance. Instead, their employees would have to seek individual health insurance in the exchange in the employee's state of residence. With only 32% of the District's private workforce residing in the District, the majority of those employees would end up enrolling in another state's exchange, further complicating the HBX's concerns of achieving critical mass.

More Choices ≠ Better Choices: Simply offering employees more choices does not mean that they will make better choices. Too many choices could leave to adverse selection, additional administrative burden to small businesses, and confusion for employees.

- **Employee Confusion**: Too many choices simply confuse and overwhelm consumers. Many lessons can be learned from behavioral research on worker choice in defined contribution retirement plans. For example, while it may seem counterintuitive, research shows that as a 401(k) plan offers *more* investment options, this actually leads to *decreased* plan participation and *poorer* investment decisions[1].
    - **More choice is not always better.**
    - **Education and information are not enough.**
    - **Careful and effective plan designs more likely to succeed.**

- **Additional Administrative Burden to Small Employers:** Many employees turn to their employers for advice about their health care coverage, especially in the inherently intimate working environment that is characteristic of small businesses. Employers may feel overburdened if employees have too many options.
    - If employees can enroll in multiple different carriers, employers would not be able to know the different plans, networks, claims systems, and processes for all of the different carriers in the marketplace. Employers would effectively be forced to disengage from the advisory role they currently serve for their employees.
    - Even though the HBX will calculate and report employee contributions, the employer would still be faced with payroll deduction amounts that differ for every single employee. For small employers without dedicated payroll/accounting staff,

[1] See Employee Benefit Research Institute's "Lessons From the Evolution of 401(k) Retirement Plans for Increased Consumerism in Health Care: An Application of Behavioral Research" by Jodi DiCenzo and Paul Fronstin http://www.ebri.org/pdf/briefspdf/EBRI_IB_08-2008.pdf

complicating the payroll process can be a significant burden on their limited time and resources.

- **Additional Burden on Other Resources**: If employers are unable to continue serving in an active advisory role, employees and their family members will simply turn to other health care system resources for assistance thereby increasing the demands on brokers, carriers, Navigators, the Department of Insurance Securities and Banking, and the Office of the Health Care Ombudsman.

- **Adverse Selection:** Unfettered employee choice greatly increases the risk of adverse selection. Sicker employees will select more expensive, comprehensive plans and healthier employees will select cheaper plans, creating adverse selection within the HBX and driving up the cost of comprehensive plans in the market. California's previous exchange experience is a classic example of too much employee choice resulting in an unsustainable exchange. The District's own independent consultant also expressed these concerns:
    - "The ACA also affords exchanges the option to decide whether or not to open up further this employee choice model. At the discretion of the states, the ACA allows employees to select from any available plan offered inside the SHOP Exchange. This option introduces selection at yet another level. Healthy employees could select low-cost Bronze coverage while unhealthy employees could select richer Gold and Platinum plans. Given plans will be priced based on the average morbidity of the carriers' pool, the amount by which the Bronze plan is overpriced for a healthier than average individual is not likely to be enough to offset the amount by which the Gold or Platinum plan is underpriced for the less healthy individual. This premium shortfall will put upward pressure on rates, all else equal. Offering this additional choice may be attractive to employers, and therefore it could be helpful in raising the level of participation in the SHOP Exchange. However, we recommend the District study this potential for adverse selection carefully before deciding the level of choice offered inside the SHOP Exchange."[2]

Option 1: Any QHP within a Single Metal Tier (ACA-Mandated)

- **Additional Options Needed**: As stated above, multiple employer plan selection options are critical for the continued success of small employer health insurance in the District.
- **Less Familiar than Current Benefits**: Since this plan selection option is fundamentally different and more complicated than current employer benefit offerings, this option will require a significant amount of education for employers and their employees to understand. Employers should be provided with alternative plan selection options that more closely mirror current benefit offerings to allow a smoother transition into the HBX marketplace.

Additional Employer Plan Selection Options

- **Option 2: Employer Choice of Carrier and Discrete Set of QHPs, Employee Choice from Selected Set of QHPs**
    - **Similar to Current Benefit Offerings:** Employers and employees will be more familiar with this type of plan selection option as it closely mirrors current benefit offerings and will allow for a smoother, easier transition into the HBX marketplace. Enabling an employer to select one carrier and several QHPs will not only offer consistency with today's typical market offerings, but will balance the desire to offer cost-conscious options against concerns of imposing undue administrative burdens on the employer and increasing employee selection confusion.

[2] From Mercer's report, pg 245 of Insurance Market Subcommittee Report April 2012

- **Employers as Active Advisors:** Employers would be able to continue serving as active advisors to their employees under this plan selection model. By allowing employers to select a discrete set of QHPs to offer to employees, employers can leverage their knowledge of their employee population to offer a manageable selection of plans best suited to the needs of their employees.
- **Manageable Employee Choices:** Employees would still have a choice amongst the selected QHPs to find the plan best suited to their needs.

- **Option 3: Employer Choice of Carrier, Employee Choice of Any QHP in Any Metal Tier from Selected Carrier**
  - **Employers Continue Limited Advisory Role**: By allowing employers to only offer plans from a single carrier, the employer would be able to continue providing some limited advice for employees in regards to general carrier processes.
  - **Higher Risk for Adverse Selection**: As discussed above, allowing employee choice across metal tiers can lead to the healthiest employees enrolling in lower-cost Bronze plans and the sicker employees enrolling in higher-cost Platinum plans.

- **Option 4: Employee Choice of Any QHP, Any Carrier, Any Metal Tier**
  - As discussed above, this level of unfettered employee choice carries ***significant risks*** for adverse selection, virtually eliminates the employer's ability to serve in an advisory role, and would only lead to overwhelming employees and reducing the quality of their choice.

<u>Employer Contribution Models</u>

Employer Flexibility: Employee health benefits are the second highest expense for most small employers, after compensation. Therefore, employers need flexibility to develop a contribution model that satisfies their employee benefits goals while meeting their budgetary limitations. Many small employers, particularly small start-ups and charitable non-profit organizations, have very tight fiscal resources and need as much financial control as possible over one of their largest budgetary items.

Option 1: Employer Reference Plan Model

- **Pros**:
  - Fixed employer cost; easier budgeting
- **Cons**:
  - Employer defined contributions that are not adjusted annually in proportion to increases in premiums, can lead to employee costs increasing significantly faster than premiums and an increased risk that the employer-sponsored plans will terminate because of inadequate employer support and weak participation.
  - Employee cost would be the same for each employee to enroll in the reference plan, but the cost to enroll in non-reference plan will vary by the employee's age which may cause employee confusion.
    - Massachusetts Connector experience: "In addition, when employees found out (by talking among themselves) that employers were requiring some workers to contribute more than others to health plans that basically were very similar, workers were understandably upset. The disparity arose not only because some employees selected less expensive coverage, but also because those who selected alternative coverage paid a premium contribution determined by their age rather than by the company's

composite rate that applied to the blended ages under the reference plan. According to Connector officials, this bifurcated approach to age rating was partially a response to concerns among some board members that pure list billing would result in age discrimination. However, officials despaired that mixing composite with list billing in this "overly engineered" fashion "really mucks up the works" in ways that "become very difficult to explain to anyone who is not an actuary."[3]

- Age-based *employee* contributions could violate existing IRC §125 cafeteria plan nondiscrimination rules (§125(b)(1)(B) & §125(c)) and possibly also the ACA's new insured plan nondiscrimination rules (PHSA §2716 – guidance still pending).

Option 2: Fixed Percentage Model

- **Pros**: When combined with a discrete set of employer plan selections…
  - Similar to existing contribution models used by the vast majority of today's employers which would mean a smoother transition into the DC HBX.
  - Ensures employer support remains linked to defined benefit levels rather than some arbitrary dollar amount which may fail to provide sufficient funding for the employee's coverage.
- **Cons**: When combined with employer plan selection of any plan within a metal tier…
  - Variable employer contributions based upon the employee's age and selected plan.
  - Difficult for employers to budget.
  - Potential for employee perceptions of unfairness.
    - Age-based *employer* contributions would likely violate existing IRC §125 cafeteria plan nondiscrimination rules (§125(b)(1)(B) & §125(c)) and possibly also the ACA's new insured plan nondiscrimination rules (PHSA §2716 – guidance still pending).

Additional Employer Contribution Considerations

While the pros and cons of the two basic contribution models proposed by the District are discussed above, there are numerous additional nuances to consider when developing an employer contribution model.

- **Variability by Enrollment Tier**: Employers should be permitted to vary contributions for each enrollment tier. Employers typically contribute different percentage of premiums towards coverage of family members than towards coverage of employees. Given the high costs of coverage for family members, the actual dollars spent by employers towards family coverage is still significantly more than the actual dollars spent on employee only coverage. Inability to vary contributions by enrollment tier could significantly increase employer's cost of offering coverage to family members, possibly resulting in employers dropping coverage if they are not large enough to be subject to the Employer Shared Responsibility penalties.

- **Variability by Groups of Employees**: Employers need to have the ability to define different contributions for different groups of employees based upon any bona fide employment-based classification (e.g. job classification, part-time/full-time, hourly/salary, location)

[3] Page 8, Robert Wood Johnson Foundation's "Employers' Use of Health Insurance Exchanges: Lessons from Massachusetts" by Mark A. Hall http://www.healthreformgps.org/wp-content/uploads/HCFO-Report-Hall-2012.pdf

- **Salary-based contributions**: Employers subject to the Employer Shared Responsibility provision need flexibility to be able to offer higher employer contributions for certain lower-wage employees to assure "affordability."

- **Wellness program incentives:** Employers with wellness programs that conform to HIPAA regulations should be permitted to offer different contributions based upon participation in the wellness program (e.g. discounted non-smoker contributions).

- **Employer HSA Contributions**: Employers offering qualified high deductible health plans (HDHPs) often include employer contributions into a Health Savings Account (HSA) as part of the plan offering. The DC HBX will need to be able to include these HSA contributions when illustrating the employee's cost of enrolling in HDHPs.

* * * *

We greatly appreciate the opportunity to provide input on these important issues. We look forward to working with you, your colleagues and District policymakers to ensure the success of the District's HBX. Please let us know if you have questions or seek additional information.

Sincerely,

William Brockman
President, National Association of Insurance and Financial Advisors - Greater Washington, DC

Joel Pitt
President, Greater Washington Association of Health Underwriters

CC: Andre Beard, DISB
Philip Barlow, DISB
Bonnie Norton, DHCF

August 13, 2012

Brendan Rose
Andre Beard
District of Columbia Department of Insurance, Securities, and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

Dear Mr. Rose and Mr. Beard,

Families USA is a nonprofit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage for all. We appreciate the opportunity to provide comments regarding the implementation of a Small Business Health Options Program (SHOP) exchange for small businesses and their employees in the District of Columbia, as outlined in the Health Reform Implementation Committee's Insurance Subcommittee proposal for "Employer Plan Selection and Employer Contributions in the SHOP."

Employer Reference Plan Contribution Model
Families USA supports the District's proposal to structure employers' contributions to workers' coverage in the SHOP via an "Employer Reference Plan." This model appears to align with the federal government's vision for SHOP exchanges, as initial guidance on the information that small employers will have to provide to enroll in the SHOP includes information on an employer's "benchmark plan" selection.[1]

Asking employers to select a reference plan for their workers will help ensure that SHOP coverage is affordable for small business employees, as the process will lead employers through strategic thinking about the appropriate size of their contribution to workers' coverage relative to the cost of SHOP coverage. Allowing a basic "defined contribution" model in which employers determine a uniform dollar value to contribute to each workers' coverage, on the other hand, could result in employers making arbitrary contributions towards workers' premiums, rendering the employee share of health insurance premiums too large to be affordable for workers. We therefore urge the District to move forward with a SHOP exchange that does not permit for basic defined contribution arrangements.

Employing a reference plan contribution model is particularly important in the context of the 3:1 age-rating permitted in the small group market (including in the SHOP) under the Affordable Care Act. The reference plan model provides a mechanism to significantly mitigate the effects of this age-rating on older workers, making coverage more affordable for these workers who are, on average, more in need of comprehensive health care services than their younger counterparts. It is our understanding that under the District's proposed model for employer cost of contributions to workers' coverage in the SHOP exchange, a composite rate is calculated for the employer's selected reference plan, and the dollar amount that each employee will contribute towards coverage under the reference plan is the same (with the exception of adjustments based on family category). If employees opt to select coverage through a different plan available to them through the SHOP, employees will take the dollar amount of their employer's uniform contribution to the reference plan "with them" to use towards the coverage in the alternate plan. Employees' responsibility towards the cost of coverage in the alternate plan would then be the sum of what they would have paid towards coverage under the reference plan, plus (or minus) the difference between the age-rated premium for the alternate plan and the age-rated premium they would be charged in their

employer's reference plan (without a composite rate in place).

This proposed model, which is outlined in the Institute for Health Policy Solutions' May 2011 brief, "Small Employer (SHOP) Exchange Issues," achieves the objective of spreading the costs of age-rating over an employer's workforce, as is commonplace in the small group market today. By calculating a composite rate for an employer reference plan and basing the employer's contribution to workers' coverage on that composite rate, whether enrolling in the reference plan or another permissible SHOP plan, older workers will be protected from bearing the full brunt of age-rating— an objective that Families USA views as critical to making health coverage affordable to small businesses workers regardless of age. Additionally, under this proposed model, employers' contributions to their workers' coverage will be predictable and constant regardless of which plan their workers each choose, providing important budgeting benefits to small businesses in the District of Columbia. Families USA therefore supports the implementation of this employer reference plan contribution model for the DC SHOP exchange.

Employee Plan Choice

The District proposes to allow employees qualified for SHOP coverage to choose from any SHOP plan sold at the "precious metal" (actuarial value) level selected by their employer. This model for employee plan selection provides the benefit of limiting adverse selection, as it prevents the development of a SHOP market in which only sicker workers select coverage with higher actuarial values and younger, healthier workers select the "thinnest" coverage available. While this is an advantage of permitting employee plan choice only within one tier of coverage, the drawback to this model is that employees with health needs that may make coverage at a higher actuarial value than what their employer has selected optimal for them will be locked out of such a plan. We therefore recommend that the District carefully examine whether small business employees will be able access coverage that meets their needs, regardless of health status or age, in a market where they are unable to enroll in coverage at a higher actuarial value than the level selected by their employer. On the other hand, it may also be important to examine whether allowing employee choice across tiers will incentivize employers to choose reference plans at lower actuarial values than they would otherwise and whether such a model will cause adverse selection significant enough to destabilize the SHOP marketplace. As the implementation of a SHOP exchange with employee choice is a new endeavor for the District and for all other states working on exchange implementation, Families USA encourages the District to engage in careful study of the tradeoffs inherent in limiting versus expanding employee choice before selecting a model for employee plan selection in the SHOP.

We thank you for considering our comments and appreciate the work that you have done to both ensure that consumers and their advocates can weigh-in to the Affordable Care Act implementation process in the District of Columbia and to ensure that the SHOP exchange provides affordable coverage options for small business workers of all ages and their employers and puts their collective interests first. Please do not hesitate to contact Claire McAndrew at cmcandrew@familiesusa.org or 202-628-3030 if you would like to discuss these comments.

Sincerely,

Claire McAndrew
Senior Health Policy Analyst
Families USA

[1]Centers for Medicare and Medicaid Services, *CMS Form Number CMS-10439: Data Collection to Support Eligibility Determinations and Enrollment for Small Businesses in the Small Business Health Options Program*, July 2, 2012.

CareFirst BlueCross BlueShield
840 First Street, N.E.
Washington, DC 20065-0001
Tel. 202-479-8000

August 17, 2012

Brendan Rose
Department of Insurance, Securities and Banking
810 First Street, NE 7th Floor
Washington, DC 20065

Dear Mr. Rose:

On behalf of CareFirst BlueCross BlueShield (CareFirst), which provides health insurance coverage and administrative services to nearly 375,000 District of Columbia residents, I write to offer comments on the recommendations of the District's Health Reform Implementation Committee's (HRIC) Insurance Subcommittee on the Small Business Health Options (SHOP) Exchange employer contribution and plan selection process. Given the differences in the Individual and Small Group markets, policymakers face several important decisions in establishing a SHOP Exchange in the District of Columbia. Key among those decisions is how the SHOP Exchange will meet the Affordable Care Act's (ACA's) employee choice requirements and whether to impose minimum employer participation and contribution standards. We offer these suggestions:

Market Structure

- The Exchange should establish separate portals to serve the Individual and Small Group employer market segments. This separation is necessary because ACA treats coverage for individual and small employer groups differently, including different enrollment qualification requirements; different cost sharing requirements; and different individual and group contract requirements. The ACA requires that these two types of insurance be sold separately, as shown by its references to separate Individual and Small Group market exchanges.
- The District also should maintain separate individual and small employer risk pools. Merging the two risk pools will increase premiums in the small group market as a result of the merger, thereby incenting employers to drop or reduce coverage or to self-insure. It is possible to maintain separate, yet actuarially credible pools, and avoid cost increases to the small employer market.
- The District should maintain the current 2 to 50 definition of small employer. Employers with 51 or more employees currently pay premiums based largely on their own claims experience. Requiring 51+ employer groups to purchase coverage on the Exchange could push groups with good experience to self-insure and expose the Exchange to assuming the higher risk groups, thereby increasing cost for everyone.
- Consistent with ACA's expressed intent to preserve broad consumer choice, *ACA § 1312, 42 U.S.C. § 18032*, the District should maintain an off-Exchange market.

Employer Contribution

- The SHOP Exchange should include both a defined benefit model and a defined contribution model. This would provide greater choice for small groups as they transition to purchasing coverage on the SHOP Exchange and would provide small employers with a purchasing option that matches what they have available today in the off-exchange market.
- Establishing an employer reference plan is an effective method for an employer to determine their defined contribution amount. It creates predictability for the employer by enabling the employer to make the same contribution toward each employee's health insurance costs regardless of age. When used with the employee choice model, basing the employer's contribution on the reference plan allows the employee to take advantage of the employer contribution, while also giving the employee the flexibility to select a plan other than the reference plan if the employee is willing to pay the additional cost.
- The District's proposal to require an employer to pay a fixed percentage of an employee's health benefit plan should only be applied to a reference plan. In other words, the employer should only be required to pay a fixed percentage of premiums for the reference plan at each enrollment level, e.g., individual, individual and spouse, individual and children, and family. An employer should not be required to pay a fixed percentage of ***any*** health benefit plan an employee selects under an employee choice model, because this would expose the employer to unpredictable, and potentially unsustainable, employee health insurance costs. If the employer's cost-sharing is not based on a reference plan, the employer would be unable to determine the cost of its employees' health benefits until after plan selection, and would be uncertain as to its liability. This may discourage some employers from providing coverage.
- ACA permits states to establish minimum participation requirements. *See 45 C.F.R. 155.705(a)(10).* The SHOP Exchange should establish a minimum participation requirement of 75 percent of a group's employees and a minimum employer contribution level of 50 percent of the employee's premium in order to secure coverage on the SHOP Exchange.

Employer/Employee Health Benefit Plan Selection

Implement the employee choice model required by federal regulations, and do not experiment with other defined contribution models at this time

- The proposed federal regulations require SHOP Exchanges to offer the employer the option to designate a "metal" level and to permit employees to select any Qualified Health Plan (QHP) offered by any carrier at that level. Because each employee may select a different carrier, each carrier runs the risk that it will be viewed as more attractive to employees with greater health risks.
- This problem is compounded further if employees can select QHPs at different metal levels, because employees with few health care needs will gravitate to lower metal level QHPs and those with significant health care needs gravitate to higher metal level QHPs. Due to the unintended and undesirable consequences of risk pool fragmentation this would set in motion, CareFirst does not believe that it is prudent at this time to go beyond the model required by regulation to offer broader employee choice. Until the market has more experience with employee choice in the small group environment, the Exchange should implement only what is required under federal law.

Provide an option for small employers to select a defined benefit plan for all employees, as in the current marketplace

- While the federal regulations require the Exchange to offer the employee choice model described above, those regulations also permit the Exchange to offer a defined benefit plan model. The defined benefit plan model used today in the small group market should continue in the off-Exchange market and should be an option on the Exchange as well. Under this model the small employer may select one or more health benefit plan(s) from related carriers to be offered to the small employer's employees. If the employer offers more than one health benefit plan to its employees, the health benefit plans must be underwritten by the same carrier or carriers within the same health insurance holding company.

Employers should have the defined benefit plan option on the Exchange, because it is an option with which they are already familiar in the current market. Currently, CareFirst permits a small employer to select PPO, POS and HMO health benefit plans as options for its employees. Allowing small employers to select a defined benefit plan would enable the Exchange to meet the needs of all small employers and allow employers to provide a uniform benefit package to their employees, if they wish to do so.

Thank you for the opportunity to provide comments on the SHOP Exchange operations. We look forward to working with you on other Exchange issues in the future.

Sincerely,

Tonya Vidal Kinlow
Vice President, Government Affairs – NCA
CareFirst BlueCross BlueShield

DELTA DENTAL®

deltadentalins.com

August 13, 2012

SENT VIA EMAIL
Brendan Rose
Exchange Project Director\Health Care Policy Analyst
D.C. Department of Insurance, Securities, and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

RE: District of Columbia (D.C.) Employer Plan Selection and Employer Contributions in the SHOP

Dear Mr. Rose:

I am writing on behalf of Delta Dental in response to the invitation for feedback on employer plan selection and employer contributions in the D.C. SHOP Exchange. We are pleased to offer some specific comments to help guide the D.C. exchange as it attempts to balance the needs of small group employers and their employees. We anticipate that these comments may assist you in developing the optimal approach to employer plan selection and employer contribution in the SHOP Exchange.

The recent announcement from the D.C. Health Exchange requesting public comment on employer plan selection and employer contributions presented the following two options in regards to employer contributions:

1. *The employer selects a reference plan whereby all employees, in each plan type category would pay the same premium regardless of age, if they chose the same reference plan. Their actual contribution would vary if they select a plan other than the reference. This is similar to the way the current small group market functions.*

2. *The employer pays a fixed percentage of each employee's plan selection.*

It is our position that the district should consider an alternative approach to the two options presented above with respect to employer plan selection. Although Option 1 appears to mimic the current approach to employee benefits selection for small employers, it does not fully maintain consistency with current practices. Most employers today select a specific health/dental plan, and the employee can then choose to enroll in that employer-selected plan. Option 1 would be optimal if it mirrored this current approach of benefits selection, since small groups and the brokers that support small businesses are accustomed to this process today. Minimizing disruption to the current approach to plan selection by allowing employers to select a specific plan will allow the exchange to successfully integrate key stakeholders, such as small business associations and brokers, while ensuring that the exchange can attract and not alienate current market participants.

Option 2 does not adequately protect the employer from variation in costs for health insurance because by paying a fixed "percentage," the employer becomes exposed to potentially wide fluctuations in actual

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cost that cannot be predicted or budgeted. Small businesses are extremely sensitive to fluctuations in costs, so allowing employers to pay a fixed percentage could open up small groups to potential runaway costs should a majority of employees select the most expensive option. A more preferable approach would be to allow employers to designate a flat dollar contribution, as opposed to a fixed percentage. This would allow small group employers to align annual health care costs with their budgets.

We believe that the following options will allow small businesses to balance costs with employee choice:

- The employer selects a specific health/dental plan and the employee can enroll in that plan
- The employer defines a fixed dollar amount that it will contribute towards each employee's health benefits (defined contribution approach)

The options above allow small employers to control costs, offer employees appropriate choice, and provide access to a marketplace that is stable and competitive.

Providing an adequate level of plan choice for employees is key to creating a competitive marketplace for the SHOP exchange, however, a multitude of choices can sometimes be overwhelming for enrollees, especially since insurance can be a highly complex product. The key to creating a truly competitive exchange will require that the market inside the exchange is designed to present both medical and dental options with clear and transparent pricing and benefits. Additionally, the market outside of the exchange should remain open and additional options for adults to purchase supplemental dental benefits should be made available both inside and out of the exchange.

We would welcome the opportunity to address any questions you might have regarding employer plan selection and employer contribution in the D.C. SHOP Exchange. If you have any questions, please do not hesitate to call me at (415) 972-8418, or our legislative advocate in D.C., Kevin Wrege at (202) 625-1787.

Sincerely,

Jeff Album

Jeff Album
Vice-President, Public and Government Affairs

United HealthCare (8/21/2012)

I received a couple of questions/comments from one of UnitedHealthcare's (UHC) actuaries regarding the SHOP Exchange based upon the DC request for information. I appreciate that DC may not have a response to the questions at this time, but wanted to share them with you so you may consider the issues as you move forward.

1. The employer selects a reference plan whereby all employees, in each plan type category would pay the same premium regardless of age, if they chose the same reference plan. Their actual contribution would vary if they select a plan other than the reference. This is similar to the way the current small group market functions.

   The following scenario is based upon UHC's understanding. Under this option a composite rate using all eligible employees' ages is used to create the premium rate for all available benefit plans. Let's say the employer picks Silver and there are 3 Silver QHPs. The employer picks Silver Plan 2 (mid-cost) as the reference plan. It doesn't specify if the employer is paying a dollar amount of Silver Plan 2's premium or a % of it, but if an employee picks the richer Silver Plan 1, then the employer contribution doesn't change and the employee picks up the difference.

2. The employer pays a fixed percentage of each employee's plan selection.

   Here there is no reference plan. So the employer says no matter what the premium, I am going to pay say 85% of it. In this scenario nothing is said as to how the premiums are calculated. Would they still be a composite rate using all eligible employees? Or under this approach does the premium for each employee vary by the employee's age? Under this option, the employer really does still pick a reference plan as they are going to need some reference point to pick their percentage.

3. Should the District consider an additional selection method?

   I have not been involved in how employer's decide on premium contributions but I think either a dollar amount or a % amount seems reasonable, with the employee paying more for richer benefits. The calculation of the plan premium should not be different based on employer contribution methodology, and the premium should be calculated consistently.