Planning and Establishing the North Carolina Health Benefit Exchange

Webinar for TAG Meeting #2

January 23, 2012

MANATT HEALTH SOLUTIONS

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Discussion Roadmap

- Project Goal and Webinar Objectives
- Statement of Values and Goals for TAG
- Overview of Issues for Discussion in TAG Meeting #2
- Next Steps

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Project Goal and Meeting Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI recommendations to the NCGA on Exchange-related market reform policies.*

(pursuant to North Carolina Session Law 2011-391)

"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations. The Commissioner shall submit a report to the...General Assembly containing recommendations resulting from the study."

-- Session Law 2011-391

Goals for Today's Meeting

- Present Statement of TAG Values/Goals for Consideration
- Ensure TAG Members Have a Shared Understanding of the:
  - Policy Questions Related to the Small Group Market
  - Policy and Legal Background on Each Question (e.g., Relevant Guidance, NC Statutes, etc.)
  - Potential Market Considerations Related to Each Question
  - Options and Implications for Further Discussion at the TAG 2 Meeting

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Develop and Confirm Goals for Post-ACA Market

Task:

What goals or values should guide or inform the recommendations?

TAG Feedback from 1/5 Kick-Off Meeting:

1. **Ease of customer engagement – ensure clarity to customer with regard to options in the HBE, provide options that bring value to consumers**
2. **Sustainability of the HBE**
3. **Predictability/stability for market stakeholders inside and outside of the HBE**
4. **Accountability through transparency**
5. **Coverage – increase coverage, decrease the number of uninsured**
6. **Consumer empowerment and informed choice**
7. **Improved care delivery and improved health outcomes – policy options should be considered in light of the extent to which they impact care delivery and improve health outcomes**
8. **Innovations in payment and care delivery – build the market so it does not impede innovation**
9. **Competition – improve competition among plans/carriers to provide more choices to consumers**

Statement of Values to Guide TAG Deliberations

The TAG will seek to evaluate the market reform policy options under consideration by assessing the extent to which they:

- Expand coverage;
- Provide high-value coverage options in the HBE and empower consumers to make informed choices;
- Ensure predictability for market stakeholders, competition among plans and long-term sustainability of the HBE;
- Allow for innovations in payment and care delivery that can control costs and improve the quality of care; and
- Facilitate improved health outcomes for North Carolinians.

TAG Input: Coverage; affordability to consumers

TAG Input: Consumer empowerment & informed choice; affordability to consumers; ease of customer engagement; accountability through transparency

TAG Input: Stability for stakeholders; improved competition; HBE sustainability

TAG Input: Innovations in payment & care delivery

TAG Input: Improved care delivery & health outcomes

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Small Group Market Landscape Pre- and Post- ACA

Projected North Carolina Enrollment by Group Type			
Market	Year 2013	2014	2016
ESI – Small Group *(up to 50 employees)*			
HBE	N/A	51,149	35,398
Non-HBE	634,937	549,687	468,265
Subtotal	634,937	600,836	503,663
ESI – Small Group *(51 - 100 employees)*			
HBE	N/A	N/A	22,676
Non-HBE	301,599	300,246	234,087
Subtotal	301,599	300,246	256,762
ESI – Large Group *(More than 100 employees)*			
Non-HBE	3,545,881	3,655,325	3,708,631
Subtotal	3,545,881	3,655,325	3,708,631
Total ESI Coverage	**4,482,217**	**4,556,407**	**4,469,056**
Total SHOP Enrollment	**N/A**	**51,149**	**58,074**

SOURCE: Milliman. "North Carolina Health Benefit Exchange Study." July 2011.

Observations:

- **Projected enrollment in the SHOP Exchange is low**
  - 51,149 (9% of the 1-50 market) are projected to enroll in SHOP in 2014
  - SHOP enrollment as a % of total enrollment will decline to 6% (from 9%) by 2016, as the tax credits expire
- **Small group (< 50) enrollment overall will continue to decline primarily due to issues related to affordability, some of which are irrespective of ACA**
- **Overall ESI enrollment remains relatively stagnant as gains in large group are offset by losses in groups under 100**

TAG Meeting #2 Issues for Discussion

Small Group Market Discussion Items

- **Should the Individual and Small Group Markets be Merged?**
- Should the Definition of the Small Group Market be Expanded?
- Should the Self-Insurance Statute Change in Light of ACA?
- What is the Appropriate Definition of "Employee" in Light of ACA?
- How Should Groups of "1" be Handled in Light of ACA?
- How Much Choice Should Employers Have the Option to Give Employees, in SHOP?

Relevant Laws and Regulations

ACA and Federal Guidance:

- A state may elect to merge its individual and small group markets. *(PPACA Section 1312(c)(3))*
  - If state merges the individual and small group markets, the SHOP may offer employers and employees QHPs that meet SHOP requirements for QHPs (such as those related to deductible maximums and employer choice requirements described in the ACA). If a state does not merge the markets, the SHOP may only make small group QHPs available to qualified employees. *(Exchange Establishment NPRM § 155.705(b)(7))*
- Requires insurers in the individual and/or small group market to consider all enrollees in all plans offered by the insurer in the applicable market as members of a single risk pool, both in and out of the exchange. *(PPACA Section 1312(c)(1-2))*

North Carolina Statute:

- The "individual market" is defined as "the market for health insurance coverage offered to individuals." *(NCGS § 58-68-25(a)(9))*
- The "small group market" is defined as "the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer." *(NCGS § 58-68-25(a)(17))*

NC HB 115:

- In compliance with the ACA, requires any issuer to consider all enrollees in all plans offered inside and outside the Exchange as members of single risk pool within each market; does not address the issue of merging the individual and small group markets. *(NC HB 115)*

Considerations

Merging requires insurers to place individual and small group markets into one risk pool. It does not require insurers to participate in both markets or offer the same products. In most states, the two markets do not have similar rating rules (e.g., no guaranteed issue for individuals). While the ACA will normalize the rules between markets, there may be lasting impacts on relative risk, which may or may not fade over time.

Pros Anticipated from Merging the Small and Individual Group Markets in North Carolina	Cons Anticipated from Merging the Small and Individual Group Markets in North Carolina
▪ Bring down costs for individual health insurance premiums ▪ Allow North Carolina to consider integrating the two markets beyond risk pools (e.g., products/premiums)	▪ Cause premiums to rise for the small group market[1] – In 2014, the individual market is significantly less healthy than the small group market ▪ Could lead small groups who experience significant rate increases to drop coverage – Merged market projected to decline by 130,676 (9%) ▪ Impact carriers differently based on market participation, which could cause further market disruption

[1] Under current NC law, insurers can rate an employer group up or down 25% based on the group's experience. Starting in 2014 those rate adjustments will not be allowed. Therefore, groups receiving a 25% discount, already, will receive a significant premium increase in 2014, irrespective of the option to merge the market.

SOURCE: Manatt Analysis; Milliman, "North Carolina Health Benefit Exchange Study," July 18, 2011.

Responses from Other States

Other States' Approaches to Merging the Individual and Small Group Markets

- No state has thus far elected in HBE establishment legislation to merge the individual and small group markets.
- A number of states' establishment legislation requires a study of the issue including: California, Connecticut, Maryland, and Washington.

Pre-ACA Approaches to Merging the Individual and Small Group Markets

- Legislation that established the Massachusetts HBE in 2006 required creation of a Commission to study the issue of whether markets should be merged. (Massachusetts already had guaranteed issue in the individual market.)
- The small group and individual markets were merged in 2007. MA did not require insurers to operate in both markets or offer the same products.

Options and Action Steps

Options	Action Steps
Merge the Individual and Small Group Markets	• Consider interaction with stop-loss coverage and expansion of small group market definition. • Requires legislation.
Do Not Merge the Individual and Small Group Markets	• No action required.
Defer Decision to a Later Date	• Set a timeframe to revisit the issue after 2014 when the guaranteed issue rules are the same in both the individual and small group market. • Suggest a study to either re-examine the issue at a later date, once the effects of reform are known and both markets operate under similar rating rules, or on an ongoing basis to examine potential impacts both pre- and post- ACA.

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- What is the Appropriate Definition of "Employee" in Light of ACA?
- How Should Groups of "1" be Handled in Light of ACA?
- How Much Choice Should Employers Have the Option to Give Employees, in SHOP?

Relevant Laws and Regulations

ACA and Federal Guidance:

- Prior to 2016, a state may elect to define "small employers" either as those with 100 or fewer employees, or those with 50 or fewer employees. Beginning in 2016, small employer must be defined as those with 100 or fewer employees. *(PPACA Section 1304)*
  - The SHOP must treat employers which cease to be a small employer solely by reason of an increase in the number of employees as a qualified employer until the employer otherwise fails to meet the eligibility criteria or elects to no longer purchase coverage for qualified employees through the SHOP. *(Exchange Establishment NPRM, §155.710(d))*

North Carolina Statute:

- "Small employer" means any individual actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than 50 eligible employees, the majority of whom are employed within the state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. *(NCGS §58-50-110(22))*
  - In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by the state, are considered one employer. *(NCGS §58-50-110(22))*
  - Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer is determined annually. *(NCGS §58-50-110(22))*
  - Except as otherwise specifically provided, provisions that apply to a small employer continue to apply until the plan anniversary following the date the small employer no longer meets the requirements of this definition. *(NCGS §58-50-110(22))*

NC HB 115:

- "Small employer" is given the same definition as under NCGS§58-50-110(22) *(see above)*, subject to the requirements of the Federal Act and the Public Health Services Act (PHSA). *(NC HB 115)*

Considerations

Expanding the definition of the small group market requires that groups of 51 to 100 be subjected to the same requirements as groups of 1 to 50, both in and out of the exchange. This includes rating requirements and practices.

Pros from Expanding the Small Group Market	Cons from Expanding the Small Group Market
▪ Stabilize the Market for Groups of 1 to 50	▪ Cause premiums to rise, significantly, in the 51 to 100 market for healthy groups
▪ Lower PMPM HBE administration costs, as more people will be eligible to purchase through the HBE (if the HBE is funded solely through operations)	▪ Could lead to groups who experience significant rate increases to drop coverage
▪ Make it easier for insurers to meet new MLR requirements (if NC does not expand the definition of the small group market separately for MLR)	▪ Could lead groups to consider self-insurance options
	▪ Impact carriers differently based on market participation, which could cause further market disruption

Responses from Other States & Stakeholders

Other States' Approaches to Small Employer Definition

- No state has thus far elected in HBE establishment legislation to expand the definition of "small employer" to include those with 100 or fewer employees prior to 2016.
- A number of states' establishment legislation requires a study of the issue including: Colorado, Connecticut, Maryland, Vermont, and Washington.

Excerpts of National Dialogue

- **AHIP:** "...allowing larger groups (such as those above 50 into the Exchange prior to 2016) could prove disruptive – especially taking into account that the establishment of a network of Exchanges has never been attempted before. [...] it is crucial that states take a measured and cautious approach to expanding the group size limit in order to preserve stability and choices in the market as they exist today."
- **Families USA:** "Defining small businesses as those with up to 50 workers may have different effects in different states, so states may want to conduct studies of their insurance markets to see how this option would affect consumers."

Options and Action Steps

Options	Action Steps
Expand the Small Group Market, to be Effective by 2014	• Consider implications of definition of an employee and the stop-loss statute. • Requires legislation.
Do Not Expand the Small Group Market until Required (by 2016)	• Set a timeframe for addressing the issue prior to 2016 implementation. • Consider a study to further address the market impacts prior to implementation. Study should perform analysis of market impact in a post-ACA world.

TAG Meeting #2 Issues for Discussion

Small Group Market Discussion Items

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- **Should the Self-Insurance Statute Change in Light of ACA?**
- What is the Appropriate Definition of "Employee" in Light of ACA?
- How Should Groups of "1" be Handled in Light of ACA?
- How Much Choice Should Employers Have the Option to Give Employees, in SHOP?

Relevant Laws and Regulations

ACA and Federal Guidance:

- **Exception for Self-Insured Plans and MEWAS** – The ACA exempts self-insured plans from a number of regulatory requirements *(PPACA Section 1201, 1301, 9010)* and specifies that the term "health plan" does not include "a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514" of ERISA. *(PPACA Section 1301(b))*
- **ACA does require:**
  - **Annual Report on Self-Insured Plans** – Requires the Secretary of Labor to prepare an aggregate annual report to Congress with general information (e.g., plan type, number of participants, benefits offered) and financial information (e.g., assets, liabilities) on self-insured group health plans. *(PPACA Section 1253)*
  - **Study of the Large Group Market** – Requires the Secretary of HHS to conduct a study of fully-insured and self-insured group health plans, including the extent to which ACA market reforms will prompt small and mid-size employers to self insure. *(PPACA Section 1254)*

North Carolina Statute:

- "No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers that does not comply with the underwriting, rating, and other applicable standards in this Act." *(NCGS § 58-50-130(a)(5))*

Self-Insurance Background and Trends

Group is Fully Insured	Group is Self-Insured
▪ Health insurer assumes most risk ▪ Employer/employee pay premiums to health insurer ▪ Benefits/plan designs are subject to state (and ACA) requirements ▪ Pricing of premiums is subject to the state's rating rules and requirements (and ACA) ▪ Other state and federal rules/regulations may apply (e.g., premium taxes, assessments, etc.)	▪ Employer assumes most risk ▪ Employer/employee pay premiums to the employer ▪ Employer pays a health insurer for administrative capabilities (e.g., claims payments; provider networks) ▪ Employer also may pay to separately purchase some form of stop loss protection ▪ Group is covered under ERISA; state rules/regulations may not apply (e.g., premium taxes, benefit packages, and premium rating, etc.)

NC law provides the conditions which an insurer who chooses to issue reinsurance (stop loss insurance) to a self-funded small employer group must meet in order to issue the reinsurance (stop loss insurance) coverage.

Considerations

- **Self-insurance is attractive to companies with lower than average risk**
  - Costs are cheaper for employers to self-insure if premiums are based on a risk pool comprised of companies with higher than average risk
  - A 2011 RAND study estimated that if stop-loss coverage was available with attachment points as low as $20,000, 33% of employers with fewer than 100 employees would self-insure
- **Self-insured companies are not subject to key regulatory requirements under ACA[1] and:**
  - can develop their own benefit packages that deviate from the EHB package
  - do not participate in the risk adjustment program; employees do not count toward any risk pool
  - are exempt from the annual fee assessed on insurers *(PPACA Sec. 9010)*
  - are not subject to MLR requirements (as they are not considered insurers)
  - are not subject to the rate review process
- **If the cost savings from self-insuring dissipate, employers can join the SHOP or stop offering coverage, entirely**
- **If many "healthy" small groups self-insure, premiums in the fully-insured market will rise at unsustainable rates and may cause less healthy groups to drop coverage**

[1]Self Insured groups are required to participate in the temporary reinsurance program

SOURCE: Institute for Health Policy Solutions, Inc. "Study of SHOP Exchange for the MD Health Benefit Exchange." November 9, 2011; Timothy Jost. "The ACA and Stop-Loss Insurance Statement to the NAIC ERISA (B) Subgroup."; Manatt Analysis.

Responses from Other States & Stakeholders

Other States' Approaches to Self-Insurance

- State HBE establishment legislation generally does not directly address the issue of self-insured plans.
- Connecticut's HBE establishment legislation requires the exchange to at least annually report to the General Assembly on the effect of adverse selection on exchange operations, including whether adverse selection is occurring with respect to self-insured plans.
- Delaware, New York and Oregon ban the sale of stop-loss insurance to small groups.

Excerpts of National Dialogue

• **NAIC:** "This issue can—and should—also be addressed by the states. The most straightforward approach would be to simply ban the sale of stop-loss insurance to small groups. [...] Alternatively, the current NAIC model stop-loss law could be strengthened to ensure that stop-loss insurance attachment points are high enough to ensure that it is true stop-loss insurance and not a sham."[1]

[1] http://www.naic.org/documents/committees_b_erisa_110908_jost.pdf

Options and Action Steps

Options	Action Steps
Impose a Ban on the Sale of Stop Loss Coverage to Small Group Employers	• Requires legislation. • NAIC is currently reviewing changes to the model regulation on stop-loss coverage; may be possible to use the new model regulation, once completed.
Consider Revisions to the Self-Insurance Statute which Add in Attachment Points	• Requires legislation. • Perform study that would set attachment points, review legality of such a move.
Leave Current Statute That Places Requirements on Reinsurers Unchanged	• Consider reinforcing current interpretation of statute. • No additional steps required.
Defer Decision to a Later Date	• Request that a study be conducted which would require a decision at a later date. • Possibly mandate study in enabling legislation.

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- **What is the Appropriate Definition of "Employee" in Light of ACA?**
- How Should Groups of "1" be Handled in Light of ACA?
- How Much Choice Should Employers Have the Option to Give Employees, in SHOP?

Relevant Laws and Regulations

ACA and Federal Guidance:

- The definition of employee includes full-time and part-time employees. *(PHS Act § 2791(d)(5)(1))*[1]
  - Seasonal workers do not count as employees unless the worker worked more than 120 days. *(PPACA, Section 45R(d)(5)(A))*
- An employer's number of employees is determined by averaging the total number of all employees employed on business days during the preceding calendar year. *(PHS Act § 2791(e)(2) and (4))*[1]
  - The size of employers not in existence the preceding calendar year is based on the average number of employees that the employer reasonably expects it will employ on business days in the current calendar year. *(PPACA, Section 1304(b)(4)(B))*

North Carolina Statute:

- Employee is defined as a non-seasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis. *(NCGS § 58-51-80(c))*
  - "Eligible employee" [for counting for determination of group size] means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis. *(NCGS §58-50-110(10))*

[1] CCIIO Technical Guidance (CCIIO 2011-004): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule, July 18, 2011. Available at: http://cciio.cms.gov/resources/files/20110718_mlr_guidance.pdf

Considerations

ACA increases the number of employees that count in determining group size. Employers just below 50 FTEs likely will no longer qualify as a small group. Initial federal guidance suggests that there may be state flexibility in determining a specific approach for insurance regulation purposes. The IRS is less likely to offer flexibility, which will result in less employers qualifying for the tax credit and more employers subject to the penalty for not offering insurance.

Pros of Changing the Definition to Meet Federal Requirements	**Cons of Changing the Definition to** Meet Federal Requirements
▪ Less incentive to "game the system" (e.g., hiring a person for 29 hours per week)	▪ As employers determine new process for counting FTEs, there may be confusion as to which ACA rules and provisions apply to employers with close to 50 employees (e.g., rating rules, MLR)
▪ Some employers might favorably view being out of the small group market	▪ Some employers might unfavorably view being moved out of the small group market

Options and Action Steps

Options	Action Steps
Act Now to Comply With ACA statute	• Define employee as ACA defines employee. • Reconcile current NC General Statute with ACA definition.
Wait to Define Employee Based on Flexibility that the Feds May Allow	• Wait for forthcoming federal guidance on specific definition of an employee, including state flexibility in defining an employee and the methodology for counting. • Determine NC policy based on that guidance. • May require legislation.

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- How Much Choice Should Employers Have the Option to Give Employees, in SHOP?

Relevant Laws and Regulations

ACA and Federal Guidance:

- "Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term must include employers with one or more employees." *(Exchange Establishment NPRM $155.20)*
- "Because the PHS Act definition of employer and ERISA definition of group health plan refer to at least 1 employee, they exclude sole proprietors, certain owners of S corporations, and certain relatives of each of the above." *(Exchange Establishment NPRM, Preamble)*

North Carolina Statute:

- "Self-employed individual" means an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F and which generated taxable income in one of the two previous years. *(NCGS § 58-51-110(21a))*
  - Small employers include self-employed individuals. *(NCGS § 58-51-110(22))*

Considerations

Federal guidance excludes sole proprietors from small group coverage. States that allow sole proprietors to purchase group coverage frequently do so to ensure they are subject to guarantee issue requirements – a consideration no longer needed under ACA. CMS is considering altering its interpretation of the statute to include sole proprietors.

Pros from Excluding Sole Proprietors in the Small Group Market	Cons from Excluding Sole Proprietors in the Small Group Market
▪ Impact may be minimal since ACA requires guaranteed issue in the individual market	▪ Not able to purchase coverage in the SHOP exchange, or in the small group market overall
▪ May have positive impact upon premium rates for remaining small employer groups	▪ Sole proprietors could "ping-pong" between the individual and small group exchange as they gain or lose employees

SOURCE: Manatt Analysis; NAIC Letter to CMS, available at:
http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services2.pdf

Responses from Other States & Stakeholders

Other States' Approaches to Self-Insurance

- No other states appear to have addressed this issue in enabling legislation.
- Most states that passed enabling legislation to date did so prior to the Establishment of Exchanges and Qualified Health Plans proposed regulations, and many states may have assumed that groups of one included sole proprietors.

Excerpts of National Dialogue

• **NAIC:** "We were concerned with the [NPRM]'s statement that sole proprietors, certain owners of S corporations and their relatives would not be entitled to purchase coverage in the small group market under Federal law. We are concerned with this method of counting employees in the small group market, which is at odds with the way group size has been determined in the states since the passage of HIPAA in 1996. We are particularly concerned that this provision would exclude sole proprietors from purchasing coverage through the SHOP in the eleven states that currently allow them to purchase coverage through the small group market today. At the very least, we would suggest a clarification that a state may expand SHOP eligibility to sole proprietors and certain S-corporations without preventing the application of the ACA or the Exchange regulations."[1]

[1]NAIC Letter to CMS, October 5, 2011; Comment Period on the Establishment of Exchanges and Qualified Health Plans Proposed Regulation.

Options and Action Steps

Options	Action Steps
Mirror ACA Definitions	• Amend NC statute to conform to ACA's definition of a group of "1" and methodology for determining groups of "1."
Defer Decision to a Later Date	• Await further federal guidance to determine where flexibility resides in including sole proprietors and the methodology for determining groups of "1." • Consider further analysis to determine the number of sole proprietors in NC likely impacted by the changes.

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- What is the Appropriate Definition of "Employee" in Light of ACA?
- How Should Groups of "1" be Handled in Light of ACA?
- **How Much Choice Should Employers Have the Option to Give Employees, in SHOP?**

Relevant Laws and Regulations

ACA and Federal Guidance:

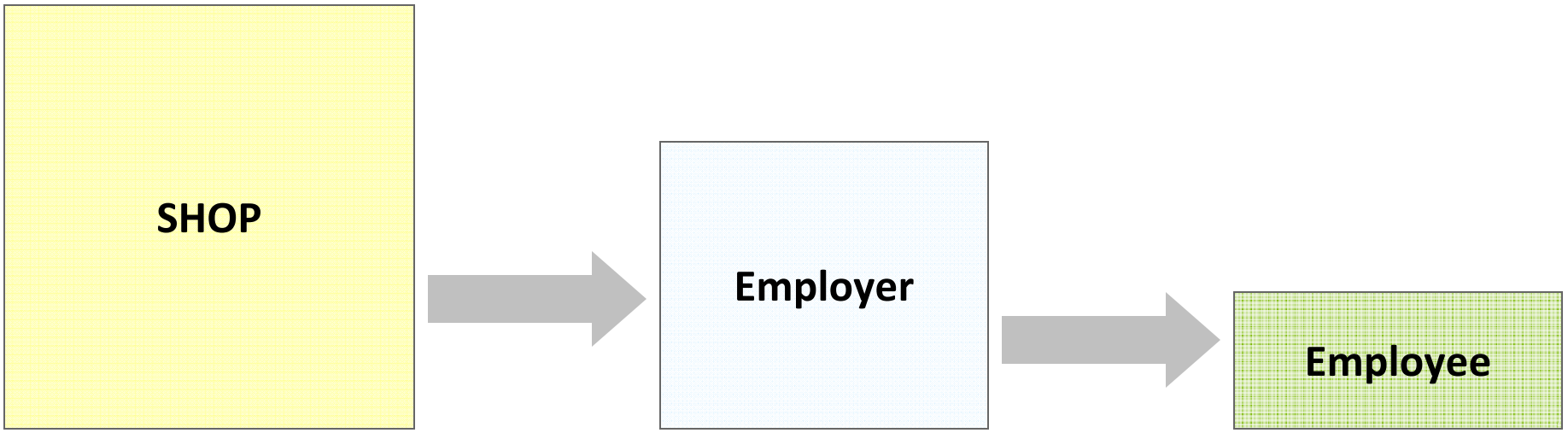
- Employers may specify a level of coverage for their employees, and employees may choose any qualified health plan that offers coverage at that level. *(PPACA Section 1312(a)(2))*
- Federal guidance provides increased flexibility for exchanges to choose additional ways for qualified employers to offer one or more plans to their employees *(Exchange Establishment NPRM, Preamble)*. For example, a state may:
  - -- (1) allow employees to choose any QHP offered in the SHOP at any level;
  - -- (2) allow employers to select specific levels from which an employee may choose a QHP;
  - -- (3) allow employers to select specific QHPs from different levels of coverage from which an employee may choose a QHP; or
  - -- (4) allow employers to select a single QHP to offer employees.

NC HB 115:

- A qualified employer either may designate one or more qualified health plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange. *(NC HB 115)*

Background

ACA mandates that the SHOP permit employers the option of offering a single benefit level (e.g., platinum, gold, silver, bronze). ACA also permits the SHOP to offer employers other options, including those that allow for more employee choice and those that allow for less employee choice.



- Must permit employers the option of offering a single benefit level
- May offer employers other options - with either more or less choice than above

- Choose among the options the SHOP offers

- Signs up for a plan based on the option the employer selected
- May have many choices or one choice

Considerations

Pros of Offering Greater Employee Choice

- Could provide employees with the option that works best for their particular needs
- Drives toward a "defined contribution model" which creates incentives for employees to select the most cost-effective plan
- Limits number of times a worker switches plans because of a switch in jobs to another small employer
- May create employer incentive to join the SHOP if employer wants more employee choice
- Allows employees more choice, which was a key policy goal of ACA

Cons of Offering Greater Employee Choice

- Departs from the way the market currently operates
- Leads to adverse selection in the SHOP, particularly if there are no constraints on movement among benefit tiers
  - While ACA contains several risk-equalizing mechanisms, these mechanisms may not entirely compensate carriers for adverse selection
- Leads to higher premiums, as insurers build in "risk premiums" to account for operating in a market where employees can select from multiple insurers
- Causes employee confusion in the number of selections available

SOURCE: Manatt Analysis; Institute for Health Policy Solutions. "Analysis of Key Maryland SHOP-Related Policy Options." November 9, 2011.

Considerations

Pros of Offering Traditional Employer "Pick and Plan" Model	Cons of Offering Traditional Employer "Pick and Plan" Model
▪ Consistent with the way most employers (and insurers) operate today ▪ No increased risk to insurer, and thus no increase in the premium to account for that risk, because all employees are in the same plan	▪ May make it difficult for employee choice model to reach critical mass

Responses from Other States

Other States' Approaches to Employer/Employee Choice

- State HBE establishment legislation does not extensively address employer choice in the exchange and generally requires compliance with basic ACA requirements (i.e., employers may select level of coverage and employee may choose plan from within the specified level).
- Maryland's legislation requires a study to determine 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."

Pre-ACA Approaches to Employer/Employee Choice

- Massachusetts started with an employee choice model and eventually scaled back to the more traditional approach whereby an employer picks 1 plan for everyone.
- Utah operates under a defined contribution plan model (employers decide only how much to contribute to employee coverage; employees, not employers, choose between plans/insurance carriers/provider networks, etc.).

Options and Action Steps

Options	Action Steps
Allow only ACA-Required Employee Choice Model	• Give employer the ability to offer a single benefit level as required under ACA. • Determine whether legislation would be necessary or desired.
Add an Option to Allow Traditional Employer "Pick a Plan" Model	• Allow employers to have the ability to select an option which would provide less employee choice, such as the employer selecting a single QHP. • Determine whether legislation would be necessary or desired.
Add an Option to Allow More Employee Choice	• Allow employers to have the ability to select an option which would provide more employee choice, such as defined contribution model, or a choice of 2 benefit tiers, or multiple plans, for example. • Determine whether legislation would be necessary or desired.
Defer Decision to the SHOP Exchange	• Include in legislation that the SHOP exchange should decide the option of allowing a traditional employer "pick a plan" model or the option of more employee choice.

Discussion Roadmap

- Project Goal and Webinar Objectives
- Statement of Values and Goals for TAG
- Overview of Issues for Discussion in TAG Meeting #2
- **Next Steps**

Next Steps and Questions

- **Consider Information Provided for Discussion**
  - At next In-Person TAG Meeting, we will briefly review each area and quickly move into a discussion of each topic.
  - Email comments or thoughts on additional considerations or options to agarcimonde@manatt.com.
- **Review TAG #1 Kick Off Meeting Notes**
  - Notes will be approved at January 27 In-Person TAG meeting.
- **Attend meeting on Friday, January 27th from 9:30AM to 12:30PM**

Any Questions?

Appendix

- National Dialogue on TAG #2 Issues

National Dialogue on TAG #2 Issues

America's Health Insurance Plans (AHIP)
Comments on Expanding the Definition of the Small Group Market
"States should consider carefully the implications of expanding the group size limit beyond 50 for purposes of determining the size of employer groups eligible to access the Exchange, and determine whether the Exchange is an appropriate channel for larger employers to access coverage in the market. Issues of transition are also very important, such that allowing larger groups (such as those above 50 into the Exchange prior to 2016) could prove disruptive – especially taking into account that the establishment of a network of Exchanges has never been attempted before. In addition, the large employer market may have very different products that are tailored to a larger employee base. In order to preserve stability in the market today, it is crucial that states take a measured and cautious approach to expanding the group size limit in order to preserve stability and choices in the market as they exist today." http://www.ahip.org/Issues/Documents/2010/AHIP-Letter-to-HHS-on-Health-Insurance-Exchange-Regulations.aspx
Comments on Merging the Individual and Small Group Market
"When considering whether to merge the markets, states should carefully consider the impact that merging of the markets will have on the cost of coverage to individuals and employers. Several states have examined this issue including Vermont, Oregon and Massachusetts. A study conducted on behalf of the Vermont Health Care Commission found that a merged market would most likely not lower average premiums appreciably and would not have a material impact on the number of uninsured residents in the state. Additionally, the report concluded that a merger could be very disruptive, causing a large increase for some individuals buying insurance with significant adverse selection possible between the group and individual markets. States should be cautious in considering the potential disruption and increase in premiums possible when merging the small group and individual markets. Any effort to do so should ensure that the phase-in occurs over the appropriate time period to allow study of the issue and evaluation of its impact." http://www.ahip.org/Issues/Documents/2010/AHIP-Letter-to-HHS-on-Health-Insurance-Exchange-Regulations.aspx

National Dialogue on TAG #2 Issues

American Academy of Actuaries
Comments on Merging the Individual and Small Group Market
"Several complexities are associated with the situation in which individual and small-group markets are merged (e.g., state regulations treat the direct pay and small-group market as one combined risk pool). The proposed regulations do not address this situation. We would welcome the opportunity to assist CMS as this issue is considered." http://www.actuary.org/pdf/health/Academy_comments_on_NPRM_on_exchanges_100611_final.pdf
Comments on Employer Choice in the Exchange
"Employee choice in a small business health options program (SHOP) exchange creates unique and complex considerations. There are two main approaches to employee choice—each approach has advantages and disadvantages. In the first approach, the employer plays a much larger role. There are many variations, but the most basic is that the employer chooses the specific benefit plan from a single carrier. This is similar to what occurs in most small-group markets today. The only choice individual employees have in this circumstance is whether to purchase insurance and what type of dependent coverage they will elect. The advantage of this approach is that individual adverse selection generally is minimized and composite rating can be retained. One disadvantage is that individual employees have no flexibility regarding the types of benefit plans and/or the provider network." "The second approach allows individual employees to choose across a wider spectrum of plans and benefit levels. In these cases, the employer can choose a specific benefit level (e.g., gold) and employees are allowed to choose among all the carriers offering gold plans. It is assumed that the employer will contribute a specific amount (defined contribution) and the employee must make up the difference depending on his or her choice. The advantage of this second approach is that employees have the opportunity to choose the health insurance plan most closely aligned with their own and/or their dependents' health care needs. One disadvantage of this approach is that it maximizes the potential for adverse selection, which will have to be adjusted for in any risk-adjustment model. There also is the possibility that this second approach would increase the administrative costs of the exchange, given the parsing of enrollment from within a group and the complexity associated with tracking individuals on a stand-alone basis or aligned within their group [...]we suggest that the SHOP exchange require the employer to make the carrier or plan selection for all employees." http://www.actuary.org/pdf/health/Academy_comments_on_NPRM_on_exchanges_100611_final.pdf

National Dialogue on TAG #2 Issues

Center on Budget and Policy Priorities
Comments on Merging the Individual and Small Group Market
"Merge the Individual and Small-Group Markets over Time: Merging the small-group and individual insurance markets within a state can allow one exchange to serve both individuals and small businesses, substantially increasing its potential enrollment volume. While larger enrollment does not guarantee a risk pool for the exchange that is well-balanced between the healthy and the sick, it does make it more likely. Greater enrollment also will promote more robust competition among insurers within an exchange. Depending on the nature of the insurance market in a state, merging the individual and small-group markets may increase prices for non-grandfathered plans in either the individual or small-group market to some extent. In Massachusetts, merging the individual market with the larger and more stable small-group market helped bring down premium costs for people purchasing coverage on their own, though it may have raised prices modestly for some small-group purchasers. Merging the markets would mean that insurers would establish the same base prices for products sold to both individuals and small businesses, prior to applying premium differentials related to age and other allowable factors. In other words, insurers would treat their individual and small-group enrollees as one pool when setting their prices and offer them the same products. States considering whether to merge these markets have many factors to weigh, and some states may be reluctant to do so immediately in 2014. States may wish to focus first on instituting the Affordable Care Act's major changes in the premium rating rules in both their individual and small-group markets. Starting in 2014, the health reform law bars non-grandfathered plans in the small-group and individual markets from considering health status and gender when setting premiums for individuals or small businesses, and insurers will face new limits on how much they can take age into account. This is likely to initially cause some substantial shifts in premiums, whether up or down, for individuals and small firms. Once the new rules are in place in both the individual and small-group markets, however, it would likely be easier for a state to merge these markets. Therefore, a state could merge the markets several years after the Affordable Care Act's major changes in rating rules are implemented in 2014. Because the new premium rating rules will be consistent across the individual and small-group markets and will have been in effect for several years, these markets could be merged within an exchange at that time with less risk of market disruption." http://www.cbpp.org/cms/index.cfm?fa=view&id=3267

National Dialogue on TAG #2 Issues

Families USA
Comments on Expanding the Definition of the Small Group Market
"Defining small businesses as those with up to 50 workers may have different effects in different states, so states may want to conduct studies of their insurance markets to see how this option would affect consumers." http://familiesusa2.org/assets/pdfs/health-reform/Guide-to-Exchanges.pdf
Comments on Merging the Individual and Small Group Market
"Having a larger risk pool could attract more insurers to the exchange and spread risks better among enrollees. It could also help reduce administrative costs. Combining markets may cause some shift in premiums (for example, increased rates for small employers and lower rates for individuals), so states may want to study the effects of merging these markets before proceeding. States can also wait a few years after the exchange starts to merge the markets, leaving time for both the small group and individual markets to adjust to the new rating rules under the Affordable Care Act." http://familiesusa2.org/assets/pdfs/health-reform/Guide-to-Exchanges.pdf

National Dialogue on TAG #2 Issues

National Association of Insurance Commissioners (NAIC)
Comments on Expanding the Definition of the Small Group Market
NAIC would like to "include the self-employed in the small group market [...] should HHS go forward with this interpretation of the meaning of “at least one employee” we request clarification that states are free to go beyond this definition of small employer, as they did with HIPAA, and expand the small group market to include the self-employed.” "ACA specifically allows states to merge their small group and individual markets, if they choose. There is no reason to prevent states, at their option, from continuing to allow sole proprietors, certain owners of S corporations, and their relatives the choice to purchase coverage in the small group market where they can participate in the SHOP, or in the individual market where they may be eligible for subsidies." http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services2.pdf
Comments on Changing the Self-Insurance Statute
“This issue can—and should—also be addressed by the states. The most straightforward approach would be to simply ban the sale of stop-loss insurance to small groups. Delaware, New York, and Oregon currently ban the sale of stop loss insurance to small groups, so there is ample precedent. Alternatively, the current NAIC model stop-loss law could be strengthened to ensure that stop-loss insurance attachment points are high enough to ensure that it is true stop-loss insurance and not a sham.” http://www.naic.org/documents/committees_b_erisa_110908_jost.pdf
Comments on Employer Choice in the Exchange
“NAIC agrees with your interpretation of section 1312(f)(2)(B) of the ACA to permit “employer choice” whereby an employer can select a single QHP for its employees.” http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services2.pdf

National Dialogue on TAG #2 Issues

State Health Access Data Assistance Center (SHADAC)
Comments on Merging the Individual and Small Group Market
"States have the option of creating separate exchanges for individuals and small businesses or of combining the non-group and small group markets into a single exchange (generally, this will be feasible only if states choose to combine these markets outside the exchange as well). [...] Separate exchanges for individuals and small businesses might allow states to better focus on the needs of the target group but could be more costly than a combined exchange. A combined exchange could support more consumer choice but might also create challenges if the risk profiles of non-group and small group markets differ." http://www.shadac.org/files/shadac/publications/IssueBrief23.pdf