State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
December 2012

Design Considerations in Structuring Employee Choice for SHOP Exchange

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TABLE OF CONTENTS

Introduction & Executive Summary 3
Employee Choice Models 4
Adverse Selection 5
Mitigating Market Adverse Selection in Shop 6
Employee Choice 6
Standardization 7
Minimum Employer Contribution 8
Summary 8

Introduction & Executive Summary

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

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

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

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

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

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

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

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

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

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

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

Employee Choice Models

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

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

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

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

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

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

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

One Plan

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

One-Issuer/Multi-Tier

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

Multi-Issuer/One-Tier

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

Multi-Issuer/Multi-Tier

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

Full Menu

	Health Plan A	Health Plan B	Health Plan C	Health Plan D
Platinum				
Gold				
Silver				
Bronze				

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

Adverse Selection

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

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

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

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

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

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

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

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

One Silver Plan Offered to 2-Person Group:

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

In a Choice Situation, Employee A Selects Bronze:

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

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

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

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

Mitigating Market Adverse Selection in SHOP

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

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

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

Employee Choice

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

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

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

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

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

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

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

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

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

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

Standardization

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

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

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

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

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

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

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

Minimum Employer Contribution

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

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

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

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

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

Summary

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

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

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

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

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

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

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2 See, for example, Jonathan Gruber. *"Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?"*. Henry J. Kaiser Foundation, March 2009;
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