State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
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Premium Allocation and Employer Contribution Strategies for SHOP

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The Problem

The primary value proposition for the Small Business Health Options Program (SHOP) is to promote employee choice of health plans. A key challenge in doing so is to develop premium rating methods, without discriminating against older employees, that will support (a) employee choice of health plans based on value (including premiums), (b) a defined employer contribution[1], (c) a fair allocation of premiums among issuers, and (d) a premium invoice which employers can understand. This brief explains the challenge and six options that SHOP exchanges can consider for resolving it. Various combinations of billing and contribution approaches define the six methods. None of the six are perfect, and each presents different incentives for employees, and liabilities for employers and issuers.

As of 2013, health plans generally develop and invoice small group premiums under adjusted community rating by one of two methods: list billing or composite billing. With the former, each employee is individually rated and his/her particular premium is shown on the employer's invoice. With the latter, one average employee rate is computed for each group and displayed by rating tier. ("Rating tier" refers to the composition of subscriber plus dependents under coverage, e.g., employee-only, employee + spouse, 3+ family.) In many states, composite rating and billing is the norm, either for all small groups or those above a certain threshold size, generally five to ten employees. It is simpler for customers to follow than tracking different premiums for each employee. Absent state law to the contrary, federal regulations give small employers their choice of billing methods, and for reasons we discuss below, those who are accustomed to composite billing are likely to retain it.[2]

As of 2013, employers generally contribute toward group insurance by one of two methods: a fixed-dollar amount or a percentage of premium. With the former, the same dollars are contributed by the employer for all employees in a rating tier. By contrast, when employers contribute a percentage of premium, if the employees are list billed or given a choice of health plans, the employer's dollar contribution is not fixed, but will vary with allowable rating factors and/or employees' plan choices.

[1] "Defined contribution" in the context of employee health benefits refers to a dollar amount per employee that the employer contributes, regardless of which plan an employee selects. However, legitimate rating variables – including age in most markets and family size even under pure community rating – affect premiums, so "pure" defined contribution may not mean the same dollar contribution from an employer for each employee.

[2] 45 CFR, Parts 144, 147, 150, 154 and 156 (February 22, 2013), Section 147.102(c)(3) Fair health insurance premiums; and CFR 45, Parts 144, 147, 153, 155, and 156 (June 19, 2013) Section 155.705 Functions of a SHOP.

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Robert Wood Johnson Foundation

The Centers for Medicare & Medicaid Services' (CMS) final market rule, published February 22, 2013, requires that, as of plan years beginning in 2014, rates be computed by carriers in the nongroup and small-group markets on the basis of allowable rating factors (age, family size, geography and tobacco use) applied to each individual beneficiary—subscriber, spouse, dependents 21 years or older, and the three oldest dependents under 21.[3] This is individual rating. However, where employers are accustomed to composite rating, carriers are likely to continue to average these individually computed rates across the entire employee group for the purpose of invoicing employers. We will refer to this as "composite billing" to distinguish it from composite rating. Federal rules allow issuers to present small group rates as average employee amounts, and they even allow states to require carriers to do so.

To illustrate the difference between composite and list billing, we provide examples of the two types of bills for the same small employer group. On our sample composite bill, only two rates appear: $532.86 for employee-only and $1,404.66 for families. By contrast, on the list bill each employee's premium rate (in red type) is unique.

Composite Invoice from Carrier

GROUP NUMBER	GROUP NAME	INVOICE PERIOD	PAGE NO 1

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

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

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

[3] Ibid.

List billing makes transparent to the employer what they generally know, but may tend to forget, that older employees cost more than younger employees for equivalent coverage. Also, list billing automatically adjusts premiums for changes during the plan year in the enrollee census, e.g., when a 64-year-old retires and a 25-year-old is newly hired, the older employee's larger premium is no longer invoiced, and a younger person's lower rate will be added. On the invoice below, each employee-only and family rate is unique to that subscriber. Jane Black's premium ($356.74) is lower than Ann Smith's ($558.96) because Jane is younger and therefore likely to incur lower claims than Ann.

List Invoice from Exchange

GROUP NUMBER	GROUP NAME	INVOICE PERIOD	PAGE NO 1

SUB NO.	SUBSCRIBER NAME	TYPE CHG	DATE	RATE	COVERAGE TOTAL	TOTAL AMOUNT DUE
	PRIOR AMOUNT BILLED:					$ 7,067.53
	PAYMENTS RECEIVED:					$ 7,000.00
	ADJUSTMENTS / INTEREST:					$ –
	BALANCE FORWARD:					$ 67.53
	BENCHMARK PLAN: **HMO BLUE NE SILVER**					
	CHARGES BASED ON RATES AND ENROLLMENT THRU 7/16/12					
123	SMITH, ANN				$ 558.98	
456	DOE, JOHN				$ 1,454.66	
789	BLACK, JANE				$ 356.74	
321	JONES, BOB				$ 1,058.08	
654	RAMSEY, OSCAR				$ 708.98	
987	MICHAELS, RICHARD				$ 1,003.99	
369	JOHNSON, BARRY				$ 1,203.99	

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

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

The difference between the two billing methods can be so dramatic that most small employers will want to continue with their current billing method, if only to avoid "rate shock" for employees. Consider, for example, a group of two employees, aged 24 and 60, who had gold level family coverage in 2013 for a monthly premium of $1,200 per employee; the employer contributes 50 percent ($600 for each), and the employees contribute the remaining 50 percent ($600 for each). In 2014, the group moves to list billing and, despite no change in total group premiums, the bills for the two employees swing wildly, to $600 for the 24-year-old and $1,800 for the 60-year-old. The employer continues to contribute 50 percent, but now the older employee has to kick in an extra $300 a month ($1,800 x 50% - $600). The younger employee reaps savings of exactly the same size. In effect, their relative compensations just changed by $600/month.

Composite billing also makes defined contribution relatively straight-forward: the employer decides how much of the average rate he/she will contribute, and that same dollar amount applies to everyone in a rating tier. In a multi-plan, employee-choice situation, such as SHOP exchanges will offer, the same defined contribution would apply to whichever plans the employees select. With the employer's dollar liability fixed, employees pay the difference in average premiums among the plans they select. By putting the marginal cost of choosing among different plans on the retail customer, this approach motivates value-

conscious shopping by the employee. (Private exchanges report strong tendencies of employees to buy lower-priced plans when given a choice of plans and a defined contribution.[4])

There is also more budget predictability for employers during the year with composite premiums, since the issuer bears the risk associated with changes in the enrollee census until the next plan year. That is, the premiums for each rating tier are locked in for the year, with the possible exception of census changes in excess of some threshold. (The accumulation of rating changes with employee churn throughout the year can lead to large rate swings at annual renewal.) While supporters of managed competition may only care that each employee receives a fixed contribution toward a choice of plans, employers who prefer defined contribution also care about fixing their expenses, regardless of the age of employees lost or added during the year. Composite billing allows them to do so.

Unfortunately, composite billing does a very poor job of matching premiums to risk in a multi-plan, choice situation. By contrast, list billing does a much better job of allocating premiums among multiple health plan options according to risk—at least in so far as age and the other allowable rating factors capture risk—but it presents other problems. First, as previously noted, composite rating is predominantly used in many small-group markets, and the disruption to employers from switching methods would be significant. Second, it is considered by some to be discriminatory against older workers because it "tags" them with higher premium costs, even though this is specifically allowed under regulations implementing the Age Discrimination in Employment Act (ADEA).[5] Third, list billing does not readily accommodate one element of what employers want from defined contribution, which is to fix their per-employee contribution at the beginning of each plan year.

Under list billing, employers generally contribute a percentage of premiums, rather than a fixed contribution. (A fixed-dollar contribution toward list bills that vary by age is thought likely to violate non-discrimination rules under the ADEA because the employer would contribute a smaller percentage toward an older worker's premium than a younger worker's premium.) The employer's percentage contribution toward a list bill from one health plan will vary for each employee by the applicable rating factors. In a multi-plan, employee choice situation, it would also vary with base premium of the plan selected by each employee. The employer's budget is less predictable, the employer subsidizes the selection of more expensive plans and employees are less motivated to shop on price. This is not an ideal structure for encouraging value-based competition among health plans and associated provider networks, as envisioned by supporters of managed competition.[6]

Hence, there is a tie between allowable forms of (a) employer contribution (fixed-dollar vs. percentage of premium) and (b) billing methods (composite vs. list billing). As indicated in the table below, a fixed-dollar contribution per rating tier under list billing will likely not pass new non-discrimination guidance, yet to be published.

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

[4] Personal communication from Simeon Schindelman, CEO of Bloom Health: 66 percent of employees in Bloom's exchange buy lower cost plans with shallower coverage than they currently have, when given the choice; Personal communication from Kenneth Sperling, CEO of Aon Hewitt's private exchange: 42 percent of employees given the choice buy plans with lower coverage and premiums, versus 26 percent who buy more coverage.

[5] Age Discrimination in Employment Act of 1967. 29 U.S.C. Section 621.

[6] Agrawal AB, Veit HR. Back to the future: the managed care revolution. Law & Contemporary Probs. 2002; 65(4):11-53.

Six Approaches

Where list billing is the dominant approach for rating small employers (Connecticut, California, New Mexico and a few other states), it works well for allocating risk among issuers. In method 1.1, we provide an example of a list bill to show how readily it works for allocating premiums among multiple carriers on the basis of age-rated risk. To meet non-discrimination tests under list billing, an employer would seem to have several contribution options. First, contribute the same percentage of the premium for whichever plan the employee selects (method 1.1). Second, contribute the same percentage of the premium for the group's "reference plan," chosen by the employer (method 1.2).[7] The second option promotes value-based choice, as the subscriber bears the full marginal cost (or savings) from his/her selection of a plan. A third method (1.3) is designed to equalize employee contributions, regardless of their age[8]: the employer selects a reference or benchmark plan and all employees in a rating tier contribute the same dollar amount toward the list price of the benchmark plan. As a consequence of strict equality in employee contributions toward age-adjusted premiums, the employer's contribution is highly stratified by age. This highly-stratified employer contribution applies to whichever plan the employee selects.

Composite billing is harder to accommodate to employee choice, but two such composite billing strategies have been developed for employee choice in Rhode Island and Oregon. Methods 1.4 and 1.5 modify composite billing for employee choice to allow employers to make a fixed contribution per rating tier, incentivize employees to shop for value, allocate premiums fairly to issuers who attract different aged enrollees, and pass non-discrimination tests.

Finally, we suggest in method 1.6 the risk allocation challenge can be solved by an entirely separate and distinct approach from billing i.e., by risk adjustment. Reliance on "concurrent risk adjustment" allows composite billing to ignore risk allocation because it would all be handled on the back end through revenue exchange among the carriers.

For simplicity, the six rating and invoicing methods described below are illustrated using employee-only enrollment in a choice of three plans on the same actuarial level (Silver), but with different base level premiums. Again, for simplicity, the only rating variable used is age. (Tobacco use would not be factored into the employer's contribution and geographic rating is generally not applicable to single-site small employers.) Nevertheless, these approaches apply reasonably well to more complex rating scenarios.

1.1 List Bill, Employer Contributes Percentage of Plans Selected by Employees

Under list billing, the SHOP exchange will invoice the employer for each employee, according to his/her QHP's age-specific rate, so premiums reflect the base rates of each plan and applicable rating factors for each employee. The employer simply contributes the same percentage of premium (for each rating tier) toward the premiums of the plans that employees select.

- Components of approach:
  - Issuers' list rates are calculated for the group.
  - To avoid age discrimination, employers contribute the *same percentage* of each member's age-specific premium (70 percent), rather than a fixed dollar amount.

The following table provides an example of how premiums are distributed among three issuers and contributions differ based on age and plans.

Employee	Age	Issuer	Plan (AV)	List Bill Premium	Employer Contribution (70%)	Employee Contribution (30%)
1	<25	A	Silver	$119	$84	$36
2	55	B	Silver	$300	$210	$90
3	64	C	Silver	$430	$301	$129
Total				$849	$594	$255

[7] To avoid discrimination in testing for the small business tax credit, IRS Notice 2010-82 uses as a minimum contribution threshold set at ***fifty percent of the reference plan's premium***, whether the rates invoiced are composited or individually listed.

[8] This method resembles a rating that was developed for the pilot employee-choice program operated by the Massachusetts Health Connector in 2009.

- Advantages:
  - All issuers are "made whole," meaning that each issuer will receive premiums according to the base premium for its plan and the age of the enrollees in its plan.
  - Younger employees are billed less than older employees for the same plan, and therefore are encouraged to take up the offer of coverage.
  - The employer does not need to select a "reference plan."
- Disadvantages:
  - Older employees are billed at a higher rate than younger employees for the same plan, which may be considered inequitable.
  - The employees' incentive to shop on value is dulled because the employer subsidizes the choice of plans with higher base premiums.
  - The employer cannot know before open enrollment what his/her contribution will total because it depends on which plans employees select.

For employers who currently contribute a percentage of premium toward the list bill, and who simply want to continue their current practice and offer more choice, this approach is easy and does not discriminate against older workers. Also, if the employer continues to offer current coverage, and adds the choice of less coverage at a lower premium, this contribution strategy would allow the employer to share in the savings realized if employees "buy down."

1.2 List Bill with Contribution Fixed as a Percentage of Reference Plan

Under list billing, the SHOP exchange will invoice the employer for each employee, according to his/her QHP's age-specific rate, so premiums reflect the applicable rating factors for each employee, and issuers can reconcile receipts to their age-rating formula. The employer selects a "reference plan," on which he/she bases a premium contribution. The employer contributes the same percentage of the reference plan premium for all employees (in a rating tier) toward the plan that each employee selects, and employees contribute the difference between the employer's reference plan contribution and the price of their own plans.

- Components of approach:
  - Issuers' individual rates are calculated for the group.
  - Employer selects a reference plan (Plan A), and contribution percentage (70 percent) for that plan. (Step 1)
  - Employees select among health plan choices with varying premiums, calculated by age for each plan. (Step 2)
  - To avoid age discrimination, employers contribute the same percentage of each member's age-specific premium for the reference plan. (Step 3, column B)
  - Employee contributions differ based on age and plan selected, less the age-specific, but fixed employer contribution. (Step 3, column D)

Step 1: Employer Selects "Reference Plan" and Contribution Percentage

Issuer	A
Metal Tier	Silver
% Employer Contribution	70%

Step 2: Employee Selections

Employee	Age	Issuer	Plan (AV)	List Bill Premium
1	<25	A	Silver	$119
2	55	B	Silver	$300
3	64	C	Silver	$430
Total				$849

Step 3: Calculate Premiums and Contributions

		Reference Plan	Reference Plan	Selected Plan	Selected Plan
Employee	Selected Issuer	List Bill (A)	Paid by E'er 70% of Plan A (B)	List Bill (C)	Paid by E'ee (C) - (B) = (D)
1	A	$119	$84	$119	$35
2	B	$273	$191	$300	$109
3	C	$358	$252	$430	$178
Total		$750	$527	$849	$323

- Advantages:
  - All issuers are "made whole."
  - Employers' contributions per employee are fixed in advance, and therefore predictable.
  - Employees feel the full cost (or savings) from selecting a more (or less) expensive plan.
  - Younger employees are billed less than older employees for the same plan, and therefore are encouraged to take up the offer of coverage.
- Disadvantages:
  - Older employees are billed at a higher rate than younger employees for the same plan, which some consider inequitable.

For employers who are list billed and who want to offer more plan choice to employees, this contribution strategy allows them to budget an amount per enrollee (in each rating tier) and contribute in a completely "neutral" way toward any of the plan options.

1.3 List Bill with Age-Stratified Contribution

This approach enables all employees (in each rating tier) to contribute the same amount toward the benchmark plan, even under age-rated list billing. If they pick another plan, there are modest differences by age in employee contributions, with older employees paying more than younger employees for higher-priced plans, and saving more than younger employees for choosing lower-priced plans.

- Components of approach:
  - Issuers' list rates are calculated for the group.
  - Average (composite) rates are calculated for each plan, on the assumption that all eligible employees enroll in that plan. (Step 1)
  - Employer chooses a reference plan ("A") and contribution percentage (70 percent). (Step 2)
  - All employees who select the reference plan contribute the same amount, 30 percent of the composite rate for A. (Step 4, column C)
  - The employer contributes the difference between each employee's *list bill* for the reference plan and the employees' flat contribution amount, resulting in a highly age-stratified employer contribution. (Step 4, column D)
  - In addition to the employee's flat contribution for the reference plan, an employee who selects another plan pays/saves the difference between the ***list bill*** of the reference plan and the ***list bill*** of the selected plan. (Step 4, column F)

List Bill with Age-Stratified Contribution

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

Employee-only Premiums (PMPM)	
Issuer	Silver
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	A
Metal Tier	Silver
% Contribution	70%

Step 3: Employee Selections

Employee	Age	Issuer	Plan (AV)	List Bill Premium
1	<25	A	Silver	$119
2	55	B	Silver	$300
3	64	C	Silver	$430
Total				$849

Step 4: Calculate Premiums

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

- Advantages:
  - All issuers are "made whole."
  - All employees selecting the reference plan pay the same amount, regardless of age (30 percent of the composite rate for A). This can be especially important for employee groups which are now composite rated, and for which changing to different employee contributions under list billing could be very disruptive.
  - Employees feel the full cost (or savings) from selecting a more (or less) expensive plan than the reference plan.
  - Employers' contributions per employee are fixed in advance (list bill for reference plan, less 30 percent of composite rate), and therefore predictable.
- Disadvantages:
  - Younger employees are not given any discount for their lower cost (on average), and therefore may be discouraged from taking up coverage.
  - The complexity of age-stratified employer contributions may be hard to explain to employers and employees alike. For example, total costs to the employer and to employees are the same as under method 1.4, but the explanation is more complicated.

For employers moving from composite to list billing, this contribution scheme locks in the equal contribution that employees of various ages were making under composite rating. It protects older workers from paying more for the same plan, just because of list billing.

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

For employers who prefer to stick with composite billing or states which require it, methods 1.4 and 1.5 demonstrate how the exchange can re-allocate collected premiums to equal or approximate an issuer's age-rated premiums. The two methods are similar, with one key exception. Method 1.4 gives issuers exactly their age-adjusted prices for each group, whereas method 1.5 may produce a modest shortfall or excess of revenues relative to age rates in any group, but it allocates such differences equitably among the issuers. Method 1.4 was developed by Wakely's actuaries working with Exchange staff and health plan actuaries in Rhode Island. Method 1.5 was developed by Cover Oregon, that state's Exchange.

- Components of approach:
  - Issuers' list rates are calculated for the group.
  - Average (composite) rates are calculated for each plan, based on the assumption that all qualified employees of a group enroll in that plan. (Step 1)
  - A reference QHP and contribution amount is selected by the employer, 70 percent of Plan A's composite bill. (Step 2)
  - The employer pays the same dollar amount for each employee, regardless of age or plan selected by the employee. (Step 4, column C)
  - Employees who select the reference plan pay the same dollar amount (30 percent of the composite rate for Plan A), regardless of age. (Step 4, column D)
  - In addition to the employee contribution for the reference plan, the employee who selects another plan pays/saves the difference between the ***list bill*** of the reference plan and the ***list bill*** of the selected plan. (Step 4, column F)

Multi-Issuer Composite Rates: Reallocated Composite

Buy-up and Buy-down is based on the difference in list bill premiums

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

Employee-only Premiums (PMPM)	
Issuer	Silver
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	A
Metal Tier	Silver
% Contribution	70%

Step 3: Employee Selections

Employee	Age	Issuer	Plan (AV)	List Bill Premium
1	<25	A	Silver	$119
2	55	B	Silver	$300
3	64	C	Silver	$430
Total				$849

Step 4: Calculate Premiums and Reallocate Revenue

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

- Advantages:
  - All issuers are "made whole."
  - Employers pay the same amount for each employee in a rating tier, regardless of age or plan selected by the employee.
  - This methodology allows employers, employees and brokers to keep composite billing, something to which they are accustomed in many states.
- Disadvantages:
  - Younger employees may be discouraged from taking up coverage.
  - Older employees pay more than younger employees for more expensive plans than the reference QHP, and save more than younger employees for less expensive plans.
  - Depending on how mid-year census changes are handled, either the employer or the issuer absorbs the resulting change in individual rating. (See discussion of mid-year census changes below.)

For employers and employees accustomed to composite rating, this approach allows them to retain most of its advantages, while allocating risk fairly among issuers. As discussed below, if issuers are to collect their exact age rates from employers, then employers may experience some fluctuation in premium rates during a plan year which they would not experience under pure composite billing.

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

- Components of approach:
  - Issuers' list rates are calculated for the group.
  - Average (composite) rates are calculated for each plan, based on the assumption that all qualified employees of a group enroll in that plan. (Step 1)
  - A reference QHP and contribution amount is selected by the employer (70 percent of A), which determines the employees' contribution to the reference plan (30 percent). (Step 2)
  - In addition to the employee's contribution for the reference plan, if an employee selects another plan, the employee pays/saves the difference between the ***average rate*** of the reference plan and the ***average rate*** of the selected plan. (Step 4, column E)
  - Issuers receive ***adjusted*** list bill premiums. Premiums are average rated for purposes of employee choice and employer billing, but total revenues are re-allocated among issuers on an age-adjusted basis.
  - The total of the average rates collected from the employer will not necessarily equal the total of age-rated premiums. The difference between ***total composite*** and ***total list*** premiums is the adjustment applied to each issuer's list bill. (Step 4, column H)

Multi-Issuer Composite Rates: Reallocated Composite

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

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

Employee-only Premiums (PMPM)	
Issuer	Silver
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	A
Metal Tier	Silver
% Contribution	70%

Step 3: Employee Selections

Employee	Age	Issuer	Plan (AV)	List Bill Premium	Composite Premium
1	<25	A	Silver	$119	$250
2	55	B	Silver	$300	$275
3	64	C	Silver	$430	$300
Total				$849	$825

Step 4: Calculate Premiums and Reallocate Revenue

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

- Advantages:
  - Employers pay the same amount for all employees in a rating tier, regardless of age or plan selected.
  - Employees pay more/less for higher/lower average premiums than the reference plan, and all employees pay the same amount for the same plan, regardless of age.
  - Employers and brokers, who are accustomed to composite rates in many states, continue to see composite billing.
  - This approach optimizes the equity of payment among issuers: all issuers would have the same percentage adjustment to their list bill rates for the group.
- Disadvantages:
  - Younger employees may be discouraged from taking up coverage.
  - Issuers are not "made whole" with respect to the list bill premiums for the employees who enroll in their plans (i.e., their ultimate adjusted revenue will not equal their list bill premiums), and the difference must be built into issuers' rates across the entire small-group market.
  - Issuers will not be able to reconcile their revenues with only the information they have, because they are not necessarily receiving list bill rates. Rather, the exchange will need to perform these calculations and provide supporting documentation along with premium transfers to issuers.

For employers who want average billing, or for states that require composite rating, this approach retains all the features of composite billing, while allocating risk reasonably "fairly" among issuers.

1.6 Composite Billing with Risk Adjustment

If the problem with composite billing in an employee choice setting is allocating revenues to issuers along with risks, is there another way to adjust small-group revenues for the risk profile that each issuer enrolls? Actually, there is. The market reforms under the ACA include "concurrent risk adjustment" on both the nongroup and small-group markets, whereby issuers are compensated for the disease burden of their enrollees, based on actual claims adjudicated. The federal methodology for calculating risk adjustment is intended to capture variation between health plans in expected costs due to differences in morbidity, beyond those differences already captured by the allowable rating factors—for small-group, principally age rating. That is, the retrospective adjustment of revenues among carriers in the small-group market is designed not to double-count age-related risk that should already be factored into group rates.

It is theoretically possible to use risk adjustment in the small-group market to retrospectively adjust revenues for most risk factors, including age. To do so without double-counting, however, would require group-specific information be captured for the risk adjustment process, and the federally administered risk adjustment process does not capture group-specific rating information. A state might build this capability into its own rate adjustment methodology, but virtually all states are delegating risk adjustment to CMS. Therefore, it is not a practical solution without a change in the federal methodology.

For any state doing its own risk adjustment, we illustrate below how this approach works.

- Components of approach:
  - Average rates are calculated for each plan that employees of a group could select, e.g., all QHPs on the Silver tier. (Step 1)
  - Because average rates for any one plan are calculated on the assumption that all employees of the group enroll in that plan, all the average rates reflect individual rating of the group.
  - A reference QHP and contribution amount is selected by the employer (70 percent of A), which determines the employees' contribution to the reference plan (30 percent). (Step 2)
  - Employees select a QHP. (Step 3)
  - Premiums can be subsidized by employers on a fixed-dollar basis. (Step 4, column B)
  - In addition to the employee's contribution for the reference plan, if an employee selects another plan, the employee pays/saves the difference between the ***average rate*** of the reference plan and the ***average rate*** of the selected plan. (Step 4, column E)
  - Risk adjustment for each QHP incorporates the demographic differences between those who enroll in a QHP (member-specific) and the entire census from which the group's average rates were developed. (Step 4, column J)
    - In risk adjustment, the concept is that risks beyond the allowable rating factors should be calculated and spread retroactively through cash transfers among carriers. Therefore, in "standard" risk adjustment techniques, the variation of rates for employee demographics (3:1 age-rating in most states) is excluded from the net risk score. In this approach, since an issuer's rates are based on the demographics of the group rather than the individual members who select its plans, the demographic variation of the group's composite rate would be removed from each risk score associated with that group's enrollees.
    - CMS' requirement to use standard age factors in rating, just as the federal risk adjustment model uses standard coefficients for demographics, simplifies this approach.

Multi-Issuer Composite Rates: the Risk Adjustment Solution

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

Employee-only Premiums (PMPM)	
Issuer	Silver
A	$250
B	$275
C	$300

Step 2: Employer Selects Benchmark Plan and Contribution

Issuer	A
Metal Tier	Silver
% Contribution	70%

Step 3: Employee Selections

Employee	Age	Issuer	Plan (AV)	List Bill Premium	Composite Premium
1	<25	A	Silver	$119	$250
2	55	B	Silver	$300	$275
3	64	C	Silver	$430	$300
Total				$849	$825

Step 4: Risk Adjustment ("Correction")

		Benchmark Plan			Selected Plan	
Employee	Selected Issuer	Composite Rates (A)	Paid by Employer (B) = 70%*(A)	Paid by Employee (C) = (A) - (B)	Composite Rates (D)	Additional Amt Paid by EE (E) = (D) - (A)
1	A	$250	$175	$75	$250	$0
2	B	$250	$175	$75	$275	$25
3	C	$250	$175	$75	$300	$50
Total		$750	$525	$225	$825	$75

Employee	Selected Issuer	Total Premium Collected (F)=(B)+(C)+(E)	EE Age Factor (G)	Normalized Age Factors (H) = G / Average(G)	Risk Score Adjustment (I) = (H) - 1	Risk Adjustment (J) = (I) * Average (F)	Net Revenue (K) = (F)+(J)
1	A	$250	1.00	0.48	(0.52)	**-$144**	**$106**
2	B	$275	2.29	1.09	0.09	**$25**	**$300**
3	C	$300	3.00	1.43	0.43	**$199**	**$419**
Total		$825	2.10	1.00	–	**$0**	**$825**

- Advantages:
  - All employees pay the same amount for the same plan, regardless of age.
  - For states already planning on administering risk adjustment, this is an easy "fix" to a potentially complex issue.
  - For states where composite rating now prevails, the Composite with Risk Adjustment methodology allows employers and brokers to keep composite billing, something to which they are accustomed.
  - A defined contribution approach is straight-forward: the employer contribution would be a fixed dollar amount per employee, regardless of age, and all employees purchasing the same plans would pay the same amount, regardless of age. Employers need not even select a reference plan, just a fixed contribution amount (unless SHOP requires a minimum contribution percentage or employers want to qualify for the small business tax credit).

  - Issuers' ultimate revenue is adjusted to reflect their actual SHOP enrollment (but revenue will not equal list bill premiums).

- Disadvantages:

  - Younger employees may be discouraged from taking up coverage.

  - Issuers are not necessarily "made whole" with respect to the list bill premiums for the employees who enroll in their QHPs.

  - For states which have HHS administer risk adjustment, the reconciling calculations would need to be performed by the SHOP which collects demographic information for groups as part of SHOP enrollment.

For employers and employees—or states—that wish to retain pure composite billing, this approach allocates risk "fairly" among issuers.

Some Complications: Mid-Year Changes & Family Rating

To simplify the explanation of these six methods, we have skipped over a couple of issues, which we will now discuss.

Mid-Year Changes: One problem is how to handle changes during the year in the census of enrolled employees which, if known before the group was rated, would have changed their premiums. This problem is especially thorny in a defined contribution, employee-choice context because employees are being encouraged to shop for value based, in part, on price. If the prices of their options change substantially after open enrollment, as a result of someone who was expected to enroll not doing so (or vice versa), re-rating may require re-opening the whole process of employee choice. This is cumbersome at best.

All six rating methods begin with individual, age-adjusted rates—per new rating rules required by CMS—whether averaged or not for billing purposes, based on the initial census of employees and dependents eligible and considered likely to enroll. However, those who actually sign up at open enrollment may not match the expected census, and/or over time employees leave, join the firm, drop coverage, get married, exhaust their waiting period, etc. Under list billing, there is an "automatic" adjustment to individual rates for mid-year changes in the group's census. For example, under methods 1.1, 1.2 and 1.3, if the employer loses employee #3 and gains a younger single employee, the issuers would still collect their age-specific rates, and total group premium would decrease. By contrast, the employer's premium contribution per employee will vary throughout the plan year, as employees come and go.

Under composite rating, however, mid-year changes in employee rating factors generally do not alter premiums. In effect, the health plan absorbs the changes in the group's rating factors, positive or negative. (If the mid-year change in rating factors surpasses a threshold, e.g. 10 percent, set by the carrier or in state regulation, then some carriers will alter composite rates mid-year.) Under composite rating, employers enjoy more predictability for the year in budgeting their premium contributions. Of course, the accumulated changes in rating factors will be recognized when the group is re-rated for the next plan year.

Under method 1.4, if the issuers are to continue to collect their age-adjusted rates even as the mid-year census changes, then there must be an adjustment in either employer or employee contributions. (The issuers could absorb such changes, but then their revenues would not match their age-adjusted rates—a significant advantage of method 1.4.) And if the employer chooses to shield employees from mid-year changes, then the employer will absorb them, saving on benefits costs if younger employees are hired or older employees leave, and paying more per employee in the reverse circumstances. This reduces the predictability of group health insurance costs, which is one of the advantages of method 1.4, and may encourage discriminatory hiring practices.

Unfortunately, someone has to be the "sponge," absorbing these mid-year changes. At least one state has decided to maintain the "integrity" of the health plans' age rating in the face of mid-year census changes, and will make the employer the "sponge." However, the final market rules from CMS do not address how carriers should handle mid-year changes in enrollee census for purposes of re-rating small employer groups. Re-rating mid-year for changes in the census comports with the spirit of CMS' guidance to use individual rating, but not employers' desire to fix their benefits costs as much as possible for the year. CMS has not opined on whether it is permissible to re-rate for mid-year census changes or "freeze" group rates for the plan year.

Under method 1.5, as long as one or more employees select a plan other than the reference plan, the group's total premium will probably not equal the sum of its age-rated premiums. Therefore, it makes sense for the health plans to absorb mid-year changes in employee rating factors—positive or negative—since (a) the issuers are not necessarily receiving their billed

rates, absent mid-year changes, and (b) as positive and negative mid-year changes are likely to balance out over a large enough block of covered lives, the health plans are much better positioned than individual employers to absorb this risk.

Under method 1.6, mid-year changes in the relative risk profile of enrollees for each participating issuer will be reflected in concurrent risk adjustment. However, without any change to the employer's composite rates (until re-rating the next year), mid-year census changes will not be reflected in total premium changes for the group. This may not be a serious issue, since (a) this is also the case currently for composite rating, and (b) over a large enough book of business, a carrier's premium shortfalls and excesses resulting from mid-year enrollment changes will likely offset each other. Method 1.6 provides budget predictability for employers, while adjusting health plans' revenues for mid-year census changes by spreading the gain or loss in the overall composite rates generated by the mid-year change.

Family Rating: Another complication that we have ignored in an effort to simplify the explanation of these six rating/contribution approaches is dependent coverage. Conventionally, rating factors are applied in the small group market to the employee, and the resulting rate is multiplied by a standard factor to translate it to an employee + spouse rate, a parent-child rate, or a 3-person (or more) family rate. Under the ACA, however, rating groups is like list billing in that each subscriber and dependent counts toward the group's rates.

The following three steps outline the authors' analysis of composite billing methodology required under CMS' final Market Rules. To demonstrate the concepts, a six-employee group is displayed. Employees have different ages and cover different dependents. The first step is to calculate the age-based rate for each person covered; this includes employees and dependents. (The only exception is that no more than three children under age 21 are included in the calculation.) The following table (Step 1) contains the list bill premiums for each employee and their dependents. For example, the list bill premium for Ed's family is $930 per month. Ages for each adult are considered in this calculation. The total of all list bill premiums for the six employees and their dependents is $3,710 per month (item A).

Step 1: Calculate List Bill (Age-Based) Premiums Per Month

Employees	Employee Age	Spouse Age	# Children Ages 0-20	Coverage (Tier)
#1 – Sue	35	33	1	Family
Premium	$258	$253	$134	$646
#2 – Bob	55		3	EE+Ch(ren)
Premium	$471		$403	$874
#3 – Jane	25			EE-only
Premium	$212			$212
#4 – Frank	28	31		EE+Sp
Premium	$230	$245		$475
#5 – Ed	34	40	5	Family
Premium	$257	$270	$403	$930
#6 – Ken	60			EE-only
Premium	$574			$574
Total				**$3,710**

(A)

In order to convert these individual rates to average premiums, by rating tier, a standardized ratio of premiums can be used to spread a group's total premium across rating tiers. The Step 2 table contains a set of allocation factors. In this table, the premium for employee + spouse coverage would be twice the premium for employee-only coverage. Historically, issuers have used different composite rating factors; however, we believe that the rating tier allocation factors need to be standardized within a state, beginning in 2014, if composite billing is to be enabled. The sum of the sample factors below for this six-employee group is 11.4 (Item B).

The foundation of this methodology is for the total composite bill to equal the sum of individual rates. This is accomplished by calculating the employee-only premium per-member per-month (PMPM) to equal the total of the list bill (item A), divided by the sum of composite tier factors (item B); this is displayed as item C in the following (Step 3) table. The resulting composite bill for employee-only coverage is $325 PMPM. The composite bill for all other tiers is calculated by applying the standardized factors in Step 2 to the employee-only premium rate. As shown in Step 3, the overall result for the group is that the total of the composite premiums is $3,710, which is equal to the total list bill in Step 1.

Step 2: Calculate the Average Composite Tier Factor

Based on Standardized Family Tier Factors

Tier	Standardized Factors	Count of Subscribers	Total of Factors	
EE-only	1.0	2	2.0	
EE+Ch(ren)	1.8	1	1.8	
EE+Sp	2.0	1	2.0	
Family	2.8	2	5.6	
		TOTAL	11.4	**(B)**

Step 3: Calculate the Premiums by Composite Rating Tier

Tier	Premium PMPM	Premium PMPM Formulas	Count of Subscribers	Total Premiums
EE-only	$325	**(C) = (A) / (B)**	2	$651
EE+Ch(ren)	$586	**(D) = (C) * 1.8**	1	$586
EE+Sp	$651	**(E) = (C) * 2.0**	1	$651
Family	$911	**(F) = (C) * 2.8**	2	$1,823
			TOTAL	$3,710

Conclusion

None of the six methods perfectly accommodates the relevant criteria: (a) employee choice of health plans based on value (including relative premiums), (b) a defined employer contribution per employee, (c) a fair allocation of premiums among issuers, and (d) a premium invoice which employers can understand and track. Methods 1.1 and 1.2 are suitable for list bill markets, and method 1.3 may be especially well-suited for groups moving from composite to list billing. Methods 1.4, 1.5 and 1.6 accommodate composite billing, but method 1.6 requires a special effort at risk adjustment. Methods 1.1 through 1.4 all expose the employer to changes in his/her contributions for the plan year after open enrollment occurs. Methods 1.5 and 1.6 can provide more budget predictability to the employer, but do not necessarily generate revenues that match the issuers' age-adjusted rates, unless all employees select the same QHP.

Moreover, changes in billing and/or contribution methods may prove highly disruptive for current employee coverage. This would be especially true for groups moving from composite to list billing in order to accommodate employee choice, unless a method such as 1.3 were adopted to protect older employees from rate shock.

Therefore, we have generated three approaches each for list billing and composite billing on the assumption that employers will be loath to switch rating methods if doing so disrupts their current health benefits arrangements. We recommend that exchanges accommodate existing billing practices in the small group markets that they intend to serve. Especially in markets where both list and composite rating currently co-exist, the SHOP exchange may want to give small employers a choice of list and composite billing methods. Since the billing method(s) made available will directly impact issuers' revenue flow and prices in the outside market as well, such decisions should be made with considerable input from the issuers, producers, and employers expected to participate in SHOP.