Session 10PD, Small Group and SHOP Market: Things You Should Know

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**Presenters:**
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John Oliver
2018 SOA Health Meeting
SESSION 10
SMALL GROUP AND SHOP MARKET:
THINGS YOU SHOULD KNOW
Session 10 - Small Group and SHOP Market Presenters

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SOCIETY OF ACTUARIES
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- **Do not** discuss prices for services or products or anything else that might affect prices
- **Do not** discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
- **Do not** speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
- **Do** leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
- **Do** alert SOA staff and/or legal counsel to any concerning discussions
- **Do** consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

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Session 10 - Small Group and SHOP Market Presenters

Zach Davis is a consulting actuary for the Milliman Atlanta practice. He has been with the Atlanta office for the past 6 years and has been working as a healthcare actuary for over 12 years. He works with a number of health insurance companies in the southeast. His primary area of focus is commercial pricing for individual and small group ACA products as well as large group products. In addition to commercial pricing, he also has expertise in commercial risk adjustment, forecasting and reserving.

Dylan Ascolese is Director of Commercial Pricing and Forecasting at Tufts Health Plan in Massachusetts in charge of product development, rate filing, forecasting, and financial analyses related to the Commercial line of business. Past responsibilities include working on Medicare, Medicaid, and valuation work. He is a father of three, spending his free time coaching them in softball and being active. He is an avid runner, racing at various distances.

John C. Oliver IV is the founder of Oliver Insurance Agency, a national and international insurance broker based in Austin, Texas. The agency serves numerous companies, ranging from large corporations to entrepreneurial start-ups. A variety of insurance products are provided designed to protect businesses and their employees in a manner that allows them to grow and thrive.

John Price is a consulting actuary for Axene Health Partners and has held executive positions at Kaiser Permanente, Aetna Western Region, Intermountain Health Care/Select Care, and United Behavioral Health. He provides consulting services to health care providers, managed care organizations, long term care programs, and multi-employer trusts evaluating financial performance, risk, products, network design, and strategic pricing.
Session 10 - Small Group and SHOP Market Presentations

Zach Davis presents purpose and background information about SHOP

Dylan Ascolese presents from a health plan’s perspective product and competitive issues in the small group markets with references to northeastern US markets.

Zach Davis presents an overview of the small group markets as they have evolved under the Affordable Care Act and the major issues that have emerged.

John C. Oliver presents an insurance broker’s perspective and experience in the Texas small group market framed with market history and alternative solutions to the high costs health care coverage.
State of the SHOP

Zach Davis FSA, MAAA

JUNE 25, 2018
What is the SHOP

- Small Business Health Options Program
- Program to encourage small employers to offer health insurance coverage
- Why do small employers offer insurance?
- What constraints do small employers have in the health insurance market?
- Tax Credits (healthcare.gov)
  - You have fewer than 25 full-time equivalent (FTE) employees
  - Your average employee salary is about $50,000 per year or less
  - You pay at least 50% of your full-time employees' premium costs
  - You offer SHOP coverage to all of your full-time employees. (You don't have to offer it to dependents or employees working fewer than 30 hours per week to qualify for the tax credit.)
  - Eligible to receive credit for two years
  - Eligible for the maximum tax credit with 10 or fewer employees with average wages of $25,000 or less
Why was SHOP initially Unsuccessful?

- The Government Accountability Office released an initial study in November 2017 outlining the issues with the SHOP rollout
  - ‘If You Like Your Plan, You Can Keep It’
    - The ability for groups to review their Traditional Plans.
  - Delays in online enrollment
  - Lack of focus on the small group market
  - Technical Challenges and administrative burdens
- Lack of coordination with Brokers
  - Delayed vendor payments
  - Broker hostility
- Lack of “Employee Choice”

Projected 2017 SHOP Enrollment

2017 Actual to Expected Enrollment

2017 CBO
Projected
2017 SB-SHOP
Where has the SHOP been Successful

- State Based Exchanges (California and Colorado are good examples)
  - SB-SHOP still had initial issues with website portals
- ‘If You Like Your Plan, You Can Keep It’…..until 2015 then you need to buy an ACA plan
- Hiring the right people to run the exchanges
- Developing a trusted brand
- Colorado and California two of only a handful of states that changed kept the ACA definition of small group of 1-100
How can the SHOP be Aligned for Future Success

- May 15, 2017 – CMS released the “Future of the SHOP” memo
- New methods to enroll for 2018 Coverage
  - Contact your insurance company and enroll directly in a SHOP plan
  - Work with SHOP registered broker
  - No longer use healthcare.gov to enroll
- Enrollment Criteria
  - Have 1-50 full-time equivalent employees (FTEs)
  - Offer coverage to all full-time employees — generally workers averaging 30 or more hours per week
  - Enroll at least 70% of the employees you offer insurance to
  - Have an office or employee work site within the state whose SHOP you want to use
2018 SOA Health Meeting

DYLAN ASCOLESE
Session 10, Small Group and SHOP Market: Things You Should Know
June 25th, 2018
Success in the small group market requires an understanding of the State specific marketplace and your company’s identity in the marketplace
Understanding the Market

1. Regulations
2. Rating requirements
3. Competitive landscape
4. Distribution channels
Regulations

1. Guarantee Issue and Renewability
2. EHBs
3. Minimum Loss Ratio
   a. Federal is 80%
   b. Few states have a stricter requirement
4. Transitional Plans
   a. Non-ACA compliant plans
   b. Not required to cover EHBs, except preventive care
   c. Annual benefit limits allowed on non-EHB services
   d. Still operational in 32 states
Regulations

1. Small Group Definition
   a. Employers with 1 to 50 employees
   b. Up to 100 in CA, CO, NY, and VT

2. State Mandated Benefits: Fall into one of three categories
   a. Health care services or treatments that must be covered
   b. Healthcare providers other than physicians
   c. Dependents and other related individuals

3. Mandated Plan Offerings
   a. Limited/Tiered Network Plans
   b. Wellness Health Benefit Plan
Regulation – Market Comparison

1. Massachusetts has its own Individual mandate
2. Mandated Plan Offerings
   a. Limited/Tiered Network Plans (MA and RI): Plans where the premium rate is a defined percentage lower than the comparable full network plan
   b. Wellness Health Benefit Plan (RI): Eligible for lower cost share when certain criteria is met

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<thead>
<tr>
<th></th>
<th>Massachusetts</th>
<th>New Hampshire</th>
<th>Rhode Island</th>
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<tbody>
<tr>
<td>Type of Market</td>
<td>Merged</td>
<td>Small</td>
<td>Small</td>
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<tr>
<td>Minimum Loss Ratio</td>
<td>88%</td>
<td>80%</td>
<td>80%</td>
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<tr>
<td>Allow Transitional Plans</td>
<td>N</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Mandated Plan Offerings</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>
Rating Requirements

1. **Age**
   a. Federal age curve is 3:1 but a few states have own curves
   b. NY and VT do not allow age rating

2. **Geographic**
   a. Number of regions vary by state

3. **Tobacco**
   a. Federal ratio is 1.5:1
   b. 13 states have a lower ratio and/or do not allow tobacco rating

4. **Rating Methodology**
   a. Per Member
   b. Composite
## Rating Requirements – Market Comparison

1. NH and RI have one geographic region, MA has 7
2. MA Transitional rating factors allowed through 2019
   a. SIC
   b. Size

<table>
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<th></th>
<th>Massachusetts</th>
<th>New Hampshire</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>State (2:1)</td>
<td>Federal</td>
<td>Federal</td>
</tr>
<tr>
<td>Geographic</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<td>Tobacco</td>
<td>N</td>
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<td>Rating Methodology</td>
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<tr>
<td>Transitional Rating Factors</td>
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Competitive Landscape

1. Benefits and Rates
   a. Benefit comparison
   b. Rate comparison
   c. Benefit adjusted rate comparison
Competitive Landscape

1. Network Type
   a. Full, limited, tiered
   b. Coverage region

2. Market Financials
   a. Profitability by carrier
   b. Competitor medical trends
   c. Competitor rate assumptions

3. Market Size
   a. Market share over time
   b. Distribution of members by Plan/Product
Competitive Landscape

1. Product/Plan Offerings
   a. HMO, PPO, POS, EPO, Indemnity
   b. Copay only, deductible, Saver
   c. Network combinations

2. Product/Plan Pairings
   a. Number of plans offered to employees
   b. Allowable pairing rules across products

3. National vs Local Health Insurer
Competitive Landscape – Market Comparison

1. The small group market has been shrinking in all three states
2. The NH market prefers less rich plan offerings
3. The RI market is a PPO/POS market
4. Approximately 6,000 small group lives are on the MA SHOP

<table>
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<th></th>
<th>Massachusetts</th>
<th>New Hampshire</th>
<th>Rhode Island</th>
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<tbody>
<tr>
<td># of Carriers</td>
<td>11</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td># of Lives</td>
<td>460,004</td>
<td>68,606</td>
<td>55,376</td>
</tr>
<tr>
<td>Market Share of Dominant Carrier</td>
<td>52.5%</td>
<td>45.9%</td>
<td>81.1%</td>
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<tr>
<td>% of Membership in PPO Plan</td>
<td>14.5%</td>
<td>12.5%</td>
<td>74.5%</td>
</tr>
<tr>
<td># of Plans Offered (Dominant Carrier)</td>
<td>42</td>
<td>28</td>
<td>33</td>
</tr>
</tbody>
</table>
Distribution Channels

1. SHOP
2. Brokers
3. Direct Sales
4. Intermediaries
5. Private Exchanges
Distribution Channels - SHOP

1. Employer controls the coverage offered
   a. One plan
   b. Multiple plans and insurers
   c. Health only, dental only, or both

2. Choose how much to pay towards premiums and whether to cover dependents

3. Start coverage at any time of the year

4. May qualify for a small business health care tax credit
Current State of Small Group Market

Zach Davis FSA, MAAA

JUNE 25, 2018
Why was the Small Group Market included in the ACA in the first place?

- 1996 HIPAA laws laid the groundwork for requiring guaranteed issue and renewable coverage in the small group market
  - HIPAA did not prohibit insurers from adjusting premiums based on the group’s medical history or industry type
- Create comprehensive standards at the federal level
- Lack of choices for small groups
- Large swings in premium from the employer group health status
- No requirement to cover prescription drugs
Small Group ACA Market

- Got off to a rocky start
  - In most states there was a bifurcated market, as transitional was allowed to continue
  - Many small groups less than 10 initially shifted their members to the Individual Exchange
  - The SHOP program had very poor participation

- Starting to Make a Come Back
  - As individual ACA plans go to narrower and narrower networks, small groups are making their way back into the SG ACA blocks.
  - Low to moderate trends in recent years, consistent with medical trend
  - Employers need to offer coverage to stay competitive

- Future Challenges
  - Competition with Level Funded, Transitional and AHPs
    - Young and health are leaving the SG ACA for plans that allow for more alignment of their demographic and risk characteristics.
  - Significant churn each year, as small groups are shopping around multiple options for the lowest cost at renewal.
Small Group ACA Market (Continued)

- Small Groups make up an estimated 25% of the workforce
- Small business owners are more aware of the age rating because of how the ACA rates each member based on their age.
Small Group Transitional and Grandfathered Market

- The long standing or dominate carriers are maintaining their large transitional and grandfathered blocks.
- For most other states, issuers have discontinued or transitioned their groups into ACA compliant plans.
- As groups are actively shopping for the lowest plan, it is important to rate each transitional group in both their current plan and ACA equivalent plans and adjust both blocks of business for this selection impact.
State's Transitional Policy Action

https://www.healthinsurance.org/blog/2016/03/22/like-your-grandmothered-health-plan/#renew
The Return of the Association Health Plan (AHPs)?

“Despite efforts to kill it, ACA remains on employers' radar”

“Association Health Plans: Will Trump Proposal Invite Repeat Crime Wave?”

“AHPs Headlines”

“Small business affordable health insurance coming?”

“Trump Rule on Association Health Plans Could Devastate Small-Group Markets”
Association Health Plans a Brief History

- Pre-ACA (before 2014)
  - There was a varying level of regulation by states in the small group market. The more regulated markets were powerful incentives to joins associations

- Post-ACA (after 2014)
  - AHP’s were required to comply with the market regulations of the underlying group or members (i.e. associations made up of small groups must comply with the ACA small group market reform)

- Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans (Proposed Rule)
What’s in the Proposed Rule?

- Allow employers to form an association health plan if the association members are either:
  - In the same trade, industry, line of business, or profession (with or without a geographic nexus) OR
  - In the same geographic vicinity (e.g., same state, county or metropolitan area) (with or without a trade, industry, business or profession nexus)

- Allow sole proprietors to join association health plans to provide coverage for themselves and their spouses and children

- There are other requirements
  - The sponsoring association must have a formal organizational structure with a governing body and bylaws
  - The functions and activities of the sponsoring association must be controlled by its employer members
  - The association health plan must meet certain nondiscrimination requirements

- Comment period ended March 6th 2018, so a final rule could be out in early to late summer
How will AHPs affect the Small Group Market

Benefit Analysis

- Advantages for Small Groups
  - The ability to provide coverage that is exempt from some ACA requirements
  - The ability to join together to take advantage of economies of scale
  - Could make healthcare more affordable compared to other options in the small group market
  - Can purchase health insurance across state lines

- Disadvantages for Small Groups
  - The ability to provide coverage that is exempt from some ACA requirements
    - Not required to cover all EHBs
    - Less stringent rating requirements
  - Less stringent rate filing requirements could lead to solvency issues
  - Could create adverse selection for the groups remaining in the ACA single risk pool
Arguments from Both Sides

- State DOI’s – concerns about jurisdictional issues
  - Montana – “we support the provisions indicated in the proposed rule in regard to satisfying the commonality requirement, i.e., in the same trade, industry, line of business or profession, same state or metropolitan area, or a smaller geographic area such as a city or county”
  - California – “the proposal regarding “working owners,” which would permit enrollment through attestation, could result in fraudulent enrollment by individuals in substandard products, in the absence of additional substantiation.”
  - NAIC – “we encourage you to confirm that states retain full authority, as recognized by the Erlenborn-Burton amendment to ERISA, to set and enforce solvency standards for all MEWAs, and comprehensive licensure requirements and oversight for non-fully-insured MEWAs”
  - Pennsylvania – “With fewer benefits covered, people who have existing medical conditions will be driven to ACA-compliant plans, which will create an ad hoc high-risk pool, driving up premiums and driving out competition.”
  - North Dakota – “those who do not qualify for a federal subsidy have been forced to either purchase their insurance off the Exchange and directly experience the full burden of the rate increases or have foregone insurance altogether. This pattern is likely to continue and we appreciate that this rule is an attempt to address this alarming trend.”

Quick Overview of Small Group Level Funding

- Combines typical components of a Self-Funded contract into one:
  - Self-Funded arrangement
  - Administrative service arrangement
  - Stop-loss coverage
  - Claims processing
  - Disease management programs
- Typically these are designed to look like fully-insured products
  - Level premiums paid each month (eliminates typical cash flow issue of self-funding)
- Appealing to younger and healthier groups who don’t need protection from community rating
## Level Funded Premium Build Up

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<tr>
<th>Item</th>
<th>Employer A</th>
<th>Employer B</th>
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<tbody>
<tr>
<td>Manual rate small group block (PMPM)</td>
<td>$400.00</td>
<td>$400.00</td>
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<tr>
<td>Group specific rating factors (age, gender, industry, benefit, etc.)</td>
<td>0.75</td>
<td>1.25</td>
</tr>
<tr>
<td>Group specific manual rate (PMPM)</td>
<td>$300.00</td>
<td>$500.00</td>
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<tr>
<td>Claims above the attachment point ($5,000) (PMPM)</td>
<td>($225.00)</td>
<td>($375.00)</td>
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<tr>
<td>Expected claims the ER will &quot;self funds&quot; (PMPM)</td>
<td>$75.00</td>
<td>$125.00</td>
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<tr>
<td>Aggregate attachment</td>
<td>1.25</td>
<td>1.25</td>
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<tr>
<td><strong>Maximum employer claims liability (PMPM)</strong></td>
<td><strong>$93.75</strong></td>
<td>$156.25</td>
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<tr>
<td>Specific stop loss premium (PMPM)</td>
<td>$300.00</td>
<td>$500.00</td>
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<tr>
<td>Aggregate stop loss premium (PMPM)</td>
<td>$25.00</td>
<td>$41.67</td>
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<tr>
<td>Non-Benefit expenses (admin and commissions) (PMPM)</td>
<td>$75.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>Level funded premium (PMPM)</td>
<td><strong>$493.75</strong></td>
<td>$772.92</td>
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<tr>
<td>ACA premium quote (PMPM)</td>
<td>$550.00</td>
<td>$725.00</td>
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</table>
Stop Loss Regulation – State Perspective

- Connecticut (2016)
  - Stop loss contract policy provisions
  - Lasering (3x max)
- Vermont (2016)
  - $28,700 Specific stop-loss
  - 120% aggregate
- Maryland (2015)
  - $22,000 Specific stop-loss
  - 120% aggregate
- California (2013)
  - $35,000 Specific stop-loss (40,000 after 2016)
  - 120% aggregate
  - Guaranteed renewability

- New Mexico (2017)
  - $10,000 Specific stop-loss
  - 110% aggregate
- NAIC (1999)
  - Specific: At least $20,000
  - Aggregate (groups of 51 or more): At least 110% of expected claims
  - Aggregate (groups of 50 or fewer): At least the greater of 120% of expected claims, $4,000 times the number of group members or $20,000.
Stop Loss Attachment Point Example

- Illustrative example using Milliman Health Cost Guidelines (HCGs) to simulate Employer costs at different attachment points.
- Assumes a simplified plan design with $2,500 deductible, 25% member coinsurance and $6,500 MOOP.
- Average claims PMPM are estimated to be $367.
Small Group Market Segmentation

- In some states, you could have up to four different regulated small group products being offered in the marketplace.
- “There is a lack of momentum for Obamacare in the state. Part of what is making the ACA in Colorado less desirable is that companies are finding ways to get out of it.”
Change to the Small Group Risk Adjustment Transfer

- “In states where HHS operates the risk adjustment program, CMS will provide States with the flexibility to request a reduction to the otherwise applicable risk adjustment transfers in the individual, small group or merged market by up to 50 percent beginning with the 2020 benefit year.”

- Justification for allowing States control over Risk Adjustment Transfer
  - Calibrating the risk adjustment transfer on a national dataset could result in drastically different results by state.
  - State specific dynamics could help mitigate the effects of anti-selection in the small group market
    - If states can demonstrate this difference the regulatory in that state can request a percentage adjustment to the transfer payment beginning in 2019
  - States must notify HHS of their intention within 30 days of the release of the Final Notice of Benefit and Payment Parameters, to allow sufficient time for carriers to include in pricing.
  - States continue to have the option run their own risk adjustment models, but currently no states are opting for this.
### MLR Impact by Reducing Risk Adjustment Transfer by (X%)

#### 2016 Alabama Small Group Risk Adjustment Transfer Data

<table>
<thead>
<tr>
<th>Carrier</th>
<th>MMs</th>
<th>Claims</th>
<th>Premium</th>
<th>RA</th>
<th>MLR (100%)</th>
<th>MLR (80%)</th>
<th>MLR (70%)</th>
<th>MLR (50%)</th>
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<tbody>
<tr>
<td>Carrier 1</td>
<td>96.8%</td>
<td>$344.62</td>
<td>$402.97</td>
<td>$0.90</td>
<td>85.3%</td>
<td>85.3%</td>
<td>85.4%</td>
<td>85.4%</td>
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<tr>
<td>Carrier 2</td>
<td>0.0%</td>
<td>$590.18</td>
<td>$476.09</td>
<td>($53.39)</td>
<td>135.2%</td>
<td>132.9%</td>
<td>131.8%</td>
<td>129.6%</td>
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<tr>
<td>Carrier 3</td>
<td>1.5%</td>
<td>$265.77</td>
<td>$368.90</td>
<td>($0.93)</td>
<td>72.3%</td>
<td>72.2%</td>
<td>72.2%</td>
<td>72.2%</td>
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<tr>
<td>Carrier 4</td>
<td>0.6%</td>
<td>$288.14</td>
<td>$349.86</td>
<td>($72.85)</td>
<td>103.2%</td>
<td>99.0%</td>
<td>96.9%</td>
<td>92.8%</td>
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<tr>
<td>Carrier 5</td>
<td>1.1%</td>
<td>$295.97</td>
<td>$369.31</td>
<td>($39.23)</td>
<td>90.8%</td>
<td>88.6%</td>
<td>87.6%</td>
<td>85.5%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>$342.66</strong></td>
<td><strong>$401.81</strong></td>
<td><strong>$0.01</strong></td>
<td><strong>85.3%</strong></td>
<td><strong>85.3%</strong></td>
<td><strong>85.3%</strong></td>
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MLR Impact by Reducing Risk Adjustment Transfer by

2016 Alabama Small Group Risk Adjustment Transfer Data

JOHN C. OLIVER
Session 10: Small Group and SHOP Market: Things You Should Know
June 25, 2018
Texas Individual Market Deteriorates.. Impact to the Small Group Market

• BCBS, United & Aetna stop selling PPO products on the Individual Market in Texas Jan. 1, 2016

• Humana Follows suit and pulls all Individual Policies July 2017...Leaving only Medicare Supplements

• Only 1 product with a household name remains for Individual Insurance in Texas.... BCBS HMO
Texas Individual Market Deteriorates.. Impact to the Small Group Market

• Only way to access a PPO is through the group insurance market.
  o Void in options created a rush of 2 person groups to the small group market.
    ➢ Many of these groups were created as husband and wife groups by adding a spouse to payroll or by adding the spouse as a manager of an LLC.

• Effect was 25% to 35% increases to these groups in 2017 & 2018.
How To Avoid Community Rating In The Small Group Market?

• Underwriting the group with Individual Health Statements
• Level Funding has proven to be the solution.
  o Form of self funding with added benefit of stable monthly costs
  o Fixed monthly premium covers: Stop Loss Insurance, Admin Fees & Claims Funding

- Admin Fees 25%
- Stop Loss 35%
- Claims 40%
How To Avoid Community Rating In The Small Group Market?

• Monthly Payment is the maximum exposure to the employer.
• Unused claims dollars are returned to the group.
  o Claims are fairly dialed in so actually not much to recapture.
  o The main driver behind Level Funding is low premiums.
  o A solution for lower to moderate risk groups
  o Further deteriorates community rated small group population risk
• Case Study:
  o Bakery in Houston, Texas. Fully Insured / Community Rates were 77% higher than the same carriers Level Funding rates.
Small Group Level Funding: The Carrier Model

• National Carriers can have limitations
  o Unused Claims Funds are partially returned via admin credit
  o Tend to offer similar plan designs
  o Only offer plan designs that are ACA compatible
  o Limited to their own Stop Loss and PBM
  o Have elevated admin costs due to overhead
Small Group Level Funding: The TPA Model

• Flexibility with Plan Design:
  o Non ACA compliant plan designs are available at lower premiums.
  o GAP Insurance is easily paired with Non ACA plan designs.
  o Cash Refund of unused claims.
  o Lower admin costs because of lower overhead.
  o Claims payer not an insurer. Less customer service noise.
  o Contract with multiple networks.
  o Ability to shop Stop Loss carriers and PBM services.
Small Group Level Funding: The TPA Model

• Case Study # 2:
  o Lumber Company in Austin, TX. Wanted a plan with deductible / co-insurance for Doctor visits and copays for Rx. Carrier model couldn’t accommodate this.
  o TPA was able to design the exact plan design the ER envisioned.
Small Group Level Funding: The TPA Model

• If ER has the highest deductible available with an ACA compliant plan design there’s no way to mitigate increases at renewal.

• Non ACA compliant plan designs allow higher deductibles and can utilize GAP benefit enhancements for ACA compliance to limit employee exposure.

• This would allow some employers to break the artificial ceiling of ACA compliant deductibles and actually mitigate the never ending spiral of annual increases.