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Mr. Michael Lujan
Director – Small Business Health Options Program (SHOP)
California Health Benefit Exchange
560 J Street Suite 290
Sacramento, CA 95814

RE: Selection Risks for SHOP Exchange Scenarios

Dear Michael:

The California Health Benefits Exchange (the Exchange) retained Milliman to provide an independent opinion about the impact of selection on the relative market risk of three possible SHOP Exchange scenarios:

Scenario 1, Employer Choice: The employer designates the metallic benefit plan; employees get the choice of carriers offering plans in that metallic tier. Federal regulation requires the SHOP to offer this option.

Scenario 2, Paired Choice Plus: Employer designates two or three issuers and two contiguous metallic levels; employees choose plan and metallic tier. This option would be offered only for groups with 10 or more enrolled employees.

Scenario 3, Employee Choice: The employer designates a carrier; the employee gets to choose any benefit plan (at any metallic level) offered by that carrier.

Other scenarios are possible, but these are the three the Exchange asked Milliman to review. They represent the two key dimensions of choice between SHOP options, the metallic level, and the carrier and specific plan provisions for options within a metallic level. Note that the names given to the scenarios, such as Employer Choice, refer to who chooses the metallic level.

Prior Analysis

Earlier this year I was retained by Kaiser Permanente (Kaiser) to review the market risk implications of certain SHOP scenarios. My July 3, 2012, letter to Kaiser summarized our findings. Kaiser submitted this letter to the Exchange. The Exchange contacted me with questions about the letter and asked that I address the questions by expanding the letter and addressing it to the Exchange. Kaiser was comfortable with this approach but did not provide input for or receive an advance copy of this expanded letter.

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This is an unusual situation so I would like to highlight that the opinions I expressed in the original letter to Kaiser were my own and were not influenced by Kaiser. Similarly, the additions to this letter to address questions raised by the Exchange are my own opinions and are not influenced by Exchange staff. The implementation of the ACA creates many actuarial challenges because it represents a major change in the health insurance market. Other actuaries and stakeholders may have different opinions. I tried to state the assumptions and reasons for my conclusions in this letter and welcome questions or comments.

Conclusion

I believe Scenario 1 produces the lowest market risk due to selection because it places the most limits on the choice of coverage level available to an individual employee. I believe Scenario 3 produces materially higher market risk than Scenario 1 or 2 if SHOP carriers offer a wide choice of plans. While all Scenarios can cause differences in the *distribution* of health status risk between carriers and plans with the SHOP, Scenarios 2 and 3 also cause an increase in the *total* health status risk across all carriers and plans. This is because it allows individuals with existing medical conditions to purchase more insurance coverage than healthier individuals would likely choose. This increase in total health status risk is likely to require higher average premiums for the entire Exchange under Scenarios 2 and 3 than under Scenario 1.

Market Risk and Selection

I define market risk for purposes of this discussion as how much the overall market rates would increase to cover the carriers' collective selection risk. This risk can be divided into two components:

1. The selection risk faced by the Exchange as a whole. Alternatively, this can be viewed as the selection risk if the Exchange consisted of just one carrier
2. The additional selection risk as perceived by a carrier that believes it will attract a different risk mix than the average in the Exchange, summed across all carriers.

Selection occurs when an individual's demand for insurance (either the propensity to buy insurance, or the features and amount purchased, or both) is positively correlated with the individual's risk of loss (e.g. higher risks buy higher amounts of insurance, or insurance with different features).

With respect to health insurance, differences in the amounts purchased can be quantified by the plans' Actuarial Values, or metallic levels. For individuals with chronic health conditions, typically, it will be in their best financial interests to purchase insurance that will cover a larger percentage of their healthcare expenses during the coverage period, e.g., the Gold (80% actuarial value) or Platinum (90% actuarial value) plans. Healthy individuals will be more inclined to purchase a Bronze plan (60% actuarial value) because it will have the lowest premium cost and they expect to use fewer services.

The different features of health insurance that can affect selection include:

- Specific cost sharing features relative to other plans with the same metallic level
- Provider network
- Coverage of services from non-network providers
- Limits on specific services
- Carrier reputation
- Premium, both in total and the portion paid by the employee

These features can also affect the financial interest of individuals with chronic health conditions and their qualitative assessment of plans. For example, an individual with a specific chronic condition will consider the cost sharing and limitations associated with the services they are likely to need. Individuals that prefer

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certain physicians or hospitals will either choose a plan that includes them in their network or choose a plan that has good coverage for non-network providers. Conversely, healthy individuals will be less concerned about these features and, so, tend to focus on the lowest premium cost.

Sources of Selection Risk – Employer and Employee Choices

The Exchange and carriers will assess their selection risk by focusing on two distinct choices. First, the small employer decides to provide employee health insurance through the Exchange and defines the combination of carriers and plans from which employees can choose. Second, each employee then chooses a carrier and plan, or opts out.

The maximum amount of selection occurs when each employee has the broadest choices. Any reduction in those choices due to limits by the employer will decrease the risk of selection.

The employer's choice within any of the three scenarios can also be a source of selection to the extent the employer considers the overall health status of their employees and chooses the options to offer based on their perception of the financial interests and qualitative assessments of all of their employees. This is a greater risk for smaller employer groups, such as 2-5 employees, where the business owner may consider their own health status or their perceived health status of other employees. Still, the impact of this selection is less than when each individual has free choice because all of the other employees are subject to the same option limits.

The remainder of this letter focuses on the selection impact of individual employee choice within each scenario.

Selection Risk Faced by the Exchange as a Whole

Many commentators focus only on the selection risk faced by a SHOP Exchange as a whole due to the choice by employers to purchase insurance either inside or outside the Exchange. Specifically, since small groups are subject to underwriting outside the Exchange, employers whose employees have worse than average health status may be more likely to join the Exchange.

Once employers have decided to join the Exchange, however, the degree of choice given to their individual employees is usually discussed as affecting the distribution of a fixed amount of risk among the Exchange carriers, and not affecting the overall risk and average premium levels in the Exchange. This is not the case, however, because it does not consider the impact of selection on overall market premiums. The following is from a publicly available Milliman report for the State of Ohio, titled "Assist with the First year of Planning for Design and Implementation of a Federally Mandated American Health Benefit Exchange:"

> *Although employee choice may be the largest advantage the SHOP exchange offers relative to ESI[Employer Sponsored Insurance]-small group coverage, it also poses the greatest risk to the success of the SHOP exchange and the overall morbidity of the ESI small group risk pool. Adverse selection may increase with the introduction of employee choice among benefit tiers, carriers, and plan designs. The greatest adverse selection risk is created by allowing employees to choose plans in any benefit tier. As in the individual health insurance market, this may result in the healthiest employees selecting bronze or silver plans, and the sickest employees (or dependents) selecting gold or platinum plans. This would*

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increase average premiums in the ESI-small group market. Adverse selection created by carrier and plan design choice within a single benefit tier may occur, but its impact would be less significant than selection among benefit tiers. Employees with known medical conditions will likely favor plans that offer the least required cost-sharing for the services that they expect to use. The design of the SHOP exchange will need to balance the benefit of employee choice with the need to minimize adverse selection.

To be more specific, adverse selection due to employee choice within the Exchange can increase the average cost for Exchange coverage needed among all members. This will be mitigated by the fact that both the Exchange and the non-exchange versions of these plans must be priced on a common experience pool. The non-exchange business could end up providing a rate subsidy to the exchange products offered, with the size of the subsidy dependent on the relative size of the Exchange versus the non-exchange business.

Selection Risk Faced by the Exchange as a Whole – Metallic Level Choice

If employees that elect the richer plans are sicker than average, the employees that elect the less rich plans will be healthier than average. This is by definition, since we assume that, in total, they are average. As a result, unless carriers are allowed to reflect selection in premium rates, the premiums for the richer plans will be insufficient to cover the actual health status of the members in the richer plans, but the premiums for the less rich plans will be more than enough to cover the actual health status of the members in the less rich plans. This will cause winners and losers among the carriers, which may be mitigated with risk adjustment. The bigger problem is that the dollar amount of premium insufficiency for the members in the richer plans will be greater than the excess premium dollars for the less rich plans, leading to a net loss for all carriers.

This is true in general, but is easiest to illustrate if we assume the SHOP has just one carrier, and employees can choose any metallic level. (This is a version of Scenario 3, except there is no adverse selection between carriers since there is only one carrier.) The problem is that sicker employees can purchase a greater amount of insurance, but the extra amount charged for this additional coverage will not be sufficient to cover the additional cost. As a result, the premiums for the minimum amount of insurance will also increase to avoid an overall loss by the Exchange.

As a simple example, suppose employees can choose between two plans from the single Exchange carrier, one with a 60% Actuarial Value and one with a 90% Actuarial Value. Further, assume that the expected total healthcare costs (gross spend before cost sharing) for the two employees is $150 per month for Employee A and $50 for Employee B, producing an average of $100 per member per month. Both of the employees are the same age and are non-smokers, so their premiums must be the same for a given plan.

Attachment A illustrates the impact of adverse selection in the following sections:

- Section 1 summarizes the expected total health costs of the two employees, as described above.
- Section 2 summarizes the carrier's calculated premium, assuming this was the only employer in the Exchange. Because the premiums for both the 60% and 90% plan must be the same for both employees, the premiums are based on the average total health costs, $100 per month.
- Section 3 illustrates that if the employer requires both employees to take the same plan, the premium is insufficient for Employee A, and overly sufficient for Employee B, but that overall the premium is exactly as needed. This is true whether the employer chooses the 90% plan
- (Section 3a) or the 60% plan (Section 3b).
- Section 4 illustrates that the premiums are not sufficient if the employees are allowed to choose different plans. In Section 4a, when premiums by metal level do not reflect adverse selection, we

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see the $90 premium is insufficient to cover the actual health costs of the member in the 90% plan and the $60 premium is more than enough to cover the actual health costs of the member in the 60% plan. However, the premium insufficiency for the member in the 90% plan is a greater dollar amount than the excess for the member in the 60% plan, leading to a loss for the carrier, which in this example, is the entire Exchange.

Since this type of selection is somewhat predictable, the carrier will need to increase their premiums to cover this loss due to selection. If the carrier/Exchange wants to keep the 60% plan premium as affordable as possible, it could just raise the 90% plan premium, as shown in Section 4b. Alternatively, if the carrier/Exchange wants to maintain the premium relationship between the 90% plan and the 60% plan as the ratio of the actuarial values (90/60, or the 90% premium is equal to 150% of the 60% premium), both premiums must be increased by 10% (from $60 to $66 for the 60% plan and from $90 to $99 for the 90% plan). This is shown in Section 4c.

The required 10% increase in premiums in this example is for illustration only. A more realistic estimate for this premium load if employees can choose a plan at any metallic level is 3-5% (See Figure 4-6 from the Milliman report for Ohio referenced above).

Current carrier practices are generally consistent with this estimate for Scenario 3, although carriers limit choice to avoid needing loads of this magnitude. Carriers usually require the employer to pick one benefit value for all employees, and offer no choice. This is very common for the smaller employer groups. For "larger" small groups, carriers limit the difference between the values of options available to employees. For example, if the lowest option available is a 60% plan, the second option might be limited to a 70% plan. This difference still produces selection risk, but it represents a smaller percentage of the total premium for the employer. Carriers often add a 1-2% load to the premiums for both plans to account for this selection. Scenario 2 is a modified version of this current offering for "larger" small groups. An alternative approach used by carriers in California is that individuals in small employer groups may be offered a wide variety of benefit richness, health status impact of selection is reflected in the premiums for each option. This can create very high premiums for the richer options because the carrier assumes that the most expensive people will choose these options.

Selection Risk Faced by the Exchange as a Whole – Carrier Choice

The degree of choice employers give to their individual employees among carriers within a given metallic level affects the distribution of risk among the Exchange carriers, but has a much lower impact on the overall risk and average premium levels in the Exchange.

The total plan-paid claims for a given employer depend on the total health care costs for their employees, and the percentage of those costs that are paid by the plan. Thus, total plan-paid claims for the employer would only change due to the employees' choice of carrier if that choice affected their total health care costs or the percentage of those costs paid by the plan.

The total health costs for a person depend mainly on their utilization of services and the unit costs of those services. Utilization can vary between carriers due to the providers chosen for their network, and the medical management efforts of the carrier. Unit costs vary between carriers due to the contractual agreements between the carrier and providers.

The percentage of health costs paid by the plan is measured by the Actuarial Value. Since all plans in Scenario 1 have the same Actuarial Value, one might think that each employee's choice of carrier would

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have no effect on the percentage of the total costs paid by the plans. However, a plan's Actuarial Value is based on the expected utilization for a standard population, but a given individual will choose a plan based on their own expected utilization. They might conclude that a particular Bronze plan has a higher value for their health situation than other Bronze plans, even though they all have 60% Actuarial Values based on the standard population.

Total premiums for the Exchange can increase if the higher risk individuals choose carriers that have higher underlying cost levels due to carrier differences in medical management and provider reimbursement. For example, the total premiums for the Exchange would be higher if individuals that require more services tended to choose carriers that have higher provider reimbursement levels or less effective medical management. The premiums for these carriers would probably be higher than for other carriers, given their higher underlying cost levels. Thus, these individuals would be willing to pay higher premiums in order to have a particular carrier.

It is unlikely that higher provider reimbursement is an attribute that would attract a high-risk individual to a carrier. In fact, under Bronze and Silver plans, the individual pays a large portion of their own costs themselves, so they would have higher cost sharing payments. High-risk individuals could indirectly be attracted to such a carrier, however. For example, this would occur if the carrier's network included high cost providers that were not in other carriers' networks and high-risk individuals were attracted to those providers.

Differences in medical management may have a direct effect on a high-risk individual's carrier and plan choice. They may prefer less medical management. High risk individuals may also be attracted to carriers/plans that offer more generous out-of-network benefits. Under current federal guidance, the out-of-network benefits of a plan, if any, are not considered in the calculation of the plan's Actuarial Value.

Differences in total plan-paid health costs for the Exchange due to individuals choosing plans based on their own perception of value are likely to be small. Whereas it is easy for an individual to see that an 80% Actuarial Value plan will cover more of their costs than a 70% plan, it is difficult for the typical individual to quantify the differences between the combination of deductibles, copays, and coinsurance levels that result in a given Actuarial Value. Cost sharing that is likely to be considered by individuals with specific health issues, such as cost sharing for cancer treatment, is more likely to be subject to this kind of selection. The Exchange could minimize this by limiting these types of cost sharing differences between plans.

Selection Risk Faced by Carriers within the Exchange

If carriers view the selection risk as described above, they would all add a selection load to their premiums under Scenarios 2 and 3 to cover the adverse selection expected for the entire SHOP Exchange. Under Scenario 1, I do not believe there would need to be a similar Exchange-wide load.

All three scenarios can create selection risk for individual carriers. The distribution of individuals and their health status between carriers affects the results for each carrier. This may be mitigated by the risk adjustment methods adopted by the SHOP Exchange.

When setting 2014 premiums, carriers will assess their exposure to selection relative to other carriers and will adjust premiums to the extent they believe differences will not be addressed through reinsurance and risk adjustment. Under Scenario 3, the carriers will be concerned if they think they will attract a

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disproportionate number of the high-risk employees in their richer plans. Under Scenario 1, the carriers will be concerned if they think their benefit designs within a metallic level or their network and out-of network provisions will attract a disproportionate number of the high-risk employees. Each carrier will make their best estimate for this selection, and probably add a margin for uncertainty. Under Scenario 2, the carriers will be concerned if they think they will attract a disproportionate number of the high-risk employees in their richer plans and if they think their benefit designs within a metallic level or their network and out-of-network provisions will attract a disproportionate number of the high-risk employees. Over time, as the amount of favorable or unfavorable selection between carriers is measured, the carriers' collective uncertainty related to this choice is reduced, allowing carriers to maintain a selection load, but reduce their additional margin for uncertainty.

The Exchange may consider approaches to mitigate the Scenario 3 risk based on approaches used in the current small group market. For example, Scenario 2 reduces some of this risk by limiting employee choice among metal levels to two adjoining metals. Risk would also be reduced if the "small" small groups were not given this level of choice, again generally consistent with the current small group market.

Additional Considerations

The examples presented in this letter are simplistic and only meant to illustrate specific concepts. In reality, the mechanics of selection may be much more complicated and influenced by other variables. For example, other factors that are important in the decision-making process and influence the degree of adverse selection that can occur may include the provider network, access to non-network providers, and employer premium contribution strategy, among others. It is likely that these factors, especially the premium contribution strategy, will also be significant drivers of selection. The risk to a given carrier will also depend on what metal levels they offer. It is likely that most carriers will want to offer a bronze plan, but may be hesitant to offer a platinum plan. The carriers may choose to limit their risk under Scenario 3 by not offering plans in the richest metal level, platinum.

Differences between our projected selection effects and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

The views expressed in this report are made by the authors of this report and do not represent the opinions of Milliman, Inc.

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This work was completed under the terms of the Consulting Services Agreement between the Exchange and Milliman, dated June 30, 2012.

Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and meet the qualification standards for performing the analysis in this report.

Please contact me (858-587-5302) if you have any questions.

Sincerely,

Robert Cosway, FSA, MAAA
Principal and Consulting Actuary

Attachment A: Illustration of the Impact of Adverse Selection

Section 1: Sample Employer Group with Average Health Status but Variation by Employee

Employee	Expected Total Monthly Health Costs, Before Cost Sharing
A	$150.00
B	$50.00
Average	$100.00

Section 2: Set Premiums based on Average Health Costs

	Expected Total Monthly Health Costs, Before Cost Sharing	Actuarial Value	Expected Plan Cost	Premium
60% Plan	$100.00	90.0%	$90.00	$90.00
90% Plan	$100.00	60.0%	$60.00	$60.00

Section 3: Allow Employer to Choose Metal (Actuarial Value) for all Employees

Employer Chooses 90% Plan

Employee	Expected Total Monthly Health Costs, Before Cost Sharing	Actuarial Value Chosen	Expected Plan Cost	Premium	Exchange Gain/Loss
A	$150.00	90.0%	$135.00	$90.00	-$45.00
B	$50.00	90.0%	$45.00	$90.00	$45.00
Average	$100.00	90.0%	$90.00	$90.00	$0.00

Employer Chooses 60% Plan

Employee	Expected Total Monthly Health Costs, Before Cost Sharing	Actuarial Value Chosen	Expected Plan Cost	Premium	Exchange Gain/Loss
A	$150.00	60.0%	$90.00	$60.00	-$30.00
B	$50.00	60.0%	$30.00	$60.00	$30.00
Average	$100.00	60.0%	$60.00	$60.00	$0.00

Attachment A: Illustration of the Impact of Adverse Selection

Section 4: Allow Employee to Choose Metal (Actuarial Value)

Premiums Set Based on Average Health Costs

Employee	Expected Total Monthly Health Costs, Before Cost Sharing	Actuarial Value Chosen	Expected Plan Cost	Premium	Exchange Gain/Loss
A	$150.00	90.0%	$135.00	$90.00	-$45.00
B	$50.00	60.0%	$30.00	$60.00	$30.00
Average	$100.00	82.5%	$82.50	$75.00	-$7.50

Exchange Increases Premium to Cover Claims - Just Increase the 90% Plan Premium

Employee	Expected Total Monthly Health Costs, Before Cost Sharing	Actuarial Value Chosen	Expected Plan Cost	Premium	Exchange Gain/Loss
A	$150.00	90.0%	$135.00	$105.00	-$30.00
B	$50.00	60.0%	$30.00	$60.00	$30.00
Average	$100.00	82.5%	$82.50	$82.50	$0.00

Exchange Increases Premium to Cover Claims - Increase All the Premiums Proportionally

Employee	Expected Total Monthly Health Costs, Before Cost Sharing	Actuarial Value Chosen	Expected Plan Cost	Premium	Exchange Gain/Loss
A	$150.00	90.0%	$135.00	$99.00	-$36.00
B	$50.00	60.0%	$30.00	$66.00	$36.00
Average	$100.00	82.5%	$82.50	$82.50	$0.00

(1) Illustrative premium rates cover net benefit costs only, and do not include allowance for administrative expenses and profit.