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Key Points

- Many employers and employees will be affected by the change in the small group definition. Among employers offering coverage, employees in groups sized 51-100 comprise roughly 30 percent of employees sized 1-100.
- Groups sized 51-100 will face more restrictive rating rules, which will increase relative premiums for some groups and reduce them for others.
- Groups sized 51-100 will face additional benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums.
- The more restrictive rating and benefit requirements could cause more groups sized 51-100 to self-insure, especially among those whose premiums would increase under the new rule.
- If adverse selection occurs among groups sized 51-100, premiums for groups sized 1-50 could increase.

Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees

In the health insurance market, small employers are those employing up to 50 employees. For plan years beginning in 2016, the Affordable Care Act (ACA) expands the definition of small employers to include those with up to 100 employees. As groups with 51-100 employees renew or newly purchase coverage, they must abide by the rules and regulations governing the small group market, including those related to benefit coverage, actuarial value, and premium rating restrictions. The small group rules apply to fully insured plans, whether they are purchased through or outside of the Small Business Health Options Program (SHOP) marketplace. Plans covering groups with 100 or fewer employees will be pooled together for premium rating purposes.¹ Employers that self-insure are not subject to these requirements.

In addition to the expansion of the small employer definition, the ACA's shared-responsibility provisions—which already apply to groups of 100 and above—will begin applying to groups of 50-99 employees in 2016. Under these provisions, employers will face financial penalties if they have employees who obtain subsidized coverage in an exchange and either don't offer coverage or offer coverage that doesn't meet minimum value and affordability requirements.² As a result, be-

1. This paper refers to small groups as beginning with groups of one, although many states define small groups as beginning with groups of two.

2. See the Kaiser Family Foundation "Penalties for Employers Not Offering Coverage under the Affordable Care Act During 2015 and 2016," for more details on the shared responsibility requirements and penalties. Available from: <http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/>.

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ginning in 2016, the small group market will consist of employers with 1-100 employees - those with 1-49 employees will not be subject to the shared-responsibility penalties but those with 50-100 employees will face them.

As the small group market redefinition takes effect, it's important to consider the potential effects, not only on the groups sized 51-100, but also on those sized 1-50. The American Academy of Actuaries' Individual and Small Group Market Task Force developed this brief to examine how the rules applying to groups sized 51-100 will change and what that means for insurance offerings in the small group market. Specifically, this paper finds that:

- Many employers and employees will be affected by the change in the small group definition. Among employers offering coverage, employees in groups sized 51-100 comprise roughly 30 percent of employees in groups sized 1-100.
- Groups sized 51-100 will face more restrictive rating rules, which will increase relative premiums for some groups and reduce them for others.
- Groups sized 51-100 will face additional

benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums.

- The more restrictive rating and benefit requirements could cause more groups sized 51-100 to self-insure, especially among those whose premiums would increase under the new rules.
- If adverse selection occurs among groups sized 51-100, premiums for groups sized 1-50 could increase.

Many employers and employees will be affected by the new small-group definition

The extent of a potential disruption due to the change in the definition of a small group depends in part on the size of the small group market as well as the relative size of the 51-100 employer group market compared to the 1-50 employer group market.

Data from the Medical Expenditure Panel Survey (MEPS) Insurance Component can be used to gauge the numbers of potentially affected employers and employees, even though the firm size categories of the MEPS differ slightly from the categories affected by the small group definition change. According to the MEPS, there were 159,000 private-sector establishments with a firm size between 50 and 99 that offered only fully insured coverage in 2013.³ Upon renewal of their health insurance plan in 2016, any insurance these groups obtain must meet the ACA small group

Private-Sector Establishments* Offering Coverage and Workers Enrolled, by Firm Size, 2013				
Firm Size	Establishments Offering Only Fully Insured Coverage**		Employees Enrolled in Fully Insured Coverage	
	Number (thousands)	Percent	Number (thousands)	Percent
1-49 Employees	1,592	91%	8,393	71%
50-99 Employees	159	9%	3,413	29%
Total 1-99 Employees	1,752	100%	11,806	100%

Source: American Academy of Actuaries calculations of various MEPS Insurance Component tables available from: http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/ic13_ia_g.pdf

*Private-sector establishments include the self-employed with employees and incorporated self-employed with no employees, but exclude the unincorporated, self-employed with no employees.

**Excludes establishments offering coverage that self-insure at least one plan, even if they also fully insure at least one plan.

3. In the MEPS, the unit of observation is an establishment, but the size categories reflect the entire firm. Establishments reflect a particular workplace or physical location where business is conducted. A firm is a business entity consisting of one or more establishments under common ownership or control. A firm represents the entire organization. In the case of a single-location firm, the firm and establishment are identical.

requirements, unless they have grandfathered coverage.⁴ Although establishments with 50-99 employees comprised only 9 percent of all establishments with fewer than 100 employees that offered coverage, there were 3.4 million enrolled employees in these firms— 29 percent of the enrolled employees in firms with fewer than 100 employees.

The Employee Benefit Research Institute (EBRI) found similar results for 2012 when examining the Current Population Survey (CPS).⁵ Among enrolled employees in groups sized 1-99, 30 percent were in groups with 50-99 employees. This figure includes workers in both fully insured and self-insured plans.

Notably, both the MEPS estimates and the EBRI estimates using the CPS focus on coverage of employees by firm size but do not reflect total numbers of members, which not only includes employees but also dependents. Therefore, the total numbers of affected individuals are understated. Also, the relative size of groups 1-50 and groups 51-99 could be different when dependents are included.

Nevertheless, the number of employers and individuals who will be affected by the change in the small group definition is sizeable. How they are affected in terms of benefit coverage and whether relative premiums would increase or decrease will vary by group. These issues are discussed in more detail below.

Groups sized 51-100 will face more restrictive rating rules

Currently, issuers have broad flexibility in setting premiums for groups with 51-100 employees. There are no federal limitations in premium-rate development,

and at the state level, fewer restrictions are in place for groups sized 51-100 compared to those sized 1-50. When the small group market is expanded, groups sized 51-100 will face significant new rating restrictions. The only allowable characteristics on which the rates may vary from one small group to another are age, geographic area, tobacco use, and family size.⁶ The impact of these more restrictive rules on premiums for groups sized 51-100 will vary across groups.

Common rating variables for groups sized 51-100 that will be prohibited in 2016 include:

- *Health status/historical group claims experience.* Currently, premiums can reflect the health status or claims experience of the group. Beginning in 2016, premiums cannot vary by health status or claims experience of the group, as premiums must be set based on the experience of the risk pool as a whole, which includes all fully insured, non-grandfathered small groups that are insured by the issuer in the state.
- *Industry.* Industry is commonly used to reflect the differences in risk across groups.
- *Group size.* The size of the employer is commonly used as a rating variable to reflect administrative efficiencies and adverse selection.
- *Gender.* Although premiums do not vary by gender within a group, issuers typically use age/gender factors when determining the overall premium of the group. These factors capture not only the impact of age on the cost of coverage, but also the impact of gender, which varies by age. Gender rating will no longer be permitted and, as described below, age rating will be limited.

4. Many states have adopted the ACA transition program, which allows small employers renewing coverage prior to Oct. 1, 2016, to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.

5. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey." EBRI Issue Brief No. 390. September 2013. Available from: http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources1.pdf

6. Premium discounts also are available to groups with wellness programs.

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- *Employee participation rates and employer contribution shares.* Issuers often use these factors to reflect adverse selection, since higher participation rates and employer subsidies can be indicative of a better mix of health risks.

Additional federal limitations on the allowable rating variables that begin to apply to the 51-100 market in 2016 include:

- *Age.* Premiums for the group can reflect its age distribution, but the age rating factors are prescribed and may not vary for adults by more than a ratio of 3 to 1. That is, the rate for a 64-year-old cannot be more than three times the rate for a 21-year-old. Currently, issuers' age factors often reflect up to a 5-to-1 ratio or higher.
- *Geography.* Geographic regions within the state are prescribed and may be significantly different than the regions currently used by issuers.
- *Tobacco use.* Premiums may be increased to reflect tobacco use but not by more than 50 percent.
- *Family size.* At most, three children under the age of 21 within a family may be charged a premium. Additional children receive coverage at no additional charge.

These new rules may result in significant premium-rate changes for some groups, depending on the cumulative impact of the elimination or limitation of the various rating factors. These changes could have either a positive or a negative impact on the renewal rates for groups sized 51-100 in 2016. Premium changes will vary based on characteristics of the firm (e.g., firm size, industry, geographic location) and of its insured population, including employees and their dependents (e.g., age, gender, health status). For instance, the compression of premiums due to the age-rating restrictions will increase the relative rates for groups with a younger population and reduce them for groups with an older population. Similarly, the prohibition of health-status rating will increase the relative premiums for groups with a healthy population and reduce them for those with less healthy populations.

In addition to the changes in allowable premium rating factors, groups sized 51-100 could face a change in how issuers bill for group coverage. In the small

group market, issuers bill employers by listing the rate applicable to each enrolled employee, based on the age of each member-employee and dependent-enrolled in the plan.⁷ This is referred to as list billing. In contrast, for groups sized 51-100, issuers usually use composite rating, in which the premiums shown on the bill represent the average rate for each family size coverage tier offered. Issuers also may choose to offer its small groups a composite premium option, and the total group premium would be the same as that under list billing. The approach determining the composite premium would be the same as that under list billing. The approach determining the composite premium for the small group market, however, is very different from that currently used for groups sized 51-100. If list billing is extended to the 51-100 group market, it will introduce administrative complexity for that market that does not exist today.

Groups sized 51-100 will face additional benefit and cost-sharing requirements

When the expanded small group definition becomes effective, groups sized 51-100 will for the first time be under ACA plan-design requirements that already apply to groups sized 1-50. First, these groups will be subject to the essential health benefits (EHB) requirement, which defines the set of health care service categories that must be covered by the plan. EHBs include some benefits, such as pediatric dental, that typically are not included in plans in the large group medical market. Second, all plans must satisfy a metallic benefit level ranging from bronze to platinum, reflecting the actuarial value of the plans' cost-sharing features (i.e., the portion of covered benefits paid for by the plan, on average).

When these new requirements were imposed on small groups sized 1-50 beginning in 2014, they did not significantly impede plan-design flexibility, because these groups were already subject to a fairly limited range of benefit-design choices. Compared to groups with 50 or fewer employees, however, groups with more than 50 employees typically have had more flexibility in the benefit options from which they could choose, both from a covered-services perspective as well as for specific cost-sharing features. The ACA requires non-grandfathered plans for groups

7. As noted above, a maximum of three children under the age of 21 can be billed as dependents for a specific employee.

larger than 50 to comply with provisions related to annual out-of-pocket limits, annual benefit limits, and coverage of preventive services with no consumer cost sharing.⁸ But aside from these requirements and the 60 percent minimum value requirement, the ACA allows large groups a great deal of flexibility regarding covered benefits and other limitations on plan-design features.

As a result, the new requirements will impose a greater reduction in benefit and cost-sharing flexibility for groups sized 51-100 than they currently experience. Plans likely will need to be changed to meet benefit coverage and actuarial value requirements. Such

changes also could affect premiums. For instance, upward pressure on premiums could result if the EHB and cost-sharing requirements result in more generous coverage.

Younger and healthier groups sized 51-100 may face increased incentives to self-insure

Groups sized 51-100 that will be subject to the small group market rules may have increased incentives to self-insure. A primary reason might be to avoid a higher premium in the fully insured, small group market due to premium-rating limitations and benefit and cost-sharing requirements. A self-funded

Prevalence of Self-Funding

Employers that offer health insurance benefits can opt to purchase fully insured coverage, or they can opt to bear the insurance risks themselves and self-insure. The Employee Retirement Income Security Act (ERISA) exempts self-insured health plans from state health insurance regulations, including issue and rating rules and benefit requirements. As a result, self-insured groups can have more flexibility regarding benefit coverage and plan design, and their costs more directly reflect their actual claims. Self-insured groups are also exempt from state premium taxes and the ACA health insurance fee levied on fully insured plans. Although self-insuring can subject firms to risks of unexpected high claims, this risk can be limited through the purchase of stop-loss coverage.

Employer size, in particular, is a primary factor in determining whether it is feasible for an employer to self-insure. In smaller groups, large year-to-year fluctuations in claims can occur, making it more difficult and risky to budget directly for health costs. As group size increases, however, health claims are likely to be more predictable and stable. Indeed, the prevalence of self-funding generally increases by firm size.

Firm Size	Percent of Enrollees in Self-Insured Plans
1-10	13.1%
11-24	9.7%
25-49	11.9%
50-99	14.3%
100-999	33.6%
1,000+	85.6%

Source: American Academy of Actuaries calculations of various MEPS Insurance Component tables available from: http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/ic13_ia_g.pdf

An employer's demographic characteristics, which factor into expected health costs, also can influence whether it self-insures. For instance, groups with younger or higher-paid employees may be more likely to self-insure than those with older or lower-paid employees.

8. In addition to these provisions, plans were no longer allowed to impose benefit limitations on pre-existing conditions or to charge higher cost-sharing for emergency services provided out of network.

group's health plan costs more directly reflect its own claims experience and demographics. Therefore, groups more likely to see relative premium increases, including those with a younger and healthier population, may have the greatest incentives to self-insure. Offsetting these potential advantages are: a greater fluctuation in cash flow associated with self-funding; potentially greater financial risk, depending on the morbidity of the group; and a greater assumption of administrative responsibilities as well as compliance and reporting requirements, which generally are within the domain of the insurer. Reinsurance mechanisms and third-party administrators can mitigate these disadvantages.

Although self-insurance typically has been more prevalent among larger firms, lower stop-loss attachment points have become more available, making self-insurance with stop-loss coverage a more viable, and less risky, option for small employers. In addition, self-insuring becomes somewhat less risky to plans after the small group definition is extended, because it provides these groups the protection of guaranteed issue coverage. Currently, if a member of the self-insured group has a significant continuing claim, the employer's costs will increase. In the underwritten large group market, the employer may have difficulty renewing its stop-loss coverage or finding a fully insured plan with a premium not reflecting the high cost of that continuing claim. As a small group, however, the employer could apply for fully insured, small group coverage at rates that do not reflect health status or claims experience. Once the claim is resolved, it could be possible for the employer to revert back to self-insurance. Notably, an EBRI study found that after Massachusetts implemented health reforms in 2006, self-funding increased for all firm sizes greater than 50.⁹

If higher-cost groups sized 51-100 continue to opt for fully insured coverage but more lower-cost groups self-insure, the small group, single risk pool plans would experience adverse selection. Premiums for these plans would increase as a result.

Adverse selection among groups sized 51-100 could increase premiums for groups sized 1-50

Current premiums for groups sized 1-50 reflect the average costs for these groups. When the small group definition is extended, then premiums in the small group market will change to reflect the influx of groups sized 51-100. If the average costs for groups sized 51-100 that enter the market exceed the current average costs of groups sized 1-50, due to adverse selection or other reasons, small group rates would increase as a result. In response to any higher premiums, groups sized 1-50 may reconsider their decision to offer health insurance, especially because they are not subject to the employer-shared responsibility provisions.

Although it is possible that premiums for groups sized 1-50 would decline if groups sized 51-100 are lower cost on average than smaller groups and they opt to continue to fully insure, factors exerting upward pressure on premiums are more likely to dominate.

The premium impact on groups sized 1-50 will depend not only on the average costs of the groups sized 51-100 relative to those of groups sized 1-50, but also the distribution by group size within the 1-100 market. There are more than twice as many covered employees in the 1-50 group size category than in the 51-100 category, which would somewhat moderate the premium impact.

The full impact of the small group definition change on premiums will occur over several years

Many states have adopted the ACA-transition program, which allows small employers to delay entering the ACA-compliant marketplace until after their 2016 plan year ends.¹⁰ Groups sized 51-100 that would face higher costs or less attractive benefit plans by moving to an ACA-compliant small group plan would be more likely to renew their current plans into 2017, after which they would need to move to a small group plan if they want fully insured coverage. This postponement would likely result in higher small group market premiums in 2016. Such an increase could be

9. Paul Fronstin, "Self-Insured Health Plans: State Variation and Recent Trend by Firm Size." EBRI Notes: 33(11). November 2012. Available from: http://www.ebri.org/pdf/notespdf/ebri_notes_11_nov-12.slf-insrd1.pdf

10. The March 4, 2015, CMS Bulletin, "Insurance Standards Bulletin Series - Extension of Transitional Policy through October 1, 2016," gives states the option of deferring compliance with the expanded small group definition for groups renewing their policies on or before Oct. 1, 2016. This is a state-by-state decision. Available from: <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>

temporary to the extent that lower-cost groups eventually purchase small group plans in 2017 rather than moving to self-insured plans. Therefore, a new equilibrium may be delayed until 2018, with premium impacts differing in the intervening years.

Conclusion

For plan years beginning in 2016, the definition of small employers will expand from employers with 1-50 workers to also include those with 51-100 workers. Such a change could affect over 150,000 establishments with more than 3 million workers. Groups sized 51-100 will face more restrictive rating rules, which likely would increase relative premiums for some

groups, such as those with younger and healthier populations, and reduce relative premiums for others, such as those with older and sicker populations. Additional benefit and cost-sharing requirements could increase the comprehensiveness of coverage, and could also reduce plan-design flexibility and increase premiums. These changes may provide increased incentives for groups sized 51-100 to self-insure in order to avoid these requirements. In particular, the prevalence of self-insurance among lower-cost groups could increase. If such adverse selection were to occur, average premiums could increase not only for fully insured groups sized 51-100 but also for groups sized 1-50, because these two subgroups will be combined for premium rating purposes.