ACA Implementation—Monitoring and Tracking

Implementation of Small Business Exchanges in Six States

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states.[1] In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

The Affordable Care Act (ACA) introduces insurance exchanges as a tool to provide structure and oversight to the nongroup and small group insurance markets. Lacking the purchasing power of large employer groups, having fewer individuals over whom to spread health care risk, and facing higher per enrollee administrative costs, small employer groups often face higher premium rates and fewer health insurance options than do large groups. The Small Business Health Options Program, or the SHOP exchange, is intended to provide administrative relief as well as affordable coverage options to small businesses across the country. While both the federally facilitated exchanges (FFEs) as well as the state based exchanges (SBEs) will have a SHOP exchange, this paper focuses on SHOP development in six SBEs: New York, Oregon, Rhode Island, Colorado, Maryland, and New Mexico.[2] As our findings will show, there is much variation across the states with regards to the development and implementation of the SHOP exchanges. These six states may not be representative of all SBEs, however.

Of six states analyzed, all intend to offer employee choice through their small business exchanges, report strong interest from carriers, and do not anticipate upheaval among brokers.

This paper begins by providing an overview of the functions of the SHOP as intended by the ACA and discusses recently issued rules that affect the future and viability of the SHOP exchanges. We then delineate the available policy options for states implementing a SHOP exchange and thereafter provide an in-depth discussion of the policy options selected by the studied states. As the SHOP is targeted towards small businesses, the small business perspective and state efforts to educate employer groups about the SHOP exchanges are discussed as well. We conclude by outlining challenges to effective SHOP development and long-term maintenance of the SHOP exchanges.

Major Findings

- Policy decision-making varied state to state and appears to be rooted in specific market dynamics that exist in each individual state. For example, smaller states like Rhode Island can expect greater uniformity in SHOP participation across insurance carriers (from here forward referred to as "carriers") and brokers, while larger states like New York will incorporate more flexibility to account for market dynamics that differ across the various regions in the state;
- Brokers and agents remain a key aspect of the small group market and will be a key partner in maximizing SHOP enrollment;
- Regardless of the federal decision to delay implementation of employee choice, all studied SBE states seem likely to include some version of an employee choice model in their SHOP exchanges beginning in 2014;
- Carrier interest appears high, although in most states this interest is currently indicated by nonbinding letters of intent. The number of plans that actually commit to the SHOP exchange may decline once each state has finalized its requirements for SHOP qualified health plans;

- Small business owners face a steep learning curve related to the new exchange-based options. Many lack good information and harbor negative feelings towards the ACA, although there is evidence that individual components of the law carry significant appeal; and
- Communication efforts are just beginning in most states and implementing effective small business outreach strategies pose a significant challenge for the states.

SMALL BUSINESS HEALTH OPTIONS PROGRAM: AN OVERVIEW OF FEDERAL RULES AND GUIDELINES

The Affordable Care Act requires each state operating an individual exchange to also operate a SHOP exchange, offering small employer groups the opportunity to provide their employees comprehensive health insurance coverage that meets federal and state requirements for qualified health plans. The final exchange rules issued in July 2012 recognize that while significant overlap exists between the functions of a non-group exchange and a SHOP exchange, the SHOP exchange has many unique qualifications. Functions of the SHOP include:[3]

- Assisting qualified employers and facilitating the enrollment of qualified employees into a qualified health plan (QHP) at either the bronze, silver, gold, or platinum coverage tier;
- Allowing for a variety of employer/employee choice models:
  1. Full employee choice, wherein an employee may choose any plan at any tier level;
  2. Partial employee choice, wherein an employer chooses a tier level and an employee may choose any plan available at the selected tier level;
  3. Employers may select a specific QHP and allow employees to select that QHP at different tiers of coverage;
  4. Employers may select a reference tier level and an employee may choose plans in that tier or adjacent tiers;
  5. Full employer choice, wherein employers select a QHP at a specific coverage level (this option does not allow for any employee choice);
- In the presence of employee choice, displaying for employees the contribution required for each QHP of interest, after subtracting the applicable employer contribution;
- Aligning special enrollment periods in the SHOP with special enrollment periods in the nongroup exchange;[4]
- Aggregating premiums so that qualified employers will receive one monthly bill that accounts for premium payments for all enrolled employees. Additionally, once the bill is paid, rather than the employer paying each QHP, the SHOP or its contractors will direct payments to applicable carriers; and
- Mitigating risk and adverse selection in the SHOP exchange, as well as mitigating risk and adverse selection between SHOP products and small group market products outside the SHOP market, using risk adjustment programs, and possibly using minimum employer contribution requirements and minimum employee participation requirements as well.

While the scope of this paper focuses on SHOP implementation in SBE states, the Center for Consumer Information and Insurance Oversight (CCIIO) recently issued a set of decisions that affect both the SBE SHOP and FFE SHOP. Guidance issued by CCIIO in March, 2013 announced that, while the agency will still be moving forward with the SHOP program for FFE states, rather than include employee choice immediately, the federal government will implement a "transitional policy" of employer choice until January 1, 2015. The transitional policy will "assist employers in choosing a single QHP to offer their qualified employees."[5] The guidance allows SBE SHOPs the same opportunity to delay implementation of employee choice.[6]

SUMMARY OF POLICY OPTIONS AVAILABLE TO STATES

States developing their own SHOP exchange retain significant control over design. The policy options available include:

- Determining whether or not plans participating in the SHOP will be required to offer coverage at a particular actuarial level (or levels) beyond the silver and gold levels which are required in the federal law;
- Delineating employee and/or employer choice models offered;
- Deciding minimum employee participation requirements, if any, in order to allow a firm to participate;
- Standardizing the level of employer defined contribution, if any;
- Delineating the role of brokers as well as the mechanism for and level of their compensation;
- Implementing standardized benefits or cost sharing in the small group market beyond what is federally required;
- Developing policies for the small group market outside versus inside the market, in an effort to level the playing field between the two markets; and
- Designing and implementing consumer assistance strategies/materials to facilitate enrollment.

In addition, two policy options that affect the entire small group market have potential implications for premium rating and participation in the exchange:

- Maintaining the small group and nongroup markets as separate risk pools for premium rating purposes, or merging the small group and nongroup markets; and
- Defining the small group market as 50 or fewer workers until 2016, or defining the small group market as 100 or fewer workers prior to 2016.

Based on the information collected in our interviews, considerable variation exists among states in the design decisions they have made. However, state officials have universally indicated a desire to minimize initial small group market disruption, such as a rate increase that might cause some employers to drop or change coverage. As a result, for the first plan year, all of the participating states have chosen to maintain the small group and nongroup markets as separate risk pools. They have also decided to maintain the definition of small group at 50 or fewer employees until 2016, when the ACA requires that the threshold increase to 100 or fewer employees. While some of the smaller states in the study, like Rhode Island, considered merging the two markets, concern over the possible resulting premium increases in the small group market led the state to maintain the status quo at least until the 2014 reforms have been fully implemented and a new market equilibrium reached. According to a detailed analysis performed by Wakely Consulting and produced in a report for the state, "individual group premiums are advantaged in a merged market environment and small group rates are disadvantaged."[7]

All the SBEs in this study built new IT platforms to facilitate enrollment in Medicaid, the nongroup exchange, and SHOP exchange. In the interest of reducing the amount of work for the states, all studied states have decided to use the same IT platform for the SHOP as is being used for the nongroup exchange. Each state's IT team, however, will be able to build different rules engines for the SHOP, allowing the accommodation of unique characteristics that are only applicable to the SHOP exchange, such as composite premiums, premium aggregation and a 30-day special open enrollment period (versus the 60 day special enrollment period in the nongroup exchange).

PERSPECTIVES FROM THE FIELD: VALUE-ADDED OF THE SHOP EXCHANGE TO THE SMALL GROUP MARKET

Fully insured, nongrandfathered small group plans, whether they are offered inside or outside the exchange market, are required to comply with the private market reforms enumerated in the ACA, such as the inclusion of essential health benefits, modified community rating of premiums, compliance with actuarial value tiers,

prohibition of pre-existing condition exclusions, and excessive waiting periods.[8] Beyond the inclusion of these new regulations, contacts varied considerably in their views on whether the SHOP adds value to the small group marketplace. While some brokers were not convinced that the SHOP would add any clear value at all, many contacts mentioned two main advantages: administrative relief for employers wishing to offer coverage to their workers and the provision of plan choice for employees of small firms.

Many small businesses lack a human resources department that can offer specialized knowledge in health insurance; instead, the owner is often responsible for deciding which health plan will best suit his/her employees. Given the complexity of the shopping experience, many small employers work with a broker for guidance through the plan selection process. Even so, accessing and internalizing information on coverage options across carriers and levels of coverage can be time-consuming and difficult. Furthermore, small employers reported being aware that selecting a single coverage option will leave at least some of the firm's workers dissatisfied. SHOP exchanges are expected to provide more consumer-friendly information for plan comparison purposes, combined with an ability to compare plans more easily than in the current market, and contacts feel that these informational tools should enable employers to better understand the available options and their trade-offs.

In addition, SHOP exchanges providing some degree of employee choice of plan (discussed further below) allow employers to designate a contribution level toward their workers' coverage and then workers can independently choose from a menu of plans, the one that best suits their needs. This exchange design feature provides the employers with a mechanism for controlling their spending on health insurance to a desired level while providing more flexibility to the workers than they generally have in the outside market. This feature was most frequently mentioned in interviews as a way the SHOP could offer a value proposition for employers.

PERSPECTIVE FROM THE FIELD: DECISIONS ON DESIGN OPTIONS

The following section contains detailed information on the status of policy design decisions and their implementation in the examined states.

Employee Choice

An employee choice structure in the SHOP exchange allows small employers to offer their employees multiple health plan options, a rarity for small employers in the pre-reform marketplace and a feature noted by sources as very popular among employers and employees alike. Although recent federal guidance allows states to delay implementation of employee choice, sources stressed the importance of employee choice as a critical mechanism for attracting small employers to the SHOP exchange.

Among the states studied, Colorado, Oregon, and Rhode Island are pursuing expansive employee choice most aggressively. Oregon and Colorado will provide very similar options for employee/employer choice models. They each provide four options for the employer to choose from. The first three options are the same in both Oregon and Colorado, and the fourth option is slightly different between the two states:

1. Employer chooses one carrier and one plan (i.e., employer choice, no employee choice);
2. Employer chooses one carrier, with employees having choice of all of the plans offered by that carrier;
3. Employer chooses one actuarial value (precious metal) level, and employees choose among all carriers and their plans offered at that metal level;
4. *Colorado:* Employer chooses two adjacent actuarial value (precious metal) levels (e.g., bronze and silver, silver and gold, gold and platinum), and employees choose among all carriers and plans that are offered in those adjacent tiers; *Oregon:* Employer chooses a reference plan in a particular tier, and employees have their choice of plan in that chosen tier, one tier up in actuarial value and all tiers down in actuarial value.

Contacts in both Colorado and Oregon felt that employers as well as employees place a high value on choice, and providing these four options is a way to provide that to both groups.

Sources in Rhode Island explained that the state is planning to implement a full employee choice model, where employers could set a defined contribution level based on a reference plan, and workers could choose among any plan offered through the SHOP at every actuarial value tier. Rhode Island will also provide employers with the option of traditional employer choice where the employer picks one carrier and one plan. The state was receiving some negative feedback from carriers on the issue of employee choice. Carriers worried that once a small group divides its enrollment across multiple insurance plans, certain carriers will attract a higher cost selection of enrollees. Since carriers lack confidence in risk adjustment, they fear insurance plans selected against may not be fully compensated for a higher cost group of enrollees. However, initial negative feedback from carriers was mitigated when Rhode Island adopted a list-bill foundation to build rates, while maintaining composite rates only for the reference plan. This approach is discussed more fully in the next section.

Maryland's first year approach is to provide three options to employers:

1. Employer choice of one carrier, with employee choice of plans in any actuarial value tier offered by the selected carrier;

2. Employer choice of one carrier, with limited employee choice of plans in actuarial value tiers; or

3. Employer choice of one actuarial value tier, with employee choice of plan within that tier.

In addition, the Maryland SHOP will introduce a reference plan approach to give employers a clear basis for determining their costs. If an employee chooses a different plan from the reference plan, the employee will make up the difference in cost, as will be the case in Rhode Island. Contacts emphasized that this approach was taken in order to simplify the process for employers participating in the SHOP.

At the time of our interviews, New York had yet to delineate the details of the employee/employer choice model it will use for the SHOP, as they are awaiting additional technical guidance from HHS. However, New York's level two exchange establishment grant, as well as the invitation to participate in the SHOP issued to carriers, clearly states the intent to incorporate an employee choice model into the SHOP for 2014.[9,10] New Mexico had a late start to exchange and SHOP development as they only recently passed exchange-enabling legislation in the state. A recent New Mexico task force memo indicates that the state has not yet made a definitive decision on employee choice, although the task force recognizes the benefit of employee choice and is weighing it as an option.[11]

Composite Premium Computations Under Employee Choice

Multiple states commented on the challenge of constructing an employee choice model that also allows employers to comply with federal age-related nondiscrimination rules. Under the federal Age Discrimination in Employment Act (ADEA), employers are prohibited from discriminating against older workers in their employee benefits. It is not yet clear, however, how this law interacts with the provision of the Affordable Care Act allowing carriers to charge older individuals as much as three times the premium rate charged to a younger person. State officials expressed significant frustration in the timing and availability of federal guidance to work through these issues effectively and in a timeframe to coordinate decisions with IT development, although, since our interviews, CCIIO has approved state-proposed composite premium approaches that will help assuage SHOP administrators' concerns about complying with the ADEA.

When an employer pays only one carrier to cover all of its workers, that carrier can sum the necessary premiums across all the workers and provide the employer with an aggregate premium cost. The employer then decides how much contribution the firm will make, and divides the remainder across its workers. However, when employees of varying ages choose coverage from different carriers in the exchange, it becomes much more complex. Employer contributions must be set before workers make their plan choices so that each worker understands the out-of-pocket premium he/she faces with each insurance option. However, before each worker chooses a plan, the employer does not know the total costs of insurance for covering them, so setting employer contributions as a simple percentage of total costs is not an option. And since anti-discrimination rules require that older workers not bear the full differential in their premiums relative to younger workers, the process of setting the employer's premium contribution is particularly challenging.

Multiple states including Oregon, Rhode Island, and Maryland are poised to choose composite premium approaches from among options delineated by Wakely Consulting Group.[12] Oregon recently received approval from CCIIO to use the Wakely approach described as

"Reallocated Composite with Buy-Up/Down Equal to Difference in Composite Rates." Under this approach, composite or average premiums are calculated for each plan, assuming that all workers enroll in each plan. The employer chooses a reference plan and decides upon a contribution level for that reference plan. Based upon that information, each employee decides which plan he/she wants from among the options made available to them. If they choose a plan more expensive (or less expensive) than the reference plan, they pay (or receive) the difference between the composite premium for the reference plan and the composite premium for the plan chosen. Plans are paid premiums adjusted for the age composition of those choosing the particular plan, although premium contributions by employees do not vary by age.

Rhode Island will use Wakely's "Reallocated Composite with Buy-Up/Down Equal to Difference in List Bill Rates" option. Like the Oregon approach, this option uses a reference plan to determine employer contributions based upon a composite premium. Every worker, regardless of age, then faces the same contribution requirement if they choose the reference premium. Unlike the previous option, however, workers choosing a more expensive plan than the reference plan will face the full age-rated difference between the chosen plan's premium and the composite premium for the reference plan. Under the Oregon approach, workers choosing a more expensive plan than the reference plan would still pay a contribution based upon composite premiums. In this way, the Oregon approach shields workers from age rating differences in premium contributions regardless of the plan the worker chooses, whereas the Rhode Island approach shields workers from a substantial amount of those differences, but not all of it if the worker chooses a plan with a higher premium than the reference plan. Simple examples of the composite premium calculations for these two approaches and the resulting employer and employee responsibilities are shown in the appendix to this report.

Brokers and Agents

Across all of the studied states, there is a clear consensus that brokers/agents will play a significant role in the SHOP. For convenience, we refer to brokers in the following sections, although we recognize that the term "agent" is preferred in some markets. Many state contacts noted that brokers are the main conduit between health insurance and small businesses. While the share of the market mediated by brokers varies somewhat across the states, it is consistently high in the small group market, with one interviewed state reporting approximately 90 percent of the small group market using broker services. Brokers we interviewed acknowledged that most state discussions about their role in the exchanges has been inclusive and indicates recognition of the services they can offer to the exchange and small businesses. Regardless of the state efforts to educate and engage brokers, many of them still fear that programs such as navigators and in-person assistors, whose functions include some roles traditionally played by the brokers, will negatively impact brokers' business.

Broker Licensing. In order to sell health insurance as a broker in any state, brokers must follow individual state licensing laws that vary across the country. Across the board, brokers interviewed did not believe that statutory changes to licensing laws would be required; however, some brokers noted the need for additional training in order to better understand the new federal requirements under the Affordable Care Act.

Depending upon the state and market, brokers may be certified to sell insurance only through particular carriers, while in other states with fewer carriers, brokers may sell coverage for all carriers. Some states with brokers limited to selling coverage for particular carriers have taken steps to ensure that any broker selling SHOP-based coverage can provide information and sell any product offered in the SHOP. Without taking such steps, small employers interested in SHOP coverage may not be exposed to all the available options unless they explore plans independent of a broker.

Brokers in Rhode Island operate independently of carriers today, and all have appointments to sell coverage for each of the state's three carriers, so there will be no issue with regard to SHOP-based sales. In Maryland, however, not all brokers have appointments with all carriers. Maryland will not require brokers to have appointments with all carriers as a condition of discussing plans with SHOP-eligible employers. Brokers will, however, have to obtain carrier appointments to be compensated for SHOP sales. The appointment may be obtained by the broker as late as the point of sale, with the expectation that carriers will accept appointments of authorized SHOP exchange brokers. However, a carrier is still permitted several statutorily defined reasons for denying such appointment.

Recognizing that there may be many different carrier offerings in the SHOP and recognizing the regional differences that exist within the small group market,

larger states like New York and Oregon are not requiring brokers to obtain appointments with all plans offering in the SHOP. Still, these states did express some concern that larger carriers could have an unfair advantage in the SHOP, because they have more brokers selling their products. In an attempt to mitigate this potential bias, Cover Oregon is itself appointed with all carriers as the broker; they will then certify individual brokers that have been trained to sell all the products available on the exchange (the term "agent" is used in Oregon but we continue to use "broker" here to avoid confusion). Employers may use any exchange certified broker to assist them. There remains the option of purchasing coverage directly through the online portal without agent assistance.

Broker Compensation. Consistent with the theme of minimizing the number of changes taking place, most states seem to be relying on the mechanisms that already exist in order to compensate brokers, with carriers paying the brokers for group policy sales. Oregon has, however, decided that the SHOP will be the mechanism through which broker compensation flows. The carrier will pay the SHOP the broker fees, and the SHOP will pass through 100 percent of those fees to the broker who brought the client to the SHOP. If the group uses the online portal through Cover Oregon, the carrier will not owe a fee to the SHOP.

Most states are also requiring that broker compensation be the same inside and outside the exchange market, as they are sensitive to any incentives that brokers may have to steer enrollment outside of the exchange. If the compensation for brokers were greater outside the exchange market, brokers would be more inclined to show and thus sell products outside of the market to small businesses. The only threat to this equilibrium that falls outside of the control of state regulators is the presence of private exchanges (discussed further below) which may be able to offer brokers greater compensation for small group policies in an attempt to encourage brokers to sell more private-exchange plans.

Planning Offerings in the non-SHOP Small Group Market

Among the six states interviewed, there was little planned regulation of the nonexchange small group market beyond the federal requirements. One SHOP exchange director commented, "We have to merge into existing traffic and earn our way." This means that carriers can offer different plans outside of the SHOP than inside it, carriers can offer as many non-SHOP plans at each actuarial level as desired outside, and, with one exception, may offer coverage outside of the SHOP without participating in SHOP. In Maryland, however, carriers with significant business in the current small group market—those with a current book of business of $20 million or more—must participate in the SHOP if they are to remain in the state's small group market at all. If they choose, New York small group carriers may offer coverage in the non-SHOP small group market only; however, those that do so must offer coverage at every ACA-designated actuarial value level.[13] This approach prevents carriers from attempting to select the best risks by, for example, only offering bronze level coverage outside the exchange environment.

Plan Offerings by Carriers Participating in the SHOP

Three of the states contacted for this study, Maryland, Oregon, and New York, have placed limits on the number or type of plans that carriers can offer in the SHOP exchange. These limits and requirements are intended to make plan comparisons easier for consumers, limit confusion, increase the efficiency and effectiveness of the insurance shopping experience, and encourage competition through greater comparability of options while still allowing room for carrier innovation in plan design. In Maryland, each participating medical carrier and any of their legal entities are limited to offering four or fewer plans at each actuarial value (precious metal) tier in the exchange. At this time, the state is not requiring plans to provide standardized benefits or cost sharing; they must only be compliant with applicable federal rules. Participation in New York's SHOP exchange requires carriers to offer a standard product at each metal level; carriers can offer up to three nonstandard products as well. There are no limits beyond the federal requirements in the non-SHOP small group market. In the SHOP market in Oregon, carriers will offer a standardized plan at bronze, silver and gold levels. In addition, carriers may offer two more plans per tier and three plans at the platinum level. If carriers develop innovative plans, they may offer an additional two innovative plans per tier. As a result, each carrier could offer up to five plans per tier.

SHOP Administrative Supports

State contacts emphasized the desire to make SHOP participation as easy as possible for small employers. All states in the analysis are planning to do premium aggregation and disbursement to the carriers, as required by federal law. A number of states, including Oregon and Colorado, mentioned their intent to assist employers with

COBRA administration, provide flexible account support, and/or provide administrative support in establishing section 125 plans. However, most of these additional supports were not expected to be online in October 2013, but are expected to be available sometime after the required SHOP components are fully established.

Small Employer Attitudes and Plans for Education and Outreach

Contacts in each state acknowledged that many employers' attitudes have been colored by the heated political debate surrounding reform, and many others remain unaware of or feel they lack information about the impending changes to the small group marketplace. Confusion and fear of change seem to have been exacerbated by considerable misinformation. All state officials recognize that a small employer educational effort is both necessary and challenging, given these factors. Contacts in Rhode Island and Colorado noted that when the components of the small group reforms are described to small employers in a factual way outside of the context of the political debate, for example in focus groups, many employers are very enthusiastic about specific reforms in the Affordable Care Act. When they are described as a component of "Obamacare," the reaction is often strongly negative. There was also agreement that the true reaction will have to wait until the actual plan and premium offerings are available, given the cautious nature of many small employers. As one contact noted, "People like to be followers, not leaders, so there may be some hesitance to adapt. No one wants to be the test group."

Oregon state officials were planning for a media education blitz related to the SHOP exchange which was set to begin within a couple of months of our conversation. The Colorado SHOP has an outreach effort already in progress, and it is heavily focused on the state's broker community, since 93 percent of the state's 33,000 small groups obtain coverage with one. Thus, they are concentrating on educating the broker community on the SHOP's value proposition and encouraging them to expand into industries that have traditionally not offered coverage to their workers (e.g., restaurants, landscaping firms) as a way for them to expand their business. Relatedly, the state SHOP is interacting with associations that have many members without coverage, exploring how these workers can be navigated into the nongroup exchange.

When we spoke to New York officials in January, they noted that they were in the early stages of developing their communications with small employers, but wanted to be able to train brokers first. Brokers would then be able to help train small employer groups, as a majority of small group coverage in New York is mediated by brokers, relieving the state of being the sole party responsible for educating small groups. Maryland had also begun discussions on how to target communications towards small employer groups, but at the time of our conversation there were no concrete plans in place, either from the state or the Chamber of Commerce, to educate small employer groups about the SHOP.

Carrier Participation

Contacts in all states noted that carrier interest appeared high, as evidenced by the volume of letters of intent submitted by the carriers in each state, although, with the exception of Oregon, carriers had yet to formally commit to participating in the SHOP when we spoke. Thus, it is possible that the high interest states are initially seeing may not reflect actual plan participation. The letters of intent are nonbinding and are merely a way for carriers to get their foot in the door; there is nothing precluding them from committing to the SHOP exchange once the state has determined final rules governing participation. Maryland has accounted for six medical carriers who will offer plans in the SHOP, and Oregon announced that 13 plans intend on offering insurance plans in the state's SHOP.[14] Rhode Island has three participating carriers that have filed 16 SHOP plans between them. Maryland, New Mexico, and Oregon also anticipated new entrants into their small group markets, including co-op plans. Officials in New Mexico noted that the state's five largest carriers already participate in the state created nonprofit Health Insurance Alliance program, suggesting that they will also participate in SHOP.

Private Exchanges

Sources in all the states participating in this study reported some private exchange activity, although the concept of private exchanges seemed to still be in the definitional stage. Multiple contacts consider them simply to be a different way to market existing plans. In Colorado, for example, some private exchanges consist of brokers paying a monthly fee to display online proposals from an array of carriers to clients who have electronically entered their employees' information. The Colorado SHOP officials view these broker-driven entities as potential opportunities for partnership with the SHOP. A particular opportunity may present itself in coordinating with large web-based agencies.

New York has had a number of private insurance exchanges for some time, although insurance industry contacts do not consider them to be very popular. Additional private exchanges are appearing in response to the ACA, and are being marketed as adding similar value as the state's SHOP exchange, namely employee choice, defined contribution and administrative supports. Federal tax credits available to the smallest and lowest wage employers will only be provided through the public exchanges, creating some expected draw from the existing private exchanges to the new public one. Some speculated that carriers could participate in both the private and the public exchange.

Maryland's third-party administrators, (TPAs), which support the vast majority of brokers selling small group coverage in the state, are considered by many there as prototypical private exchanges. These TPAs and their administrative structures have been explicitly incorporated in the state's exchange structure, creating a platform that is more likely to make them collaborators than competitors. However, at least one large carrier in the state reported exploring a private exchange option themselves. Others felt that private exchanges could gravitate to focus on larger groups or self-insuring small groups, rather than small groups.

While no private exchanges currently exist in Rhode Island, some entities, including United Health, were reportedly considering developing them. Contacts in Oregon believed that the state's bipartisan history of support and focus on a public exchange means that private exchanges would struggle there.

Overall, the potential disruptive effect of private exchanges competing with the SHOP is unclear at present, and will likely vary by state. Monitoring these entities, considering opportunities to partner with them, and assessing differential compensation of brokers between private and the public exchange will likely be valuable.

PERSPECTIVES FROM THE FIELD: CHALLENGES TO DEVELOPMENT AND MAINTENANCE OF ROBUST SHOP EXCHANGES

Contacts noted an array of challenges facing the SHOP. Frequently, sources cited the education of small employers regarding SHOP's value proposition as an enormous job that was only just beginning. They recognize these tasks as critical to obtaining a sustainable level of enrollment. Some cited low employer enrollment in the Massachusetts Connector as a warning signal, a likely consequence of the state's dominant carrier not participating in the SHOP. More skeptically, a number of brokers we spoke to were uncertain that there was a value proposition to the SHOP, and they doubted its long-term viability. Others noted that timely outreach, education, and coordination of navigators, in-person assistors, and brokers are critical activities that pose additional challenges. As is the case with virtually any conversation with individuals involved in implementing exchanges, contacts participating in this analysis mention the tremendous challenges of the IT system build. The desired functionality of the SHOP exchanges is extensive. Everything from capacity for employers to do anonymous shopping, sorting and filtering of plan options, account set up, plan view, estimation of tax credits, check-out, interface with other entities, and alignment of the build with the individual exchanges are in the works. In fact, after our interviews, Maryland announced that it would be delaying open enrollment for its SHOP exchange from October 1, 2013 to January 1, 2014, to allow for implementation alignment with market partners.

In general, state officials expressed frustration that questions to the federal government have been unanswered and promised tools, such as employer and employee applications, have not been delivered. In addition, one state official lamented "continually changing federal interpretations that always seem to occur at the eleventh hour. Every time they issue something that differs from their initial direction, it is mind boggling and frustrating for the states that started ahead of time."

CONCLUSION

Five of the six states studied (Maryland, Oregon, Rhode Island, Colorado, and New York) have aggressively pursued implementation of state-based SHOP exchanges. One state, New Mexico, has had their progress stymied by delays in legislative authorization of exchange establishment. Although legislation was enacted in New Mexico since our interviews, these delays imply an enormous challenge for the state to meet federal deadlines for SHOP implementation. Variations in SHOP policy approaches across the other five states reflect, in part, the diversity of their pre-reform small group markets.

Employee choice and administrative simplification for employers emerged as the most significant expected value-added of the SHOP exchanges, and as a result, each state plans to move forward quickly with an employee choice framework despite federal guidance providing for a delay. Brokers are afforded a central role in all the SHOP's plans, and will be relied upon to play a critical role in educating small employers about the new marketplaces, a process that is in its very early stages in most of these states and poses one of the largest challenges of successful SHOP establishment.

APPENDIX: EXAMPLE COMPUTATIONS OF COMPOSITE PREMIUMS AND EMPLOYER AND EMPLOYEE CONTRIBUTIONS UNDER THE SHOP MODELS INCLUDING EMPLOYEE CHOICE OF PLANS

We provide examples for the calculation of composite premiums and premium shares used by Wakely Consulting in delineating two of the composite premium approaches they developed.[15] In both examples, the theoretical small employer has three workers (numbered 1 to 3) covered by the firm, one age below 25, one age 45 to 49 and one age 60 to 64. None are tobacco users, so age is the only factor on which premiums will vary between them for a given plan. For simplicity of exposition, each of the workers purchases single coverage (as opposed to family) at the silver (70 percent actuarial value) level. There are three carriers (A, B and C), each offering one plan each from which the workers may choose coverage.

Example 1: Oregon's Planned Approach: Reallocated Composite with Buy-Up/Down Equal to Difference in Composite Rates

Step 1: Assume that all three workers buy plan A, and compute the average monthly premium for covering them, given their age. Repeat for plans B and C as well.

Employee-Only Coverage	
Carrier	Average Monthly Premium Computed as if All 3 Workers Enroll in Each Plan.
A	$250
B	$275
C	$300

Step 2: Employer chooses a reference plan and a contribution level. Plan A is chosen in this example, and the employer chooses to contribute 70 percent of the composite premium for that plan.

Step 3: Employees choose which plan to enroll in. In this example, they recognize that they will pay 30 percent of the composite premium for the reference plan (here, 30% * $250 = $75), plus the difference between the composite rates of the reference plan and of the selected plan. If the employee chooses a plan that is less expensive than the reference plan, she will pay less than $75 (although the reference plan is the cheapest plan in this example) and if she chooses a more expensive plan, she will pay more than $75. In this example, employee 1 chooses plan A, employee 2 chooses plan B and employee 3 chooses plan C. Note that regardless of the age of the particular worker, the additional (or lower) amount paid for the worker for choosing a more (less) expensive plan is the same.

Employee	Age	Plan	List Bill Premium for Chosen Plan for Person of This Age	Composite Premium for Chosen Plan
1	<25	A	$119	$250
2	45–49	B	$300	$275
3	60–64	C	$430	$300
Total			$849	$825

Step 4: Premium contributions for each worker are calculated and premium collections are reallocated by the SHOP for payment to each carrier.

It is worth noting that in this example, insurers are paid 2.8 percent less than the list bill premiums for the enrolled individuals. Other examples can be generated where the carriers might receive higher payments than the list

Selected Plan	Reference Plan Composite Premium	Employer Premium Contribution	Employee Premium Payment for Reference Plan	Composite Premium for Plan Chosen by Each Employee	Additional Amount Paid by Employee (Chosen Plan Composite Minus Reference Plan Composite)	Total Premium Collected (Employer plus Employee Contributions)	List Bill Premium for Worker Choosing Each Plan	Adjustment to List Bill (Total Premiums Collected Divided by Total List Bill Premiums)	Total Premiums Paid to Carriers
A	$250	$175	$75	$250	$0	$250	$119	-2.8%	$116
B	$250	$175	$75	$275	$25	$275	$300	-2.8%	$292
C	$250	$175	$75	$300	$50	$300	$430	-2.8%	$417
Total	$750	$525	$225	$825	$75	$825	$849	-2.8%	$825

bill total. As such, there is room for SHOP exchanges to reallocate premiums beyond what is shown here to more closely approximate list bill payments to insurers across all SHOP enrollees.

Wakely Consulting's list of composite premium computations and payments includes other alternatives, chosen by Rhode Island and the District of Columbia's exchange board (for example) that do guarantee that total premium payments to insurers matches total list bill premiums for enrolled individuals. While these options make the carriers "whole," they have the disadvantage of having older adults not choosing the reference plan paying higher premiums for the same coverage than their younger counterparts. That age differential is avoided under the approach chosen by Oregon.

Example 2: Rhode Island's Planned Approach: Reallocated Composite with Buy-Up/Down Equal to Difference in List Bill Rates

Steps 1 and 2 are identical to the first example using Oregon's approach. The differences emerge in steps 3 and 4.

Step 1: Assume that all three workers buy plan A, and compute the average monthly premium for covering them, given their age. Repeat for plans B and C as well.

Employee-Only Coverage	
Carrier	Average Monthly Premium Computed as if All 3 Workers Enroll in Each Plan.
A	$250
B	$275
C	$300

Step 2: Employer chooses a reference plan and a contribution level. Plan A is chosen in this example, and the employer chooses to contribute 70 percent of the composite premium for that plan.

Step 3: Employees choose which plan to enroll in. In this example, they recognize that they will pay 30 percent of the composite premium for the reference plan (here, 30% * $250 = $75), plus the difference between their list bill premium for the reference plan and their list bill premium for the plan they choose (with list bill premiums varying by age). If the employee chooses a plan that is less expensive than the reference plan, she will pay less than $75 (although the reference plan is the cheapest plan in this example) and if she chooses a more expensive plan, she will pay more than $75. In this example, employee 1 chooses plan A, employee 2 chooses plan B and employee 3 chooses plan C. Note that, unlike in example 1, the additional (or lower) amount paid for the worker for choosing a more (less) expensive plan varies by the age of the worker.

Employee	Age	Plan	List Bill Premium for Chosen Plan for Person of This Age
1	<25	A	$119
2	45–49	B	$300
3	60–64	C	$430
Total			$849

Step 4: Premium contributions for each worker are calculated and premium collections are reallocated by the SHOP for payment to each carrier.

In this case, the sum of the list bill premiums for the chosen plans is the precise amount of premiums collected across the employer and the workers. Total premium collections are reallocated such that each carrier is paid exactly the list bill premium for each worker that they enroll.

Selected Plan	Reference Plan Composite Premium	Reference Plan List Bill Premium	Employer Premium Contribution	Employee Premium Payment for Reference Plan	List Bill Premium for Selected Plan	Additional Amount Paid by Employee (Chosen Plan List Bill Minus Reference Plan List Bill)	Total Premium Collected (Employer plus Employee Contributions)	Total Premiums Paid to Carrier
A	$250	$119	$175	$75	$119	$0	$250	$119
B	$250	$273	$175	$75	$300	$27	$277	$300
C	$250	$358	$175	$75	$430	$72	$322	$430
Total	$750	$750	$525	$225	$849	$99	$849	$849

ENDNOTES

1. This report focuses only on state based exchanges included in the RWJF study.

2. On April 23, 2013, New Mexico received approval from the Center for Consumer Information and Insurance Oversight (CCIIO) to take primary responsibility for the state's SHOP exchange while CCIIO will take primary responsibility for development and operation of the state's nongroup exchange.

3. Federal Register. Vol 76, no. 136. Friday, July 15, 2011. Proposed Rules.

4. Recent rules issued by CCIIO amended the rules for special enrollment period in a SHOP due to the uniqueness of the SHOP market versus the individual market.

5. Department of Health and Human Services. 45 CFR parts 155 and 156. Proposed Rule, March 5.

6. Some have speculated that challenges in the development of premium aggregating mechanisms are the impetus for delaying employee choice in the FFE states. Some carriers had expressed concern that CCIIO's IT system would not be developed in time to allow for the accurate completion of the plan forms required for successful premium aggregation. While the employee and employer will still need to know their necessary contribution levels, the absence of premium aggregation allows carriers to directly bill small groups, as they do today, rather than having billing and premium collection go through the SHOP exchange itself.

7. Wakely Consulting. Dec. 2011, "Actuarial Analysis: Impact of the ACA on Small Group and Non-Group Market Premiums in Rhode Island." http://www.healthcare.ri.gov/documents/Wakely Actuarial Report on Rhode Island Exchange w market policy considerations - 12-13-11 FINAL.pdf

8. See the link for all of the private market reforms http://www.kff.org/healthreform/upload/8399.pdf

9. New York State Department of Health. Jan, 2013. "Invitation to Participate in the New York Health Benefit Exchange." http://www.healthbenefitexchange.ny.gov/sites/default/files/Invitation to Participate in NYHBE_0.pdf

10. Project Narrative. http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/project_narrative_final.pdf

11. New Mexico Human Services Department. Apr, 2013. "Final Advisory Task Force Recommendations." http://www.hsd.state.nm.us/pdf/hcr/Final Advisory Task Force Recommendations 04 09 2013 (2).pdf

12. Wakely Consulting. March, 2013. "Methods for Premium Allocation among SHOP Issuers & Employer Premium Contribution." http://hbx.dc.gov/sites/default/files/dc/sites/Health Benefit Exchange Authority/event_content/attachments/Wakely-MethodsforPremiumAllocationamongSHOPCarriers_0.pdf

13. New York State Department of Financial Services. "Instructions for the Submission of 2014 Premium Rates for SMALL GROUP On-Exchange Plans and Off-Exchange Plans." http://www.dfs.ny.gov/insurance/health/exchanges/EOE_chklst_SHOP.pdf

14. Cover Oregon Press Release. January, 2013. http://coveroregon.com/PR_1_14_13.php

15. Wakely Consulting. March, 2013. "Methods for Premium Allocation among SHOP Issuers & Employer Premium Contribution." http://hbx.dc.gov/sites/default/files/dc/sites/Health Benefit Exchange Authority/event_content/attachments/Wakely-MethodsforPremiumAllocationamongSHOPCarriers_0.pdf

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