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An Early Look At SHOP Marketplaces: Low Premiums, Adequate Plan Choice In Many, But Not All, States

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ABSTRACT **The Affordable Care Act created the Small Business Health Options Program (SHOP) Marketplaces to help small businesses provide health insurance to their employees. To attract the participation of substantial numbers of small employers, SHOP Marketplaces must demonstrate value-added features unavailable in the traditional small-group market. Such features could include lower premiums than those for plans offered outside the Marketplace and more extensive choices of carriers and plans. More choices are necessary for SHOP Marketplaces to offer the "employee choice model," in which employees may choose from many carriers and plans. This study compared the numbers of carriers and plans and premium levels in 2014 for plans offered through SHOP Marketplaces with those of plans offered only outside of the Marketplaces. An average of 4.3 carriers participated in each state's Marketplace, offering a total of forty-seven plans. Premiums for plans offered through SHOP Marketplaces were, on average, 7 percent less than those in the same metal tier offered only outside of the Marketplaces. Lower premiums and the participation of multiple carriers in most states are a source of optimism for future enrollment growth in SHOP Marketplaces. Lack of broker buy-in in many states and burdensome enrollment processes are major impediments to success.**

With little publicity, the Small Business Health Options Program (SHOP) began operations in 2014. Created by the Affordable Care Act (ACA), SHOP Marketplaces are online Marketplaces where small employers (those with fifty or fewer full-time-equivalent employees) can purchase coverage from multiple carriers and plans. In 2016, companies with a hundred or fewer employees will be able to participate. The Congressional Budget Office has estimated that SHOP enrollment will reach three million people in 2017.[1] The Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight has not disclosed SHOP enrollment in federally facilitated Marketplaces, but the Government Accountability Office has reported 78,000 people were enrolled in state-based SHOP exchanges in June 2014.[2]

SHOP aims to help small businesses offer affordable coverage to their employees and to provide individual employees with choices among plans and issuers. Prior to the passage of the ACA, the small-group insurance market was in decline in many states and was characterized by medical underwriting (the use of an individual's health status to determine the cost of, or to deny, coverage) and unexpected premium changes from year to year.[3] Between 2002 and 2014 the percentage of firms with three to nine workers that offered health benefits declined from 58 per-

cent to 44 percent.[4] For the smallest employers (those with 1–9 workers), premiums for similar benefit levels averaged 18 percent more than for large employers (1,000 or more workers) in 2002.[5]

Brokers play a major role in the workings of the small-group market and will likely continue to do so with the SHOP Marketplaces. Eighty percent of small employers use a broker or an agent, who often serves as a de facto benefit manager. Eight-four percent of brokers select health plans, 79 percent enroll employees, and 59 percent provide customer service such as claims adjudication.[6] Brokers' resistance to SHOP Marketplaces can represent a major obstacle to the use of exchanges, as discussed below.

Under the ACA, states can establish and administer their own SHOP Marketplaces, and seventeen states and the District of Columbia have decided to do so. States can also decide to participate instead in the federally facilitated Marketplace, managed by the Department of Health and Human Services, or to operate a SHOP Marketplace in partnership with the federal government, with each party assuming some responsibilities.[7]

SHOP Marketplaces can adopt one of two general models: the "employer model" or the "employee choice model." In the employer model, the employer chooses a single plan, and all employees who opt for coverage can enroll only in that plan.

In the employee choice model, the employer makes a fixed contribution toward plan offerings in the SHOP Marketplace based on a designated metal tier. States offer different variants of this model.

One approach allows employees to choose plans from all tiers, while another allows employees to choose plans only from the employer's designated metal tier (in 2014 nine states allowed employees to select plans from multiple insurers and multiple tiers).[8] In either case, employees must pay for higher-cost plans out of pocket to make up any difference between the premium for their chosen plan and the employer's contribution. In 2014 all but one state-based SHOP Marketplace used the employee choice model, while states relying on the federally facilitated or federal-state partnership approach used the employer model.[9]

Health insurance exchanges for small employers are not a new idea. Over the past twenty-five years a number of states—including California, Colorado, Connecticut, Florida, Kansas, Kentucky, North Carolina, and Washington—attempted to build what were termed "health insurance purchasing cooperatives," but none enjoyed widespread success.[10]

There are clear lessons from these earlier attempts. The first is that underwriting rules must be the same for plans inside and outside the cooperatives or similar organizations.[11] In earlier models, many states prohibited medical underwriting within the health insurance purchasing cooperative pools but allowed it outside them. The inevitable result was adverse selection, which in turn led to high medical claims, expenses, and premiums.

Another lesson from the failure of cooperatives was that large insurers often did not want to participate because they feared that they would lose market share to smaller insurers with greater and more transparent choice of carriers. Without the participation of large insurers, brokers and small employers viewed the cooperatives as an inferior source of coverage. Fearing adverse selection, insurers also were reluctant to offer preferred provider organization (PPO) plans because sicker people were more likely to enroll in them, seeking a broader choice of providers.[12]

If SHOP Marketplaces are to succeed where health insurance purchasing cooperatives failed and enroll substantial numbers of small employers, they must not only address these problems but also demonstrate value-added features not available in the traditional small-group insurance market. First, insurance carriers can set premiums for plans offered in the SHOP Marketplace that are lower than the premiums they offer outside it. Second, employers with fewer than twenty-five workers can receive tax credits if they purchase plans in a SHOP Marketplace.[13] Third, the Marketplaces can enhance employee choice. When using the employee choice model, employers can make a defined contribution and allow employees to select from plans among multiple carriers and, in some states, multiple metal tiers—instead of being able to select just one plan from one carrier. Fourth, with defined contributions, employers can reduce the financial risk of future increases in premiums.

In this study we examined evidence that the SHOP Marketplaces have laid the groundwork for their success in providing the value-added features noted previously. First, we compared premiums for plans sold in the Marketplaces with premiums for plans sold only outside of them. Insurers participating in Marketplaces such as these customarily offer some plans only outside of the Marketplaces as well. According to the rules promulgated by the Center for Consumer Information and Insurance Oversight, plans offered in the SHOP Marketplaces must also be sold outside of them but underwritten as if they were one plan.

Second, we assessed the availability of plans offered in the SHOP Marketplaces by metal tier and number of carriers to determine whether there are sufficient numbers for the employee choice model to offer meaningful different alternatives. To our knowledge, this study provides the first comparison of plan choices in and outside of the SHOP Marketplaces and the first comparison of the costs of coverage for plans from the same metal tier in and outside of the Marketplaces.

Concentration In The Small-Group Market

A major concern of the Obama administration was whether sufficient numbers of carriers would sell plans in the SHOP Marketplaces. The small-group market is heavily concentrated, with the largest insurer—usually a Blue Cross and Blue Shield plan—holding 50 percent or more of the market in twenty-six states.[14] To encourage large carriers to participate in the SHOP Marketplaces in each state, in 2014 the Center for Consumer Information and Insurance Oversight applied a "tying" provision in states with federally facilitated Marketplaces. The provision, which remains in effect for 2015, requires insurers with a share of at least 20 percent in the small-group market to participate in the SHOP Marketplace as a condition for participating in the larger and potentially more profitable individual Marketplace in the same state.[15]

In 2014 the Department of Health and Human Services did not implement key features of SHOP Marketplaces in federally facilitated Marketplaces. These features included online enrollment through the SHOP website and employee choice. As a result, the initial appeal of the SHOP Marketplace was limited.

In 2015 employee choice is still not available in eighteen of the thirty-two states with federally facilitated or partnership Marketplaces.[16] In states where employee choice is offered in the federal SHOP Marketplace, choices are limited to plans available at a single metal tier (bronze, silver, gold, or platinum) chosen by the employer. Thus, the ultimate ability of the federal SHOP Marketplace to attract employers is likely to remain unclear for several years.

We interviewed officials at nine insurance carriers to elicit their views about the SHOP Marketplaces. The carriers were a mixture of large and small and of publicly traded, nonprofit, and cooperative carriers. The officials agreed that the primary reasons employers would purchase health insurance for their employees through the SHOP Marketplace were to obtain the tax credit and to offer employee choice. But the officials believed that the tax credit would not induce many small employers to change how they obtained insurance because the credit was too small, was available for too short a time, and required too much paperwork.

The officials also expressed some concern that brokers may have deliberately downplayed the benefit of the tax credit to small employers, discouraging some employers from applying for the credit. In general, officials believed that most brokers do not feel "plugged in" to the SHOP concept and view it as competition. Officials also noted that in 2014 the federally facilitated SHOP Marketplace was not user-friendly or transparent, and that most enrollments had to be done on paper. (Employers could view choices online but needed to contact a broker or insurer to complete the transaction.) At the very least, the officials said, small employers need to be able to shop for products and complete the enrollment process online.

In the past few years, benefit consulting firms and insurers have built an alternative to SHOP Marketplaces—private exchanges—that can offer both a defined- contribution model and multiple plans from multiple carriers. Private exchanges currently account for about 3 percent of enrollment in employer-based health insurance.[4] Hence, ease of enrollment in SHOP Marketplaces must be comparable not only to that outside the Marketplaces, but also to that in private exchanges.

Study Data And Methods

DATA AND SAMPLE DESIGN Data presented in this article are from twenty-six states (counting the District of Columbia as a state), which collectively offered more than 6,000 plans in and outside of the SHOP Marketplaces. Fifteen states in the sample had their own state-based Marketplaces (all but one of those states—Rhode Island—used the employee choice model), while eleven used the federally facilitated Marketplace or the partnership model (and the employer model; Exhibit 1). States with state-based SHOP Marketplaces accounted for more than 4,200 plans, and states with federally facilitated and partnership SHOP Marketplaces accounted for more than 1,800.

The availability of data determined which states were in our sample. We selected all states with state-based, federally facilitated, or partnership SHOP Marketplaces that had publicly accessible data on their state insurance department websites about plans offered, premiums, and cost-sharing provisions.

Within each state the sample included all plans offered in the SHOP Marketplace (regardless of

the carrier) and all plans offered outside of the Marketplace from a sample of carriers that had at least 1 percent of market share. This prevented legacy or other small carriers from skewing the estimates. A legacy carrier is one that no longer sells to new buyers but whose long-term members have been grandfathered into plans first offered years ago.

Through searches of both state insurance department websites and state SHOP websites, we collected data for plans not offered in the SHOP Marketplaces in federally facilitated or partnership states and for both plans in the SHOP Marketplaces and plans outside of them in states with state-based SHOP Marketplaces. For federally facilitated or partnership states, all information about plans in the Marketplaces was gathered from the Qualified Health Plan SHOP Medical Landscape File made public by Center for Consumer Information and Insurance Oversight.

Within each state, we sampled three geographic rating regions. These rating areas corresponded to an urban metropolitan area, a suburban area or medium-size city, and a rural area in each state. We used rating area information from the Center for Consumer Information and Insurance Oversight[17] and data from the Area Health Resources Files[18] to randomly select three rating areas in each state for analysis. For multivariate analysis, we also used the Area Health Resources Files to provide information on population, the percentage of uninsured patients, and median family income for each rating area, based on an aggregation of the characteristics of its component counties.

Among the variables downloaded from state insurance department and SHOP websites were state, carrier, data source, whether a plan was available in the SHOP Marketplace, product type (health maintenance organization [HMO], exclusive provider organization [EPO], PPO, point-of-service [POS] plan, indemnity plan, or high-deductible health plan [HDHP]), plan identification number, metal tier, plan name, premium in the sampled urban region, premium in the sampled suburban region, and premium in the sampled rural region.

WEIGHTING AND AGGREGATION The Center for Consumer Information and Insurance Oversight has not published SHOP enrollment data by plan or carrier. As a result, our study used data from 2013 enrollments and business volume to identify characteristics of carriers such as Blue Cross Blue Shield affiliation or new entrants into the small-group market (which were not listed in the 2013 records). But we did not consider 2013 enrollments by carrier for the small-group market to be an accurate proxy for enrollment in plans through the SHOP Marketplaces.[19]

Consequently, we elected to begin from the assumption that carriers in the SHOP Marketplace start on an equal footing. Thus, the weighting model did not take a carrier's characteristics into account.

However, we found significant variation in the number of options a carrier offered, from a single plan to more than 700. We considered a number of options for weighting the observations. We could weight each plan equally, by state or nationally. This would have the undesirable effect of crowding out data for smaller carriers, particularly most of the new entrants (including the cooperative carriers), in favor of the few carriers with hundreds of plans. At the other extreme, we could weight each carrier equally, dividing the carrier's weight equally among its plan offerings. This model effectively assumes that there is no value created by offering more than one plan, which is similarly undesirable.

Instead, we elected to use a weighting scheme that took the number of plan options a carrier offered into account but that heavily "discounted" carriers offering hundreds of plans. A carrier's weight within its state was therefore the log of the number of plans it offered, with a floor of 1.

ANALYSIS To address our study's research questions, we used both descriptive and multivariate analyses. To display the availability of plans in the SHOP Marketplaces, we present data on the number of carriers and plans offered in and outside of the Marketplace by tier level. To examine comparative premiums in and outside of the Marketplace, we first display descriptive statistics by metal tier for the twenty-six states in our study. We present premiums for a forty-year-old nonsmoker to standardize data across plans.

In the multivariate analysis, with premiums as the dependent variable, we estimated a generalized linear model for a pooled sample of plans in and outside of the Marketplace. There were two questions of primary interest: Is the plan offered in or outside of the Marketplace? And does the carrier participate in the Marketplace or not?

The control variables include whether the state was using the employee choice model or the employer model; characteristics of the carrier, including whether it was a tied carrier (that is, a carrier with a share of at least 20 percent of the small-group market in 2012) or a new entry and what share of the small-group market it had in 2013; characteristics of the rating area such as per capita income and percentage of the population that was uninsured; characteristics of the plan, including plan type (HMO or EPO, PPO, HDHP with a savings option, or indemnity plan) and metal tier; measures of competition such as

the number of carriers selling in the rating area in the small-group market; and a dummy variable for each state. The dummy variable for each state was intended to control for unobserved variables associated with each state, such as state regulatory requirements. Online Appendix Table 1[20] displays the means and standard errors for each independent variable used in the multivariate analysis.

LIMITATIONS The major limitations of the analysis are related to the availability of some data elements. First, it is not possible from carriers' filings with their state insurance department to determine whether a plan has a broad or narrow network of providers. Our information on networks was from the carriers' websites, and, more often than not, the providers listed were carrier specific instead of plan specific.

Second, metal tiers reflect the actuarial value of each plan based on the essential benefits required by the state. If a plan offered benefits beyond the essential ones, those data were not available to us for analysis.

Third, ideally our regression model would have included some metrics for competition in the hospital and physician markets. However, because of the complexity of the rating areas and geographic provider markets, we were not able to measure provider concentration.

Finally, our analysis was limited to twenty-five states and the District of Columbia. States whose websites did not present data on plans offered outside of the SHOP Marketplace were not included in the sample.

EXHIBIT 1

Number Of Plans In And Outside Of The Small Business Health Options Program (SHOP) Marketplaces, By State And Metal Tier

	Number of plans					
	In SHOP Marketplace			Not in SHOP Marketplace		
State/model	Bronze	Silver	Gold	Bronze	Silver	Gold
EMPLOYEE CHOICE MODEL STATES						
All	126	278	265	644	1,139	1,142
CA	4	8	2	34	49	59
CO	16	24	15	7	16	8
CT	8	12	7	8	5	12
DC	14	89	110	1	1	—[a]
HI	—[a]	3	8	—[a]	—[a]	—[a]
KY	6	8	8	14	67	39
MD	23	33	32	27	93	103
MN	9	17	19	28	87	72
NV	3	8	7	63	113	136
NY	15	18	12	314	406	438
OR	13	17	12	112	199	175
UT	9	33	28	21	46	33
VT	5	6	4	1	—[a]	—[a]
WA	1	2	1	14	57	67
Average	9.0	19.9	18.9	46.0	81.4	81.6
EMPLOYER MODEL STATES						
All	82	145	144	235	498	533
AL	4	5	5	5	13	19
FL	—[a]	2	2	—[b]	—[b]	—[b]
KS	2	3	2	—[a]	1	—[a]
ME	3	3	2	24	28	9
MI	9	19	22	7	28	45
MT	6	10	5	—[b]	—[b]	—[b]
OH	24	33	54	73	86	122
PA	13	34	24	24	75	66
RI	2	5	5	12	21	47
TN	1	4	4	39	94	58
VA	12	12	9	45	134	147
WI	6	15	10	6	18	20
Average	6.8	12.1	12.0	19.6	41.5	44.4
ALL STATES						
Total	208	423	409	879	1,637	1,675
Average	8.0	16.3	15.7	33.8	63.0	64.4

SOURCE Authors' analysis of data from state health insurance department websites, state Marketplace websites, and the Qualified Health Plan SHOP Medical Landscape File made public by the Center for Consumer Information and Insurance Oversight. **NOTE** Catastrophic and platinum plans are excluded from this exhibit because of space, but data from catastrophic and platinum plans were included in the regression analyses. [a]Insufficient sample size. [b]No data on plans sold outside of the SHOP Marketplace are available for Florida or Montana.

Study Results

AVAILABILITY OF PLANS In our sample, the average number of carriers per state was 4.3, offering a total of forty-seven plans to choose from (Appendix Table 2).[20] On average, 3.2 carriers in each state did not offer plans in the SHOP Marketplace but sold insurance to small employers only outside of the Marketplace. And in the average state, 201.1 plans were sold only outside of the Marketplace, roughly 4.3 times as many as were available in the Marketplace.

There was substantial variation across states. Only one insurer participated in Washington State's SHOP Marketplace. In seven states (Alabama, Florida, Hawaii, Kansas, Maine, Tennessee, and Vermont) only two carriers sold plans in the SHOP Marketplace. In contrast, there were ten insurers that offered plans in the SHOP Marketplace in Maryland; nine in Michigan, New York, and Pennsylvania; and seven in Ohio.

Nationally, an average of eight bronze, sixteen silver, and sixteen gold plans were available in a state's SHOP Marketplace (Exhibit 1). Among plans sold only outside of the Marketplace, the average numbers were thirty-four bronze, sixty-three silver, and sixty-four gold plans. In general, states using the employee choice model offered more plans both in SHOP Marketplaces and outside of them, compared to states using the employer model.

PREMIUMS FOR PLANS IN AND OUTSIDE OF MARKETPLACES The average monthly premium for single coverage for plans sold in the SHOP Marketplaces was $299 for bronze plans, $352 for silver plans, and $414 for gold plans

(Exhibit 2). Comparing plans in the same metal tier, the average premium for plans sold in the SHOP Marketplaces was lower than that for plans sold outside them by 5 percent for bronze and silver plans and by 4 percent for gold plans. All differences were significant ($p<0.05$).

Employee choice model states and employer model states showed different patterns, however. In the employer model states, premiums for bronze and silver plans in the SHOP Marketplaces were slightly higher than premiums for plans in those tiers offered only outside of the Marketplaces. In contrast, in the employee choice model states, plans in the SHOP Marketplaces had lower premiums for all metal tiers, compared to plans outside of the Marketplaces.

Kansas had the lowest premiums for bronze plans, and Hawaii had the lowest premiums for silver and gold plans in the SHOP Marketplaces, with Kansas and Alabama having the lowest premiums for silver and gold plans, respectively, outside the Marketplaces. New York had the highest premiums for bronze, silver, and gold plans.

When we looked at all study states together, we found that HMO and EPO plans in the SHOP Marketplaces had lower average premiums for all metal tiers than plans sold only outside of them—19 percent lower for bronze and 9 percent lower for silver and gold plans (Exhibit 3). In contrast, PPO and POS plans had comparatively higher premiums for bronze plans in the SHOP

EXHIBIT 2

Monthly Premiums Of Plans In And Outside Of The Small Business Health Options Program (SHOP) Marketplaces, By State And Metal Tier

	Average premiums ($)					
	In SHOP Marketplace			Not in SHOP Marketplace		
State/model	Bronze	Silver	Gold	Bronze	Silver	Gold
EMPLOYEE CHOICE MODEL STATES						
Average	315.73**	363.59**	429.38**	339.32	391.19	446.99
CA	304.14	368.67	460.59	320.42	397.68	478.05
CO	302.16	360.42	440.21	288.67	345.14	427.57
CT	342.31	418.87	504.33	349.75	423.47	526.27
DC	245.94	310.52	392.43	237.16	338.09	—[a]
HI	—[a]	254.93	297.01	—[a]	—[a]	—[a]
KY	284.40**	304.42**	346.19**	323.92	441.69	441.13
MD	316.08**	381.83**	453.09**	425.83	478.63	523.69
MN	281.74	332.49	384.97	267.64	328.06	388.98
NV	336.75	322.46	377.75	318.38	368.98	423.41
NY	367.60**	448.22**	531.13**	446.85	506.26	554.53
OR	304.84	390.67**	464.19**	291.18	351.98	396.37
UT	251.87	306.33**	335.43**	258.00	324.08	377.52
VT	353.06	418.09	498.21	341.95	—[a]	—[a]
WA	328.45	357.10	451.12	271.77	360.09	407.30
EMPLOYER MODEL STATES						
Average	277.83**	340.61**	398.29	267.84	331.17	403.74
AL	260.99	319.71**	373.11**	261.14	277.69	311.87
FL	—[a]	405.48	454.73	—[b]	—[b]	—[b]
KS	220.82**	267.53	305.20	208.76	245.10	321.28
ME	304.37**	347.76	436.64	266.49	339.58	415.72
MI	280.33	348.76**	394.79	260.98	305.90	388.91
MT	277.27	330.99	389.07	—[b]	—[b]	—[b]
OH	279.63**	355.07**	409.91**	291.51	392.61	473.85
PA	278.20**	314.29	362.35**	233.19	297.37	335.64
RI	263.13	308.37**	397.91**	268.18	323.13	378.45
TN	239.15**	308.37	367.11**	258.63	318.70	402.64
VA	260.62	310.14	353.73**	259.14	319.78	390.98
WI	308.94**	378.83**	452.15**	384.49	451.35	508.52
ALL STATES						
Average	298.98**	351.60**	413.90**	313.62	370.17	431.01

SOURCE Authors' analysis of data from state health insurance department websites, state Marketplace websites, and the Qualified Health Plan SHOP Medical Landscape File made public by the Center for Consumer Information and Insurance Oversight. **NOTE** Significance indicates difference between premiums for plans in the SHOP Marketplaces and those for plans outside them. [a]Insufficient sample size. [b]No data on plans sold outside of the SHOP Marketplace are available for Florida or Montana. **$p<0.05$

EXHIBIT 3

Average Monthly Premiums, By Product Type, For Plans Sold In And Outside Of The Small Business Health Options Program (SHOP) Marketplaces, By Metal Tier

	Average premiums ($)					
	In SHOP Marketplace			Not in SHOP Marketplace		
Product type/model	Bronze	Silver	Gold	Bronze	Silver	Gold
EMPLOYEE CHOICE MODEL STATES						
HMO/EPO	308.11**	351.45**	426.39**	368.57	389.54	466.27
PPO/POS	322.72	381.63	434.01	312.48	389.94	433.86
Indemnity	—[a]	—[a]			583.33	—[a]
HDHP	332.35	336.34	—[a]	305.63	325.93	340.95
EMPLOYER MODEL STATES						
HMO/EPO	261.48	326.58	380.09	257.86	321.12	375.61
PPO/POS	287.43**	351.11**	413.93**	272.32	331.86	401.27
Indemnity	—[a]	—[a]	—[a]	—[a]	484.52	1,050.40
HDHP	—[a]	—[a]	—[a]	250.96	327.49	420.61
ALL STATES						
HMO/EPO	291.46**	339.78**	406.49**	346.54	369.46	443.36
PPO/POS	303.11**	363.48	422.44	293.90	367.88	420.03
Indemnity	—[a]	—[a]	—[a]	—[a]	544.76	1,050.40
HDHP	332.35**	336.34	—[a]	281.49	326.43	404.30

SOURCE Authors' analysis of data from state insurance department websites, state Marketplace websites, and the Qualified Health Plan SHOP Medical Landscape File made public by the Center for Consumer Information and Insurance Oversight. **NOTES** Significance indicates the difference between premiums for plans in the SHOP Marketplaces and those for plans outside them. HMO is health maintenance organization. EPO is exclusive provider organization. PPO is preferred provider organization. POS is point of service plan. HDHP is high-deductible health plan. [a]Insufficient sample size. **$p<0.05$

Marketplaces, with no significant difference for silver and gold plans.

MULTIVARIATE ANALYSIS A host of intervening variables may explain why premiums are higher for plans outside of the Marketplaces. For example, it may be that such plans are more heavily concentrated in high-cost states and rating areas. To hold other factors constant, we conducted a multivariate analysis that pooled all plans in and outside of the Marketplaces (Appendix Table 3). Appendix Table 4[20] shows elasticities for continuous variables and marginal effects for binary variables.

When we held other factors constant, we found that plans sold in the SHOP Marketplaces had premiums that were 7 percent lower than plans sold only outside of the SHOP Marketplaces (see Appendix Table 4).[20] The premiums of carriers not participating in the Marketplaces were 2 percent higher than those of participating carriers.

For each additional carrier competing in a rating area, premiums for plans in and outside the SHOP Marketplaces declined substantially. Plans offered by cooperative plans and Medicaid plans had premiums that were 2 percent and 11 percent lower, respectively, than commercial plans. Overall, premiums in rural areas were 3 percent higher than in urban areas, but there was no difference in cost between urban and suburban areas. PPO and POS plans had premiums that were 3 percent higher than those for HMO and EPO plans, and high-deductible plans with a savings option had premiums that were 9 percent higher than those for HMO or EPO plans.

Discussion

To succeed in enrolling large numbers of small employers, SHOP Marketplaces must offer value-added features not available in the conventional small-group insurance market. Potential value-added features include lower premiums, tax credits, more employee choice of different carriers and metal tiers, and a defined-contribution model for employers that limits the risk of future premium increases. This study presents evidence with regard to the first three features.

In 2015 thirty-three states are expected to use some variation of the employee choice model.[8] However, if few carriers participate, and if those that do offer limited numbers of plans, then employees' selections of carriers and plans will be little different than would be the case with the employer model.

In our study we found that an average of 4.3 carriers offered plans in the SHOP Marketplaces, with an average of forty-seven plans to choose from in total. Three carriers per state on average did not participate in a SHOP Marketplace. The

Customer service—including ease of enrollment—in SHOP Marketplaces must be roughly comparable to that provided by private exchanges.

average number of carriers should be enough to offer a sufficient number of plans to make the employee choice and defined-contribution models feasible. However, some states are well below that average. For example, Washington State had only one carrier selling plans in its SHOP Marketplace, and seven states had just two carriers. We believe that those numbers are insufficient for the employee choice and defined-contribution models to function.

Many insurers participating in the SHOP Marketplaces offered a larger number of plans available only outside of the Marketplaces. Nationally, there were more than four plans offered outside of the SHOP Marketplaces for every plan offered in them.

In both descriptive and multivariate analyses, we found that plans in the SHOP Marketplaces had lower premiums than plans sold only outside of the Marketplaces. Multivariate results indicated that, on average, plans sold outside of the SHOP Marketplaces had premiums that were 7 percent higher than plans offered in the Marketplaces from the same metal tier. Carriers declining to participate in SHOP Marketplaces had premiums that were 2 percent higher than premiums of participating carriers.

Plans sold in rural rating areas had premiums that were 3 percent higher than premiums of plans sold in urban and suburban areas. This likely reflects insurers' difficulty obtaining discounts from rural hospitals and doctors in monopolistic or oligopolistic provider markets. We found that for each additional carrier competing in a rating area, premiums fell by 3 percent. Plans offered by cooperative plans and Medicaid plans had lower premiums than those sold by commercial carriers.

What do our findings suggest about the future of SHOP Marketplaces? Lower premiums should spark greater interest in the Marketplaces. But plans sold in the Marketplaces are also sold outside of them. Thus, tax credits or the availability of multiple choice of carriers and plans must be compelling selling points to employers. In some states—chiefly states that have state-based Marketplaces, use the employee choice model, and have sufficient numbers of carriers and plans—SHOP Marketplaces have a greater chance of succeeding, compared to the situation in states using the employer model with few carriers participating in the rating areas. In states with federally facilitated or partnership Marketplaces, and in those with state-based Marketplaces that have only a few carriers participating—as in Washington State, where there was just one carrier—greater participation by carriers is necessary for SHOP Marketplaces to have a chance to flourish.

Equally important for the Marketplaces' future growth is the commitment of brokers. If SHOP information technology remains clunky or nonexistent, if enrollment through the SHOP Marketplaces requires considerably more broker time than enrolling outside of them, and if broker compensation is lower for enrolling through the Marketplaces than outside of them, brokers will largely shun the Marketplaces. They may even view them as business and political adversaries. Simultaneously, customer service—including ease of enrollment—in SHOP Marketplaces must be roughly comparable to that provided by private exchanges.

Conclusion

No change in health care occurs instantaneously. Many innovations in health insurance such as HMOs, PPOs, health savings accounts, and health reimbursement accounts initially grew slowly but eventually became major insurance products. The health insurance purchasing cooperatives that preceded the SHOP Marketplaces and did not succeed often had to compete in small-group markets that had different underwriting rules than the remainder of the fully insured market. The fact that SHOP Marketplaces do not face such daunting disadvantages provides reason for optimism. ■

Jon Gabel testified before the House Small Business Subcommittee on Health and Technology on September 18, 2014. Some of the article's findings were included in his testimony. The authors thank Dean Mohs and Doug Pennington of the Center for Consumer Information and Insurance Oversight for their helpful comments.

NOTES

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3 Prior to passage of the ACA, two states used community rating, and eight states used community rating by class. Community rating prohibits setting premiums on the basis of the characteristics of insured individuals. Community rating by class allows insurers to set premiums by age and geographical region but prohibits setting rates by health status of insured individuals. See National Association of Insurance Commissioners. Rate regulation [Internet]. Kansas City (MO): NAIC; [cited 2015 Mar 4]. Available from: http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf

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9 States may use different variations of the employee choice model, which provides different breadths of plan options to employees, such as requiring them to choose from plans within a metal tier or from those offered by a single carrier. However, some states supported only limited choice for plan year 2014. These variations could be incorporated into future multivariate analyses.

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12 Wicks E, Hall M, Meyer J. Barriers to small-group purchasing cooperatives. Washington (DC): Economic and Social Research Institute; 2000 Mar.

13 The tax credits are available for companies with fewer than twenty-five full-time-equivalent employees if the average employee salary is about $50,000 per year or less, and if the employer pays at least 50 percent of the full-time employees' premium costs. HealthCare.gov. Small business health care tax credits [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2015 Mar 5]. Available from: https://www.healthcare.gov/small-businesses/provide-shop-coverage/small-business-tax-credits/

14 Henry J. Kaiser Family Foundation. How competitive are state insurance markets? [Internet]. Menlo Park (CA): KFF; 2011 Oct [cited 2015 Mar 2]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf

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16 In these eighteen states, the insurance commissioner requested an opt-out from employee choice for 2015, an option that the Center for Consumer Information and Insurance Oversight made available to a state "if the Commissioner determines that implementing employee choice would cause issuers to price products and plans higher in 2015 due to issuers' beliefs about adverse selection." CMS.gov. The Center for Consumer Information and Insurance Oversight: Small Business Health Options Program (SHOP) [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2015 Mar 16]. Available from: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html

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18 Health Resources and Services Administration. Area Health Resources Files [Internet]. Rockville (MD): HRSA; [cited 2015 Mar 5]. Available from: http://ahrf.hrsa.gov/

19 As described in the "Study Data and Methods" section, carrier data came from the Center for Consumer Information and Insurance Oversight's Health Insurance Oversight System and state insurance department websites for the state-based Marketplaces. See CMS.gov. The Center for Consumer Information and Insurance Oversight: medical loss ratio data and system resources [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2015 Mar 5]. Available from: http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

20 To access the Appendix, click on the Appendix link in the box to the right of the article online.