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Small-Employer ("SHOP") Exchange Issues

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Executive Summary:

The California Health Benefit Exchange is to operate both an Exchange for individuals and a Small Business Health Options Program or "SHOP" Exchange for small employers. This paper describes and assesses distinguishing dimensions important to the design of a successful SHOP Exchange program. These include functions unique to the SHOP Exchange which will require different administrative systems.

An important determinant of enrollment will be the number of low-wage small employers that obtain federal small-employer tax credits available only towards SHOP Exchange coverage. It is estimated that this initial population will be in the range of 500,000 persons. A low-wage small-employer group could instead refer its workers to the individual Exchange. Which they choose to do will depend in part on their employee group's after-tax costs for SHOP coverage compared to individual Exchange coverage, for which low-income workers not eligible for employer group coverage can receive individual federal tax credits. In general, younger employer groups would more often have lower net costs for SHOP than individual Exchange coverage.

In sum, the SHOP Exchange should have a significant and attractive "core" population so long as small-employer tax credits continue to be available and limited to Exchange coverage. But unless extended by Congress, beginning in 2014, these credits will be available to a given employer for only two years. More generally, a significant number of persons may be expected to switch between small-employer and individual coverage. Continuity of care, as well as incentives for plans to provide effective preventive services and to participate in the SHOP Exchange, could be improved if the Exchange were to offer the same health plans in the individual and SHOP Exchanges.

Nevertheless, the premiums for the small-group plans will be different than for the individual plans for several reasons. California's small-group and individual markets, and therefore their respective population risk pools, will remain separate for at least the first several years of the Exchange. The SHOP Exchange could uniquely allow small-employer groups to have a reference plan with an averaged premium that is the same for each worker regardless of age. Finally, even if individual and group market premiums were the same, a given person's out-of-pocket premium contribution requirements (net of tax subsidies and any employer contribution) would usually be very different for employer coverage than for individual coverage. For these and other reasons, a separate website for the SHOP Exchange seems advisable.

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Small-Employer ("SHOP") Exchange Issues

"SHOP" Exchange Basics

AB 1602 directs the California Health Benefit Exchange to establish a Small Business Health Options Program (or "SHOP" Exchange) separate from the Exchange's activities related to the individual market. The purpose is to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small-employer market. *[Government Code (GC) §100502(m), as added by AB 1602 §6.]*

Offering coverage to small employers and their workers through an Exchange is required under the federal health reform law (the Patient Protection and Affordable Care Act or PPACA).[1] *[PPACA §1311(b)(1)(B)]* Federal law gives States the option to assign this function to a totally separate Exchange entity or to serve both the individual and small-employer markets through a single Exchange entity, so long as it has adequate resources to serve both markets. *[PPACA §1311(b)(2)]* California chose the latter approach, and authorized a senior executive position to direct the SHOP Exchange.

Worker Choice of Health Plan in a SHOP Exchange

Under federal reform, a SHOP Exchange is intended to allow individual workers to choose among the various qualified health plans (QHPs) offered by the Exchange. The idea is that the employer would pick the level of coverage ("actuarial value") the employer wants to contribute toward, and the worker would pick which QHP the worker wishes to enroll in at that level. *[PPACA §1312(a)(2)]* (However, note that another provision could be read to imply that a small employer can participate in a SHOP Exchange by picking only one QHP to make available to its workers.) *[PPACA §1312(f)(2)(A)]*[2] Subsequent federal guidance will clarify states' options here,[3] but by specifically referencing the first provision, AB 1602 makes clear that California's intent is that the Exchange is to offer ***worker*** choice of health plan in the small-employer market.

Administrative Functions of the SHOP Exchange

AB 1602 also specifies that, with respect to the SHOP Program, the Exchange is to collect premiums, handle enrollment and plan payment, and administer all other related tasks needed to

[1] Public Law 111-148 (H.R. 3590), as amended by P.L. 111–152, the Health care and Education Reconciliation Act of 2010 (H.R. 4872).

[2] This provision states that a qualified employer (i.e., qualified to participate in a SHOP Exchange) is one that "elects to make all full-time employees of such employer eligible for ***1 or more*** qualified health plans offered in the small group market through an Exchange that offers qualified health plans." [emphasis supplied]

[3] As yet there is no official interpretation from HHS about worker choice in SHOP Exchanges. A possible outcome is that State SHOP Exchanges will be required to make worker choice of health plan available but will also be permitted, at state option, to allow each employer to choose whether or not to make health plan choice available to its workers. Such an interpretation by HHS would mean that California could amend its legislation to allow its SHOP Exchange to also offer a single-plan/whole-group coverage option. If it did so, it would be critical to require that all participating QHPs ***also*** be available as a worker-choice option. Otherwise, the State's SHOP Exchange might not be able to gain sufficient participation by desirable health plans to make the worker-choice option attractive and viable.

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make the offering of worker plan choice as simple as possible for small employers. *[GC §100503(w), as added by AB 1602 §7]* The federal law is silent with respect to these functions, so the State authority to authorize additional measures pertains.

This provision recognizes that, to properly serve small employers and offer worker choice among QHPs serving that market, the Exchange's role with respect to premium collection, enrollment, and plan payment will have to be considerably different and more robust than for the individual market, as the next section discusses.

SHOP Exchange Functions Are Different Than for the Individual Exchange

A basic function of an Exchange, in both the individual and the small-group markets, is to make available standardized price and quality information about (qualified) health plans so that people can easily compare plans and choose the one which best suits their needs.[4] Once QHPs are selected and certified and relevant information about them is gathered and displayed, however, the necessary administrative functions of an individual Exchange and a small-employer Exchange begin to diverge.

Individual Exchange

In the individual Exchange, people can qualify for a premium tax credit and for cost-sharing subsidies if their income is low enough. So the individual Exchange has a role in the income-verification process and has to make available an "electronic calculator" that people can use to estimate their actual net cost, after premium tax-credits and cost-sharing subsidies, for the various plans that are available to them.

On the other hand, even though AB 1602 authorizes it to do so *[GC §100504(a)(1), as added by AB 1602 §8]*, the individual Exchange could ultimately have little if any role in actually collecting premiums and paying health plans. First, PPACA directs that advance payments of premium tax credits will be made directly to health plans by the U.S. Treasury, ***not*** to the Exchange for subsequent disbursement to the health plans. *[PPACA §1412(a)(3)]* Second, PPACA specifically provides that individuals ***must*** have the option to pay their (share of the) premium ***directly*** to the health plan. *[PPACA §1312(b)]*

Thus, the Exchange presumably ***cannot require*** everyone who buys coverage through the Exchange to make premium payments through the Exchange. However, an Exchange serving the individual market ***is not precluded from*** establishing a system under which individuals may pay their share of the premium to the Exchange and the Exchange in turn transmits that premium share to the individual's chosen health plan. Whether, and to what degree, the California Exchange chooses to perform this function is beyond the scope of this paper.[5]

[4] How an Exchange decides which plans to certify and make available as "qualified health plans" is a separate question that is not dealt with in this paper.

[5] Note that performing this function could put the Exchange in a better position to know the enrollment status of individuals and dependents, depending on federal rules about reporting and/or administration of enrollment through the Exchange. But such a system would largely duplicate the premium-collection systems health plans serving the individual market already have in place, and thus would not necessarily help to reduce overall administrative costs. An exception might be the case of health plans that do not now have systems in place to collect premiums from individuals, but would be willing to participate in an Exchange serving the individual market if they did not have to incur the expense of establishing such systems. Such plans might include commercial carriers that currently serve

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SHOP Exchange

SHOP Exchange coverage is defined as employer group coverage,[6] so employees of SHOP-participating employers generally do ***not*** qualify for premium tax credits through the individual Exchange—except where their share of the SHOP-coverage premium would exceed 9.5% of their income. And, because California has not chosen to merge the individual and small-group markets, the gross premium amounts (i.e., before the employer's contribution) are likely to be somewhat different in the SHOP Exchange v. the individual Exchange, even for the same plan design. Therefore, the Exchange needs to provide workers with information about their net premium costs for the plans available to them after deducting the premium contribution their own employer has decided to make. (How workers' net premium costs would differ in the SHOP Exchange v. the individual Exchange—even when gross premiums are the same—is illustrated in Appendix A. Employer contribution issues are discussed in a later section.)

Therefore, it seems critically important for the SHOP Exchange to have a separate website—or at least a separate "sub-site"—that includes a calculator which allows these workers to easily see what their own premium contribution will be for competing plans, without the confusion that would be caused by also seeing prices for policies in the individual Exchange that are not available to them. Further, to make worker-choice administratively feasible for small employers, the Exchange essentially needs to bill and collect premiums from employers and then transmit the appropriate premium amounts to the workers' chosen health plans, as AB 1602 directs it to do. *[GC §100503(w) per AB 1602 §7]* If the Exchange did not take on this role, small employers would have to receive bills and make monthly premium payments to multiple different health plans. The employer would also need to deal with myriad plans as new workers come, old workers leave, dependents are added, etc. The latter situation is illustrated in Exhibit 1.

Instead, the Exchange can make the process much simpler for the employer by issuing a single monthly "list bill" itemizing the health plans and family coverage categories selected by each worker, the contribution to be deducted from the pay of each worker (which allows these contributions to be tax-sheltered under Section 125 of the Internal Revenue Code [IRC], thus reducing the net out-of-pocket cost to the worker), and the total amount due for the employer's group. This approach makes the employer's level of effort to offer worker-choice of health plan through the SHOP Exchange similar to contracting with a single carrier (which might offer different benefit-level options). The work flow is illustrated in Exhibit 2.[7]

primarily large employer groups, new co-operative or provider-system-based plans, and plans that currently enroll primarily Medicaid and CHIP populations.

[6] Federal law defines a "qualified employer" (i.e., an employer qualified to use the SHOP Exchange) as "a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered ***in the small group marke***t through an Exchange that offers qualified health plans." *[PPACA §1312(f)(2)(A), emphasis added]* The use of the phrase "in the small group market" indicates that the law considers SHOP-Exchange coverage to be employer-sponsored group coverage.

[7] While this administrative capacity seems essential, it should also be noted that performing these functions efficiently, timely and accurately is essential to the Exchange's success. Thus, operational competence—whether these functions are carried out by internal staff or by a contracted vendor—is critical. In the past, a number of small-employer choice exchanges learned this lesson the hard way.

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Exhibit 1: Employer "SHOP-You-Would-Drop" Exchange

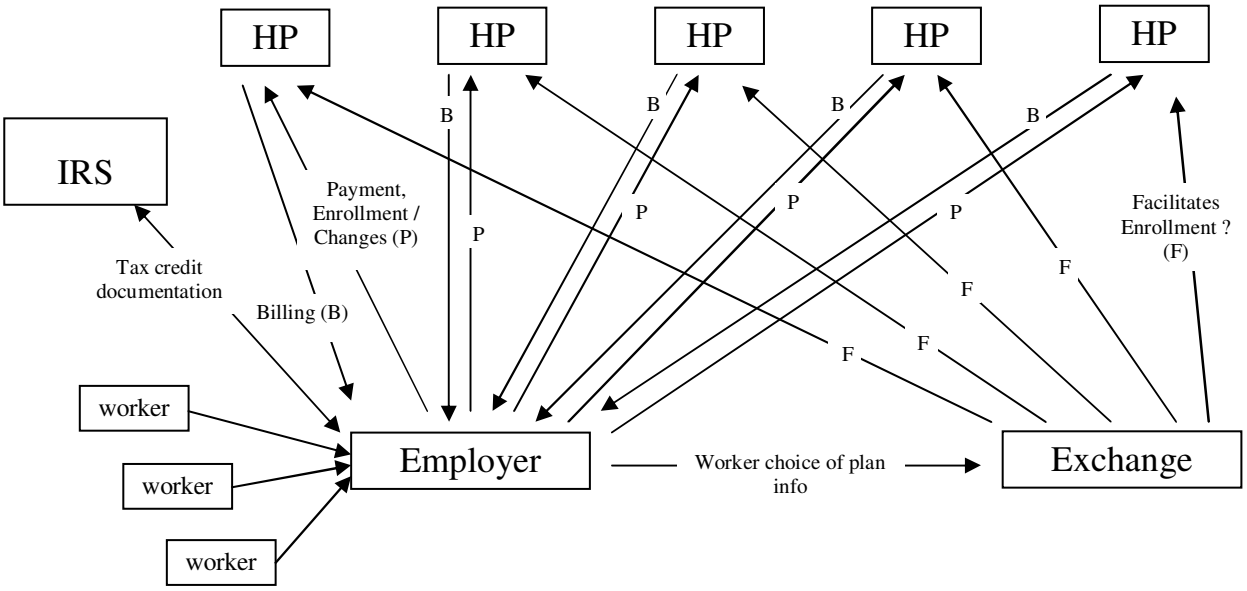
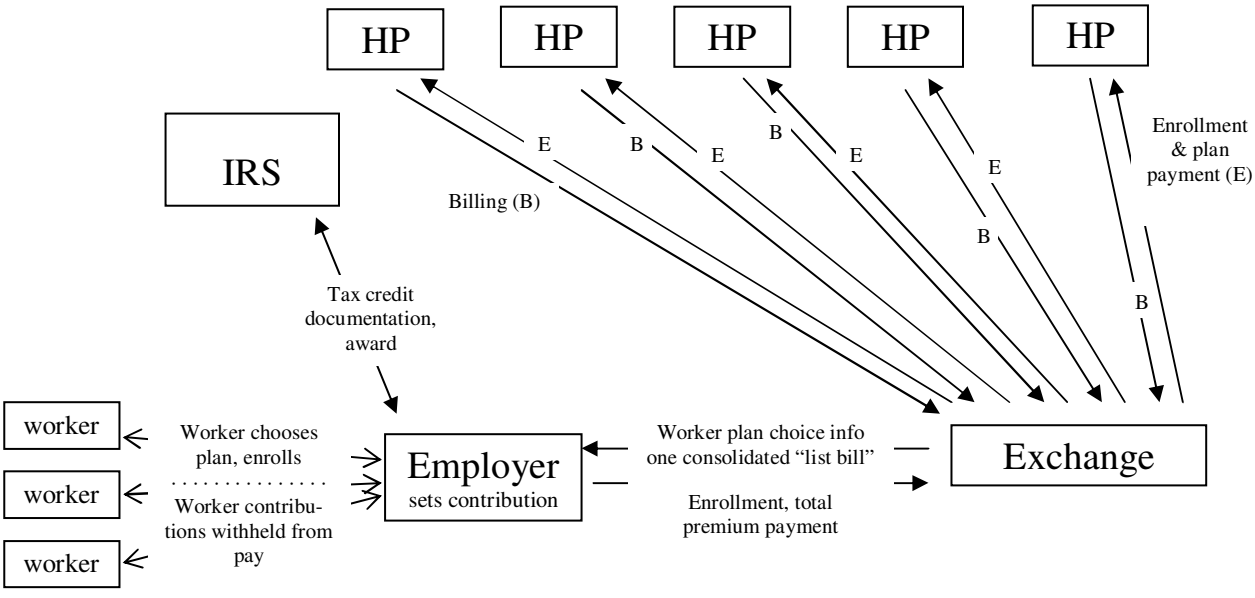


Exhibit 2: Employer One-Stop SHOP Exchange (to make employee choice work for the employer)



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How Often Will Employer Premiums Increase?

Another administrative difference between the individual Exchange and the SHOP Exchange relates to the period over which initial premiums are guaranteed.

When deciding whether or not to offer coverage, employers consider it particularly critical to know what their contribution obligations will be for the coming year.

In the commercial market, a new purchaser (whether individual or group) typically receives a guarantee that his/her premium will not increase for some specified period, usually 6 or 12 months. So someone who buys or renews coverage in March (for example) is assured that their premium rate will stay the same at least through August (or the following February, if the guarantee is for 12 months). But someone who buys coverage in April or May may pay a slightly higher premium than the March purchaser (although that premium will in turn remain fixed at least through September or October).

In public programs like Medicaid, on the other hand, the rate schedule paid by the state typically changes only once a year, and the state's payment rates change at the same time for all enrollees, regardless of how long they have been enrolled in the program. This system does not create any problem for the enrollees, because typically their contribution toward the premium (if any) does not change when the underlying premium changes.

To date, federal guidelines have not been issued on this question, but the structure of the individual tax credit suggests that premiums in the individual Exchange are likely to change once a year, at the same time for all enrollees. (To allow rates to increase through the year for new enrollees, as in the commercial market, would make computation of the applicable tax credit considerably more complicated.) If premium rates in the Exchange increase (say) each January, then someone who buys coverage for the first time in September will have to pick a plan knowing that their premium will almost certainly change in January, by some amount that will not be known until perhaps November (when, presumably, there would be an open enrollment season to allow people to change plans).

However, the annual change in premium prices will presumably coincide with the annual change in the respective individual tax credits eligible individuals will receive. The result would be one change per year in the net premium amounts individuals pay for plans, with premium changes largely offset by tax-credit changes for recipients whose income status remains constant.

But requiring premium changes at a single fixed date each year, regardless of when the employer group initiated coverage, would likely be unacceptable to many small employers considering the SHOP Exchange. That is, employers would be very reluctant to purchase through the SHOP Exchange in September, knowing that rates will increase by an unknown amount in January, because they could instead purchase coverage outside the Exchange and get a 12-month rate guarantee. (Note that the small-employer tax-credit percentage does not change due to premium changes.)

To address this problem, the SHOP Exchange could provide that its plans guarantee premium rates for 12 months after initial purchase or renewal but ***allow plans' rates for new small-employer purchasers to increase once per calendar quarter***. Quarterly rate increases should be

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more manageable than monthly increases, while not putting the SHOP Exchange at a significant disadvantage if the outside market continues to adjust new-business rates on a monthly basis. This paradigm has been used successfully for many years by the Connecticut Business and Industry Association's small-employer purchasing pool, "Health Connections." It was also used by California's HIPC/PacAdvantage small-employer program.

Separate SHOP Exchange Systems Are Needed

As discussed above, enrollment, premium collection and plan payment operations will differ between the individual and SHOP Exchanges, as will premium levels. And the associated customer service needs will often be different as well. A critical early decision for the Exchange will be the selection of systems and/or vendors for these SHOP Exchange functions. Experience with the HIPC/PacAdvantage and other small-employer exchanges has demonstrated how challenging and important these systems are to the initial and ongoing success of the Exchange. Because these functions are considerably different than those of the individual Exchange, the Exchange should consider separate RFPs for the development, adaptation, or operation of such systems. To the extent that a vendor wants to bid on both and can demonstrate superior service for both Exchange operations as well as advantageous synergies for the Exchange and its participants, the ultimate decision might be that one vendor can provide the best services on both sides of the Exchange. But to assume this will be the case—i.e., to require a single vendor across both Exchange programs—could well lead to inferior service for SHOP Exchange employers and workers.

On the other hand, to the degree the Exchange decides to make the same QHPs available as both group and individual products (see later discussion) and decides to operate premium collection, plan payment and enrollment functions for the individual Exchange as well as the SHOP Exchange, it may make sense to require vendors or teams of vendors to submit bids that demonstrate efficient coordination across the individual and small-employer Exchanges. In any event, it will be important that small employers perceive the Exchange to be a reliable business partner that is responsive to their needs. Small employers are often averse to dealing with government agencies. The California HIPC chose an administrative vendor with considerable small-employer-market experience. That organization was in many senses the face of the HIPC with small employers and helped provide initial credibility in the small-employer market.

Will a SHOP Exchange Be Viable in California?

California's earlier, voluntary small-employer purchasing pool—the Health Insurance Plan of California (HIPC), later PacAdvantage—ultimately failed because of adverse selection. Since using the SHOP Exchange will be optional for small employers, California policy makers are concerned that the same fate might befall it.

For a number of reasons, however, the SHOP Exchange will be less subject to adverse selection problems than the HIPC was, and should therefore be more viable. In the new, reformed environment:

- Insurance market rules will be tighter. Health rating will not be allowed, in either the Exchange or the regular small-group market. Risk adjustment will be in place across the entire small-group market, both inside and outside the Exchange. Therefore, it will be more

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difficult for carriers selling outside the Exchange to attract lower risk small-employer groups using favorably low rates and, to the extent they are able to do so through marketing techniques, they will have to pay more into the risk-adjustment system than they receive back for high-cost cases. Further, carriers that sell both inside and outside the Exchange will be required to combine *all* their small-employer coverage into a single risk pool.[8]

- The individual market will be operating under the same rules—guaranteed access, with no health rating and the same age rating as for small groups. So, unlike the current market, there will be little incentive for small employers with low-risk workforces to leave the small-group market and send their workers to the individual market (where, previously, low rates would have been available for healthy workers), or for low-risk individual workers to decline employer coverage and seek lower rates in the individual market.

- Importantly, the SHOP Exchange, unlike the HIPC, should have a "core" population: small employers eligible for the federal small business (health insurance) tax credit. Beginning in 2014 (when the SHOP Exchange will have begun operation), small employers will be ***required*** to purchase coverage through the SHOP Exchange in order to qualify for the credit. This group is likely to constitute a normal risk distribution. We believe that in California a range of 450,000 to 650,000 covered lives is a realistic estimate for this core population.

  - ***Note, however, that this estimate does not adjust for currently offering small firms that might decide to drop coverage when the individual tax credits become available in 2014.*** (The financial incentives small employers will face in this regard are discussed below, beginning on page 11.) While any resulting enrollment reductions will be somewhat offset by enrollment from newly offering low-wage small employers, it seems unlikely that many currently non-offering small employers will choose to begin offering coverage. State credits focused on such employers have had very limited enrollment.

  Although this credit is available only to a subset of small employers (those with fewer than 25 full-time-equivalent employees and average wages less than $50,000) and (after 2013) is only available to any employer for two tax years, it nevertheless could provide the SHOP Exchange with enough "critical mass" for an effective launch, with a relatively "normal" core population based on employer size and wage profile, rather than on health risks. (Additional details about this credit, and about our estimates of the number of people likely to make use of it are provided in Appendix B.)

  If the SHOP Exchange provides very good service, it is reasonable to assume that most of its initial employers that continue to provide coverage will continue with the SHOP Exchange even when they can no longer claim the tax credit. These small employers will have been relieved of the need to select a health plan to serve the myriad workers with differing circumstances and needs. And once workers experience the value of being able to choose their own health plan, they are likely to want to continue with the arrangement. (Note that the California HIPC experienced high employer retention, apparently for this reason.) In addition, new small firms or previously non-offering small firms that decide to start offering coverage will be able to claim a tax credit only if they arrange coverage through the SHOP Exchange.

[8] The same requirement will apply to the individual market for carriers selling both inside and outside the Exchange.

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Employers with 51-100 Employees

The preceding comments apply to what might be called the "traditional" small-employer market—businesses with up to 50 employees. Under the federal reform law, employers with 1 to 100 employees are considered "small employers" and thus qualify to purchase coverage through the SHOP Exchange. *[PPACA §1304(b)(2)]* But for plan years beginning before January 1, 2016, states can choose to keep the small-employer definition at 1 to 50 employees. *[PPACA §1304(b)(3)]*

- Neither SB 900 nor AB 1602 (nor any other 2010 California legislation) dealt with the definition of "small employer," apparently reflecting legislative intent to leave the existing small-employer definition (up to 50 employees) in place during 2014 and 2015.[9]

The size cut-off for the small-employer market is an important issue because businesses with 51 to 100 workers are more likely to have alternative coverage arrangements marketed to them, including TPA-administered "self-insured" plan arrangements with stop-loss reinsurance. Therefore, allowing such businesses into the SHOP Exchange immediately could raise premiums in the SHOP Exchange because of adverse selection: businesses with healthy workforces would choose to self-insure (probably in conjunction with stop-loss insurance), while businesses with less healthy workforces would choose to take advantage of the non-health-rated coverage available through the SHOP Exchange (and in the small-group market generally).

- Thus, it would seem prudent for California to take specific action to maintain its small-employer threshold at 50 workers until 2016. Otherwise, the viability of the SHOP Exchange, and of the small-employer market more generally, could be threatened.[10]

- Even in 2016, adverse selection will present a clear and present danger to the viability of the small-employer market as long as businesses with 51to 100 employees have arrangements marketed to them that are not subject to state rating rules, for example, self-funded plans involving various reinsurance arrangements. Because these arrangements would be differentially attractive to groups when they are low risk, it would leave the small-employer rating pool with higher costs and risks. It is not known whether federal guidance will be issued at some point to ameliorate this danger.

Relationship to Individual Tax Credit

Once premium tax credits for individual coverage become available in 2014, financial incentives will discourage a number of low-wage employers from offering coverage. As we illustrate and discuss below, the direction and magnitude of these incentives will depend on the family income

[9] To conform with federal law, California's definition of "small employer" will have to be revised to include businesses with one employee. (California's definition is currently 2-50 employees.) But it may be prudent to wait until federal implementing regulations are published, since there are open questions about who constitutes an "employee" for this purpose.

[10] On other hand, there are some non-offering firms in the 51-100 employee range, and those firms will now be subject to a penalty if they do not offer coverage to their full-time workers. Participation in the SHOP Exchange might be of interest to such firms, and they could help the SHOP Exchange attain the necessary critical mass to operate efficiently.

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and age composition of the small-employer group, as well as on its size and average wage (the factors which determine the employer tax-credit percentage).

Because the bases for calculation and application of the individual and the small-employer tax credits are very different, and because employers generally do not know their workers' family incomes, it will not typically be clear to a given employer what the trade-offs for that group are.

Exhibit 3 compares the net premium cost for single coverage in 2014,[11] after applying all available tax subsidies, to employers and their workers (combined) for two small employers: one that qualifies for the maximum 50% credit under the small-employer tax credit—that is, a for-profit employer with 10 or fewer workers and average wages of $25,000 or less—and one that does not qualify for ***any*** small-employer tax credit. Under the two employer-coverage scenarios, both employers are assumed to contribute 100% of the premium, and the regular tax savings associated with employment-based coverage are calculated as explained in the notes for Exhibit 3.[12] Exhibit 3a makes this comparison for an employer group with young workers and Exhibit 3b for a group with older workers.

Under the third scenario in each part of Exhibit 3, the employer does not offer coverage and makes no contribution, so the workers buy coverage individually through the Exchange. Under this scenario, the worker's net cost equals the lesser of the full premium or the sliding-scale percent-of-income contribution amount specified in PPACA. (For simplicity, this illustration assumes that the employer offers, and the workers purchase, Exchange coverage that costs the same amount as the coverage on which the premium tax credit is based.[13])

Exhibit 3a shows, for a young worker who is in a young employer group, at what incomes the net premium cost for purchasing single coverage individually is less than the (combined) net cost for group coverage. From the Exhibit, we can see the incomes at which the net premium cost for purchasing single coverage individually is less than the (combined employer and worker) net cost for group coverage. These "break-even" points would remain the same at different premium levels, so long as the age-rated SHOP and individual Exchange premiums are equal.

- Where the employer qualifies for the maximum small-business tax credit, buying individually is less expensive ***only*** for workers with (family) incomes below about 175% FPL (about $20,000 per year in 2014 or $19,000 in 2010).

- If an employer with a younger workforce does not qualify for any of the small-business tax credit, however, buying individually is less expensive for workers with incomes below about 250% FPL (about $28,625 per year in 2014 or $27,075 in 2010).

[11] This discussion focuses on single (worker-only) coverage because of uncertainties regarding pending federal rules pertaining to affordability standards for dependent spouses' access to individual tax credits. Further, legal resident children in families below 250% FPL are eligible for the Healthy Families program.

[12] By "regular tax savings" is meant the income and payroll tax savings that accrue to the worker, and the payroll tax savings that accrue to the employer, because employer contributions toward health insurance are excluded from the workers' wages for tax purposes, and the workers' contributions can also be excluded under IRC §125. Even for the lowest wage full-time workers, these federal tax savings are worth at least 25% of the premium, and the presence of a state income tax increases that percentage.

[13] Specifics are given in the notes for Exhibit 3.

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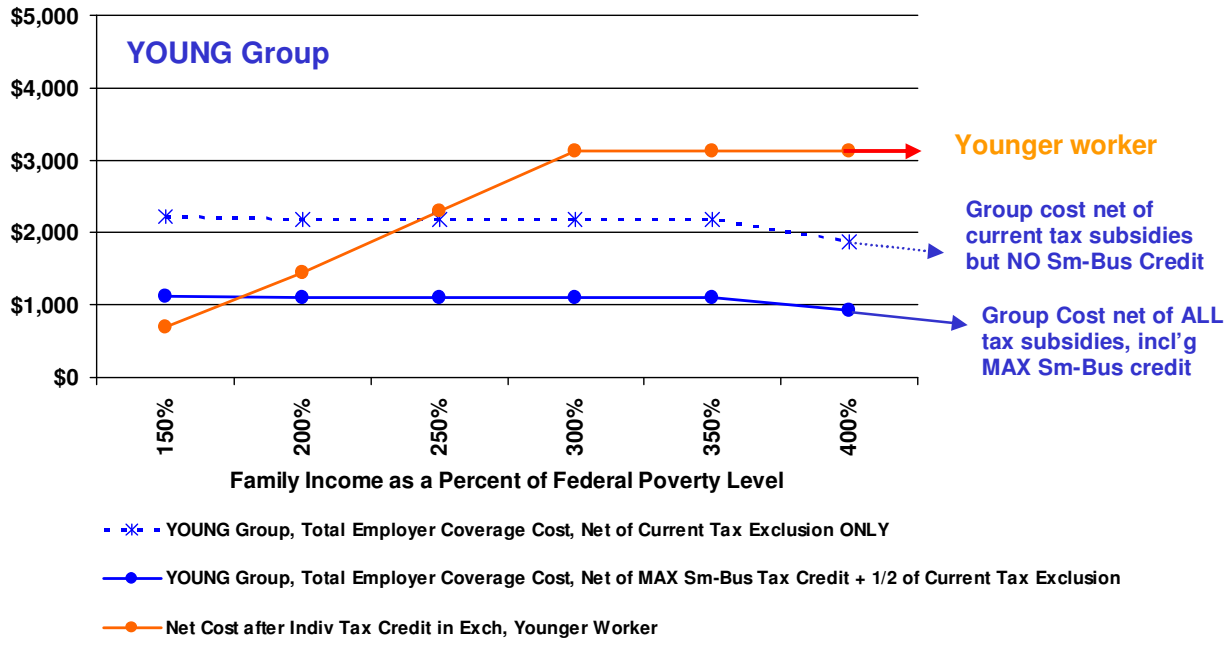
Exhibit 3: Net Cost to Employers and Workers for Individual v. SHOP Coverage

(For Single Coverage, after All Available Tax Subsidies under PPACA as amended, for Exchange Coverage Where Small Employer Offers and Contributes toward Coverage v. Where Workers Purchase Coverage Individually with No Employer Contribution, by Workers' Family Income, 2014)

3a: Employers with a Young Workforce v. Young Workers Purchasing Individually



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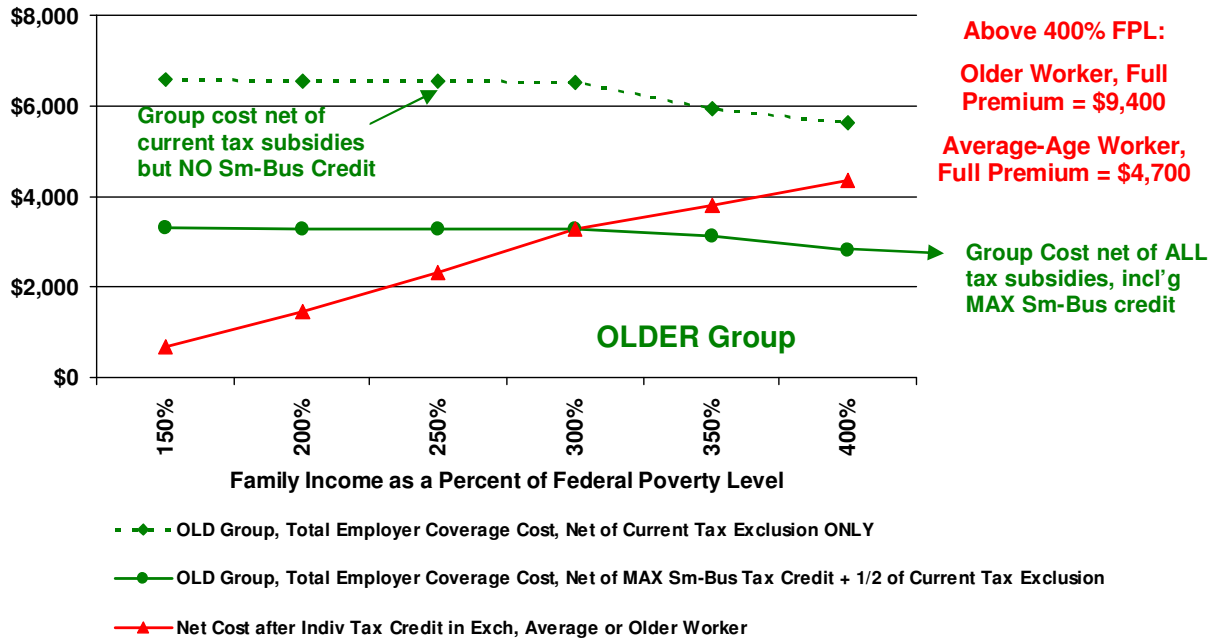
3b: Employers with an Older Workforce v. Older Workers Purchasing Individually



Notes: The lines labeled "Net Cost after Indiv Tax Credit in Exch" represent the case where workers purchase coverage individually. The 2 employer-coverage ("Total Employer Coverage Cost") scenarios compare a small employer that qualifies for the maximum 50% employer tax credit with a small employer that does not qualify for any credit. Exhibit 3a compares these values for a small employer with a young workforce and Exhibit 3b one with an older workforce.

Both employers are assumed to contribute 100% of the premium, and the regular tax savings associated with employment-based coverage are calculated as the worker's income-tax savings plus the payroll tax savings both the worker and the employer realize because the employer's contribution (net of the small-business tax credit) is excluded from the worker's taxable income. (Note that, if the small employer qualified for less than the maximum small-business tax credit—due to more than 10 workers or average annual wages higher than $25,000—or qualified but contributed less than 100% of the premium, then the combined net cost to the employer and the worker would fall between the two examples shown.)

Workers are assumed to purchase coverage that costs the same amount as the coverage on which the premium tax credit is based. This premium amount is assumed to be $4,700 for an average-age worker or group in 2014, deflated from CBO's estimate of $5,200 for 2016. The youngest workers/ groups are assumed to cost two-thirds that amount or $3,133, and the oldest workers/groups cost twice that amount or $9,400. These age adjustments were made by the author based on data from the Kaiser Family Foundation's health reform subsidy calculator (http://healthreform.kff.org/subsidycalculator.aspx), adjusted so that the average for likely individual tax credit eligibles (people with incomes from 150% to 400% FPL who had neither government nor employment-based insurance in 2009, per CPS) matches $4,700 figure. The poverty level for a single individual in 2014 is estimated to be $11,450, deflated from CBO's estimate of $11,800 for 2016.

Source: Institute for Health Policy Solutions calculations based on PL 111-148 as amended by PL 111-152.

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Exhibit 3b shows that, where an employer has only older workers, purchasing single coverage through the individual Exchange with a tax credit is less expensive up to much higher income levels—about 300% FPL (or $34,350 in 2014) if the employer qualifies for the maximum small-business credit, and 400% FPL otherwise.[14,15]

- Note that, because of the way the individual tax credits are structured, an older individual qualifies for a substantially higher individual tax-credit amount—both in dollar terms and as a percent of premium—than a young worker with the same income. Premiums in the individual Exchange are age-rated, and the individual tax credits are designed to reduce the cost of a benchmark plan to the same amount for all individuals of the same income. Therefore, a larger credit, which is also a larger percentage of premium, is needed to reduce an older individual's age-rated premium to the same dollar amount than is needed to reduce the lower premium for a younger individual.

- Note also that, above 400% FPL, workers purchasing individually have to pay the full premium with no tax credit and no other tax subsidies, so employer group coverage—at the same "actuarial value" benefit level—will always be less expensive, because the regular tax exemption for employer-paid premiums remains in place. Above 400% FPL, these subsidies typically total at least 40% of the premium—and more in a state like California that has a state income tax.

If a substantial majority of a small employer's workers could use tax credits to purchase coverage through the individual Exchange at a total cost lower than for group (SHOP Exchange) coverage offering equivalent benefits, then the employer would have a strong financial incentive to forego group coverage and send their workers to the individual Exchange. (Interestingly, Exhibit 3 shows that this is more likely to be the case when an employer has an older workforce.)

But several factors suggest that this will be the case only for a subset of small employers:

- The younger the employer's workforce, the lower the income at which individual Exchange coverage is less expensive. If virtually all the employer's workers are under 30 and single with no additional income, most would have to earn less than $10 per hour or work less than full-time to make comparable individual coverage less expensive than group coverage.

- While employers obviously know what they pay their employees, wages and family income are not perfectly correlated, so employers generally do not know their workers' family incomes. For example, a low-wage employee could be the secondary worker in a two-earner

[14] If our younger and older workers were part of an age-heterogeneous employer group, then the net (post-tax-credit) cost of purchasing single coverage through the individual Exchange would remain unchanged, but the net cost of group coverage would be higher than shown in Exhibit 3a and lower than shown in Exhibit 3b. As a result, the "break-even" point for the young worker would be at a higher income, and the break-even point for the older worker would be at a lower income.

[15] Also, when dependents are also covered, individual Exchange coverage will be less expensive than employer group coverage up to higher income levels (relative to poverty), because the sliding-scale required contribution for individual coverage remains the same as a percentage of family income at each income level (as a % FPL up to 400% FPL) regardless of how many family members are covered, while adding dependents raises the cost of employer group coverage. Workers below 250% FPL will be likely to enroll any children in Healthy Families, so at those income levels the only likely dependent would be a spouse.

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family with much higher family income. While this is not a frequent occurrence, it is also not uncommon—1 of 6 workers earning less than $20,000 per year is in a family with income above 400% FPL. (See Exhibit 6 in Appendix C.)

- Workers with family incomes above 400% FPL get ***no*** tax benefits whatsoever if they buy coverage through the individual Exchange. They cannot even use IRC Section 125 to buy individual Exchange coverage with tax-sheltered payroll deductions. *[IRC §125(f)(3), as added by PPACA §1515]* Hence, if an employer has a number of valued higher-income employees who cannot get comparable coverage through a spouse's employer, maintaining group coverage, with its associated tax benefits, may be more attractive for that employer.

In sum, it seems probable that some number of small, low-wage employers may decide not to offer coverage and instead encourage their income-eligible workers to qualify for premium tax credits and cost-sharing subsidies for purchasing individual coverage through the Exchange. The number is difficult to estimate, but it seems unlikely that a large proportion of currently offering small employers would decide to drop coverage, at least so long as the small-employer tax credit is available to them. If it, or an alternative, is not extended beyond the two years available under PPACA, it seems likely that many of the smallest and lowest-wage currently offering firms, particularly those with older workforces, will drop coverage.

Good Service Is Critical to Continuing Success

Despite the uncertainties just discussed above and at greater length in Appendix B, it is reasonable to expect that the small business tax credit will generate a sufficient "core population" to allow the SHOP Exchange to launch successfully and operate efficiently. But after 2015, most currently offering small employers will no longer be eligible for the small business tax credit. (While the credit will still be available to new small firms, they are likely to be few in number.) Therefore, it will be critical that the SHOP Exchange provide very good service from the outset. If it does so, then it is reasonable to expect that the SHOP Exchange could:

- Attract some newly offering employers. (Small, low-wage firms will qualify for the small business tax credit for the first two years they offer coverage through the SHOP Exchange.)

- Retain a significant share of employers that chose to enter the Exchange to receive the tax credit but have received good service and whose workers value the choice among health plans that the SHOP Exchange offers. (These employers are less likely to continue offering SHOP Exchange coverage if their workers' family incomes are low enough to make individual Exchange coverage less expensive than group coverage after the small-business tax credit is no longer available. See the higher group-cost lines in Exhibits 3a and 3b.)

However, success in attracting employers that are too large or whose average wages are too high to qualify for a significant small-business tax credit will depend more on providing excellent service to employers and a compelling worker-choice menu of plans that can improve worker satisfaction compared to a single employer plan.

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Health Plan Selection and Contracting

One key role for the California Health Benefit Exchange is to establish standards and criteria (in addition to federal standards) for qualified health plans (QHPs) and to select and certify the plans it will offer based on those criteria. A key question is whether decisions regarding QHPs will be separate or combined for the SHOP vs. the Individual Exchange. This would be a straightforward decision if California decided to merge its individual and small-employer markets.

The Option to Merge Its Individual and Small-Employer Markets

Federal law provides that "[a] State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate." *[PPACA §1312(c)(3)]*

If California were to merge its individual and small-employer markets, the same plans and rates would be offered across the merged market. In this context, the Exchange could logically and easily select, certify, and offer the same set of QHPs in its SHOP and Individual Exchanges. However, AB 1602 essentially forestalls the prospect of a merged market for the first five years of Exchange operations.

California policymakers chose to forestall a possible market merger because they understood that the impact on the small-employer market could be substantially different than that experienced in Massachusetts. In Massachusetts, merging the two markets reduced premiums for individuals while raising them only negligibly for small employers. But Massachusetts' individual market was very small relative to its small-group market, and it already required guaranteed issuance of coverage under adjusted community rating (with very tight limits) even before the Commonwealth's 2006 reform law was passed. Given that, pre-2006, there were no requirements for individuals to participate in coverage, and no subsidies to encourage participation, Massachusetts' individual market experienced adverse risk selection, and the cost of individual coverage was very high. Combining the markets greatly reduced individual-market premiums while causing only negligible premium increases in the much larger small-group market. The markets for individual health insurance in most other states differ considerably from Massachusetts' pre-reform individual market.

In particular, California's individual market is large and aggressively underwritten, with relatively low premiums. It is about as different from Massachusetts' pre-reform individual market (small, guaranteed access with no health rating, and high premiums) as it is possible to get. So an immediate merger of the two markets could very well lead to a result completely opposite that experienced in Massachusetts. At best, the result is impossible to predict, given all the other changes in market rules scheduled to be implemented in 2014.

Therefore, the California Exchange legislation takes a prudent approach, requiring a report based on at least two years of data after the Exchange begins operation. The report is to analyze "the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained." And the due date (no later than December 1, 2018) is set so that the initial (transition) year or two can be excluded and still allow the report to be based on two full years of data. *[GC §100503(v) per AB 1602 §7]*

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Another consideration arguing against an immediate (2014) merger of the two markets is that small business groups almost invariably believe that merging them with the individual market would increase their premiums. Whether or not that is a correct apprehension, policy makers decided to defer a final decision on whether to merge the two markets until the Exchange(s) have been functioning for long enough to permit a definitive analysis of the probable impact.

Separate Markets but Same Rules

California's individual and small-employer markets, and therefore health plan rates and quite possibly offerings, will remain different for some time. But the rating factor components and limits (e.g., no health rating and an age-rating band of 3 to 1) will be the same across the markets, as will requirements regarding access, essential health benefits and Actuarial Values. Given the large number of new participants expected in the individual market, along with the provisions to address adverse selection, it is reasonable to assume that small-employer-market carriers will generally want to also participate in the individual market. Thus, it should be feasible for the California Health Benefit Exchange to offer essentially the same QHPs in the individual (nongroup) and SHOP (small employer) Exchanges, albeit at differential individual v. group rates.

Other Considerations for Consolidated Exchange Selection of SHOP and Individual QHPs

One reason to offer the same QHPs across the SHOP and individual Exchange programs is to assure that workers and their dependents can keep the same plans and associated providers when they switch between individual and SHOP employer-based Exchange coverage. This seems particularly important given the historic fluctuation in offer rates among small employers, and the relatively high turnover in workforce among the low-wage small employers (eligible for the small-employer tax credit) most likely to participate in the Exchange, as well as the two-year duration limit on that tax credit.

Another consideration is that California's previous small-employer exchange experience saw some major group carriers preferring to directly enroll "whole groups" and compete against, rather than participate in, the HIPC/PacAdvantage. This experience exacerbates apprehension that carriers may again take this tack regarding a SHOP Exchange. (Such apprehension persists even though the small-employer tax credits, as well as tighter market-wide rules and risk adjustment, should put the SHOP Exchange in a much better position to obtain health plan participation and avoid adverse selection than was the HIPC/PacAdvantage).

It appears that carriers would more likely seek to participate in the SHOP Exchange if doing so were a condition of participating in the individual Exchange.

Assuming that the existing PPACA constructs (including tax credits and penalties) are not changed, it is reasonable to expect that carriers will be more motivated to participate in the individual than in the SHOP Exchange. The individual Exchange core population is expected to be substantially greater, around 3 million lives, or about 5 to 6 times the "core" population enrollment of the SHOP Exchange. This individual Exchange population would constitute a much greater share of the total individual market (half or more) than the comparable SHOP Exchange share of the small-employer market (around 13% to 29% of the under-50 market—see Appendix B—or less than 20% of the under-100 market). Further, the individual tax credits

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available only for Exchange coverage are permanent, while the small-employer tax credits last for only two years for a given employer.

Coordinated Health Plan Contracting

For these reasons, the California Health Benefit Exchange should consider consolidating its selection of QHPs for the SHOP and individual Exchanges. One sensible strategy would be to require that carriers submit applications for Exchange participation for both the individual and the small-group markets and to then select QHPs based on scoring a carrier's application across both. If some carriers do not participate in one or the other market for reasons the Exchange determines to be acceptable, it could adopt an exceptions policy. Or the Exchange could require that QHPs participate in both markets, noting that any interested carrier could fully meet its obligation to guarantee access in either or both market(s) via participation in the Exchange.

The Exchange could use its flexible authority to establish standardized benefit plans and/or criteria for health plan selection in a variety of different ways to make such a consolidated QHP selection process work. For example, it could require that a given carrier's plans have the same benefit packages for the SHOP and individual markets (to help determine whether and how the relative value proposition stacks up across these plans). Or it could specify standardized benefit plans across the two market segments to be included in all applicant carriers' portfolios and which would serve as the primary basis for selection of a given carrier's health plans. Or, possibly after several years experience, it could specify standardized benefit packages for all QHP applications and offerings.

In short, if the California Health Benefit Exchange determines that it should consolidate QHP selection across its individual and SHOP Exchanges, it has a variety of market constructs, tools and strategies available to make this a viable approach.

Employer and Worker Contributions in a SHOP Exchange

Some policy makers and stakeholders assume that, when an employer participates in the SHOP Exchange, its workers would pay the same amount for coverage regardless of their respective age, just as large-firm workers do. For insured group coverage in the larger employer market, a carrier typically charges and is paid the same "composite" rate respectively for each enrolled worker in the same family category (worker only, worker + spouse, family, etc.). This rate reflects a weighted average of the (premium) costs across participating workers, and workers pay the same amount (for a worker-only or family plan) regardless of a given worker's age. (In the small-employer market, composite billing is typically used in some states, and "list billing" in others, like California.[16])

But when individual workers have a choice of competing health plans through a SHOP Exchange, the age distribution of those workers in an employer group who choose to enroll in a

[16] In California's small-employer market, list billing is prevalent. I.e., the carrier sends the employer a bill listing all enrolled workers and the age-adjusted premium applicable to the coverage tier each worker is enrolled in. In Oregon, on the other hand, composite billing is typically used even in the small-employer market. In other states, plans may use list billing for the smallest firms (e.g., those with fewer than 10 workers) and composite billing for "larger" small firms.

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particular health plan will usually be different, often very different, from that of the employer's whole group. Each health plan's costs will reflect the ages of the workers it enrolls from that employer, and the plan will need to be paid accordingly. Given that it will have no other source of revenue, the SHOP Exchange will therefore need to collect from each employer group the corresponding age-rated premium amounts for all of the plans chosen by its members.[17]

In other words, the SHOP Exchange will need to collect premium payments from each participating employer group that equal the sum of individually age-rated premiums for the health plans that its workers choose.

Percentage of Premium for All Workers

One way to achieve this is for the employer to pay a percentage of each worker's respective plan age-rated premium, and have the worker pay the remaining percentage. As long as the employer paid 50% or more, this would be compliant with employer contribution requirements for the small-employer tax credit.[18] Such compliance is a critical attribute given that, as discussed earlier, small employers eligible for this credit should constitute a critical initial core enrollment base for the SHOP Exchange.

But this approach literally requires that, e.g., 62-year-old workers pay three times more than 25-year-old workers for coverage—an ironic outcome given the non-discriminatory intent of the PPACA contribution provision.

- *For example, if Plan "Y" had age-rated premiums from $225 to $675 for worker-only coverage, and the employer paid 60% and the worker paid 40% of age-rated premiums, a worker's share would vary from $90 to $270. (This example is displayed in Exhibit 4 under the heading "Employer Pays Same Percentage of Each Worker's Age-Rated Premium.")*

And it would require that the employer make an open-ended commitment to pay a percentage of the premiums of whatever plan choice the worker makes; which could encourage workers to choose more expensive plans in order to receive the employer's higher matching payment for that choice (an ironic outcome given the cost-sensitive individual-choice-of-plans goal for Exchanges).[19]

The basic components of an alternative approach that would address these shortcomings are described below. With respect to goals, the SHOP Exchange should make it easy for an employer to structure and administer employer and worker contribution policies so that:

[17] If the Exchange instead attempted to cross-subsidize costs across participating employers whose differing age workers are in a given plan, it would suffer severe adverse selection because of higher prices for younger employer groups (and lower prices for older groups) than outside market group plan rates.

[18] More precisely, the IRS guidance states that an employer could contribute a different percentage of the age-rated premium for each plan, so long as that percentage is 50% or more and so long as the same percentage is used for all workers enrolled in the same plan. [IRS Notice 2010-82, <http://www.irs.gov/pub/irs-drop/n-10-82.pdf>] For simplicity, the text omits this nuance.

[19] However, an employer could pay a lower percentage of premium for higher cost plans, so long as it paid at least 50% of the premium for each plan (see previous note).

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Further, the SHOP Exchange should make it easy for an employer to structure and administer employer and worker contribution policies so that:

- older workers in a given employer group are not required to contribute much more than (i.e., up to three times as much as) younger workers;
- the employer's contribution levels can be prospectively known and defined by the employer (as they are for traditional employer coverage) before the workers choose their plans;
- workers have a choice of the Exchange's competing plans and (given the employer contribution) can see what their own contribution requirement would be for each choice; and
- once workers' plan choices are made, the employer can be informed of its own and each worker's respective contribution amount (so that amount can be withheld from pay).

The approach also needs to comply with employer contribution requirements to qualify for the federal tax credit for low wage small firms. As we have discussed earlier, beginning in 2014, these tax credits will be available only to firms obtaining coverage through an Exchange, and such firms are expected to constitute a reliable core enrollment base for the small employer Exchange for the first two years.

PPACA's small-employer tax-credit provisions indicate that to qualify, an employer must make the same percentage contribution towards the coverage of all participating workers. Fortunately, recent additions to the IRS guidelines for the small-employer tax credit clarify that an employer offering more than one plan has several options for structuring its contributions to meet the requirements for the credit.[20] In particular, the employer can use the alternative described below, which involves the employer selecting an employer reference plan, and set its contributions such that, for a given family category, workers of all ages pay the same flat composite rate for that reference plan.

The Employer Reference Plan (ERP) / Uniform Worker Contribution by Family Category Approach

Each employer would designate a reference plan for which a composite rate would be calculated for each family category (based on the age distribution of the people in each family category).[21] The employer would choose what portion of the premium it would pay for each worker in a given family category; and regardless of age, workers would pay the same remaining portion of the composite rate for their family category for the Employer Reference Plan (ERP), yielding a uniform worker contribution by family category. Each worker could, however, choose a different plan offered through the Exchange and pay (or save) the applicable difference in premiums.

[20] IRS Notice 2010-82, <http://www.irs.gov/pub/irs-drop/n-10-82.pdf>. See section G. In addition to the reference-plan approach detailed here, the employer could pay a percentage of the age-rated premium for all plans, as discussed earlier. Or the employer could compute a uniform required worker contribution for each plan, so long as that contribution was not more than 50% of the composite premium for each plan. (And the employer's contribution would then make up the difference between the worker's contribution and the actual age-rated premium.)

[21] "Composite rate" means the average rate determined by adding the full age-adjusted premium rates (for the employer-designated reference plan) for all workers in the group and dividing by the total number of workers.

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Note that the Employer Reference Plan / Uniform Worker Contribution approach described here is analogous to the federal tax credit formulation for income eligibles who participate in the Individual Exchange. That is, individual tax credits are to be calculated so that different age individuals with the same income pay the same dollar amount (i.e., the same percentage of the same income for a given family size) for the second-lowest-cost silver plan, the reference plan for individual tax-credit calculation purposes.

Similarly, the ERP approach here is constructed so that, regardless of age, workers of a given employer pay the same amount for the employer's chosen reference plan. In both cases, the individual can choose another plan and will pay or save the difference in (age-rated) premium.

The ERP approach will also allow the employer to "define" its contribution level based on a reference plan, and the worker to select, and pay or save the full premium difference for the competing qualified health plan (QHP) of her choice. The small employer exchange in Connecticut (CBIA's Health Connections) has successfully offered and administered this option since it began offering coverage in 1995.

How the Employer Reference Plan (ERP) / Uniform Worker Contribution approach could work:

The employer would designate a reference plan and the employer's contributions would be based on the premiums for this plan. A composite rate would be established reflecting the weighted average of the age-rated premiums for the reference plan (ERP) under the working assumption that it enrolls all workers participating in SHOP Exchange coverage. Workers of different ages would pay the same composite rate, i.e., the same worker contribution amount for a given family category for this employer-designated ERP plan.

Here's how it could work *(italicized references are to the illustrative premiums in Exhibit 4 below)*:

- First, the employer would select which QHP will be the "employer reference plan" (ERP).
- Second, for each family category, the Exchange would calculate a single "composite" rate for the ERP based on the weighted average of what its respective worker premiums would be if all workers in the group enrolled in the ERP. A dedicated Exchange calculator could provide this to employers. *(Exhibit 4: $400 for worker-only coverage.)*
- Third, the employer would determine what share (meeting minimum requirements[22]) of this "composite rate" it will contribute *(Exhibit 4: 60%, average of $240)*. This determines what the remaining composite (uniform) worker contribution toward the reference plan would be *(Exhibit 4: worker share = 40% of composite rate, or $160)*.
- The Exchange would provide a list of plans available for each worker showing what her own premium contribution cost would be for each. This contribution would be the worker's

[22] At minimum, the composite employer contribution would be the greater of 50% of the employer-designated reference plan composite rate, or the amount that would reduce the composite worker contribution to the lowest age-rated premium for that plan. (The latter is to assure that the youngest workers do not have to pay more than their respective full age-adjusted premium amount.)

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composite-rate uniform contribution amount for the reference plan, plus or minus the difference in premiums between the reference plan and each listed plan for a person of the applicable age. *(Exhibit 4: For Plan "Y", workers' contributions would be $182, $201, and $225 respectively for youngest to oldest workers.)*

- Each worker would then select her plan.
- The Exchange would "list bill" the employer showing each worker's contribution amount given her plan choice. The employer would withhold the respective amounts from each worker's pay.
- The employer would pay the Exchange the total amount billed by combining its workers' withheld contributions plus the employer's contribution amount.
- The Exchange would pay the plan chosen by each worker the full age-rated premium for that worker.

As referenced above, Exhibit 4 illustrates how this would work for a three-worker group.

Exhibit 4: Illustrative Monthly Premiums Under Percent of Age-Rated Premium Vs Employer Reference Plan (ERP) / Uniform Worker Contribution Approach

Worker	**Art**	**Bev**	**Cal**
Base Data			
Age	25	48	62
Age Rates for Employer-Designated "Reference Plan" (ERP) for Worker Only Coverage	$ 203	$ 386	$ 610
Age Rates for Other Plan "Y"	$ 225	$ 427	$ 675
Employer Pays Same Percentage of Each Worker's Age-Rated Premium, 60%/40%:			
Worker Contribution (40%) for ERP	$ 81	$ 154	$ 244
Worker Contribution (40%) for Plan "Y"	$ 90	$ 171	$ 270*
Calculation of Uniform Worker Contribution For ERP (If Worker Pays 40%)			
Composite/Average Premium for ERP	$ 400	$ 400	$ 400
Uniform Worker Contribution for Reference Plan	**$ 160**	**$ 160**	**$ 160**
Calculation of Worker Contribution for Plan "Y" under ERP approach			
Age-Rated Premium Difference for Plan "Y"	$ 22	$ 41	$ 65
For Plan "Y" Worker Pays (Contribution for Reference Plan plus Age-Rated Premium Difference)	**$ 182**	**$ 201**	**$ 225***

* Note that the contribution difference between the two approaches when the oldest worker chooses Plan Y would be even larger except that, under the "same percentage" approach, the employer pays more in total if all workers choose Plan Y ($796) than if all workers choose the ERP ($720). Under the "ERP approach," the employer's total dollar contribution remains the same, regardless of which plan the workers choose.

Source: Illustration by Institute for Health Policy Solutions.

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In general, this approach allows the employer to set its contribution amount based on a reference plan of the employer's choosing, and allows all of its workers of varying ages to pay the same uniform amount towards that reference plan. Workers can choose the plan they prefer so long as they pay the cost difference relative to the Employer Reference Plan.

In order for the Exchange to have the revenues needed to pay plans the premiums owed them, workers choosing another plan would save or pay the difference in premiums for a person of their own age. However, they need not choose another plan, and when they do, the total premium contribution cost difference for an older worker vs. younger worker would be small. *As can be seen in the last line of Exhibit 4, under the ERP approach, the oldest worker pays only $43 more for Plan Y than the youngest younger, while the full difference in their underlying age-rated premiums for Plan Y is $450 (see 3rd line under "Base Data") and the dollar difference in worker contributions for Plan Y under the "Employer Pays Same Percentage" approach is $180.*

While the Exchange needs to "list bill" the employer for each worker's contribution obligation given her choice of plans (so the employer knows how much to withhold from respective workers' pay), alternative approaches regarding the listing of employer contribution amounts could work. *(Total employer contributions across all workers would be the same under such alternatives, such that the Exchange would have the same total revenue to fund plan payments.)* The Exchange should take into account related factors such as outside market rules and practices as well as employer billings and plan payments for new workers over a contract year. A discussion of alternatives would unnecessarily complicate this paper, but is available to interested Exchange or state officials upon request.

Simpler Would Be Better

Ideally, a reference-plan approach such as that described here could be made much easier for the employer to administer. For example, the employer might simply choose the reference plan and make its employer contributions on a composite-rate basis, and leave most other responsibilities—including billing workers for their share—to the Exchange. To work, this would require new arrangements and procedures which IRS would need to recognize as acceptable for pre-tax contributions under such arrangements. While a discussion and analysis of these measures is well beyond the scope of this paper, it should be noted that this could both make worker-choice coverage through the Exchange more attractive to employers and allow for greater similarity between SHOP and individual Exchange operations.

Conclusion

This paper has described some key dimensions and approaches that will be important to take into account in the initial design of California's SHOP Exchange. A large number of other operations and program policy design issues will also need to be decided before coverage begins. Among the most important will be user friendly, responsive service provision, as well as development of a highly credible face with small employers, who are often very wary of government agencies. Despite the California HIPC's use of a private administrative vendor with substantial market experience and credibility, competitors did their best to portray it as a government entity. The California Health Benefit Exchange is an independent agency with the latitude needed to successfully implement and operate an efficient and responsive SHOP program. Small employers

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eligible for sizable federal tax credits towards Exchange coverage are expected to constitute an initial critical mass. But to succeed in reaching and retaining private employers, the Exchange will need to be viewed by employers as a trustworthy partner and to make employers' role in providing coverage to workers as simple as possible. This in turn requires that the Exchange make it easy for employees to understand their choices and provide or arrange for worker-friendly services.

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Appendix A: Illustrating How Worker's Net Premium Costs Differ Between the SHOP Exchange (When the Employer Contributes 50%) and the Individual Exchange

The main text notes that workers' net premium costs will differ in the SHOP Exchange v. the individual Exchange—even if gross premiums are the same. And, since SHOP Exchange coverage *is* employer group coverage, workers who are eligible for SHOP Exchange coverage will generally *not* be eligible for tax credits in the individual Exchange (unless their required contribution exceeds 9.5% of their family income). Therefore, to avoid confusion, the Exchange will need to have separate entry points for people who are applying as individuals and for workers who are applying as employees of a SHOP-participating employer.

Exhibit 5 illustrates how workers' net premium cost—i.e., net cost after applying all available tax benefits—would vary between individual purchasers and SHOP participants at different income levels. For simplicity, it assumes that the gross premium is the same for workers of the same age. In actuality, the choices will vary even more widely.[23]

In Exhibit 5, the solid blue bars show how much individuals would have to pay to enroll in the second-lowest-cost "silver" plan—the one on which the tax credit is based. This plan is estimated to cost $4,700 (in 2014) for the average participant in the individual Exchange. But, for the youngest adult participants (under age 30), that plan is estimated to cost only two-thirds as much, or $3,133, so that amount is the most a young adult would pay. (See the solid horizontal line shown in green).

On the SHOP Exchange side, Exhibit 5 assumes that the employer contributes half of the premium[24] (for a specified plan[25]) and that the age-distribution of the employer's workforces generates the same $4,700 premium for single coverage. Employer plans are typically structured so that workers contribute the same amount, regardless of age. Therefore, the amount deducted from each worker's paycheck to enroll in that plan is the same—$2,350 annually. However, the illustration assumes that the workers will pay their share of the premium through a "Section 125" plan, which reduces the worker's payroll and income tax liability. As a result, the net cost to the worker, after taking into account the tax subsidies, is less than the nominal payroll deduction amount. This net cost is shown by the orange bars with a diagonal pattern. As with all employer-sponsored health insurance, the tax subsidy increases as the worker's income increases (because of the "bracket" structure of the federal income tax), so the net cost to the worker decreases.

It will be useful for the SHOP Exchange to highlight the tax benefits available by using a Section 125 plan and to find ways to make establishing and operating such plans simple for SHOP-participating employers.

[23] Individuals must pay the entire difference in premium between the plan they choose to enroll in and the second-lowest-cost "silver" plan, on which the tax credit is calculated. Employers can choose which level of coverage they are willing to support, from "bronze" through "platinum," and how much they are willing to contribute toward the premium for that coverage level, so workers' net costs will vary based on both which plan they select and the amount their employer has agreed to contribute.

[24] The workers' out-of-pocket costs will of course be lower where the employer contribution is higher. If the employer pays 100% of the premium, there are no out-of-pocket worker costs for premiums. Note, however, that economists agree that, on average, workers "pay" for employer contributions through reduced wages.

[25] Issues surrounding how to structure the employer's contribution when workers can choose among several age-rated plans are discussed under the heading "Employer and Worker Contributions in a SHOP Exchange" in the main text. For simplicity, this illustration ignores those complications.

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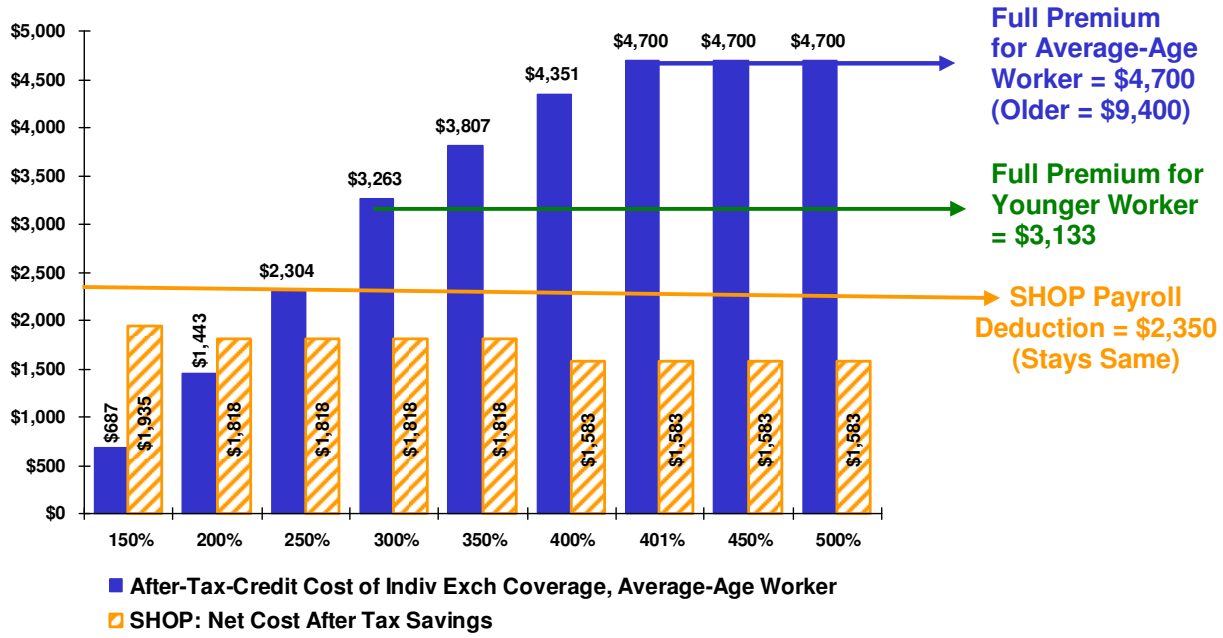
Exhibit 5: Comparing Workers' Net Cost for Single Coverage, after Individual Tax Credit or Section 125 Tax Savings (for SHOP Coverage), by Workers' Family Income, for Older and Younger Workers in an Average-Age Small Employer Group, Where Employer Contributes 50% of Premium for SHOP Coverage



Notes: The net premium cost to the worker of SHOP-Exchange coverage assumes that the small employer contributes 50% toward SHOP Exchange coverage that costs the same amount as the coverage on which the individual premium tax credit is based and that the average age of workers in the small-employer group equals the average age of tax credit recipients in the individual Exchange. (Since this chart considers only the workers' share of the premium cost, whether or not the employer qualifies for the small-business tax credit is not relevant.)

The net premium cost to the worker is calculated as the payroll deduction amount (one-half of the total premium for an average-age worker) less the income and payroll tax savings the worker would realize by paying her share through an employer-established "Section 125 plan." (Shown in orange bars with a diagonal pattern.) Because federal income tax rates increase as income increases, the worker's net after-tax-savings premium cost decreases as income increases.

Workers are assumed to purchase coverage that costs the same amount as the coverage on which the individual premium tax credit is based. This premium amount is assumed to be $4,700 for an average-age worker or group in 2014, deflated from CBO's estimate of $5,200 for 2016. The youngest workers are assumed to cost two-thirds that amount or $3,133 if they purchase through the individual Exchange, and the oldest workers cost twice that amount or $9,400. These age adjustments were made by the author based on data from the Kaiser Family Foundation's health reform subsidy calculator (http://healthreform.kff.org/subsidycalculator.aspx), adjusted so that the average for likely individual tax credit eligibles (people with incomes from 150% to 400% FPL who had neither government nor employment-based insurance in 2009, per CPS) matches the $4,700 figure.

The poverty level for a single individual in 2014 is estimated to be $11,450, deflated from CBO's estimate of $11,800 for 2016.

Source: Institute for Health Policy Solutions calculations based on PL 111-148 as amended by PL 111-152.

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Appendix B: Potential Size of a SHOP Exchange in California (among employer groups with up to 50 employees)

The Federal Small-Employer Tax Credit Is a Key Incentive for Participation

The health reform bill creates a health insurance tax credit for very small, low-wage businesses. *[IRC §45R, as added by PPACA §1421 and amended by PPACA §10105(e)]*

- Prior to 2014, the maximum credit is 35% of the amount the employer contributes toward health insurance for its workers (25% for non-profit employers).[26]
- Once SHOP Exchange coverage begins on January 1. 2014:
  - the maximum credit increases to 50% (35% for non-profit employers), ***and***
  - the credit is available ***only*** for coverage purchased ***through a SHOP Exchange*** and for a maximum of two (more) years for any one employer.
- The maximum credit is available for employers with 10 or fewer full-time-equivalent (FTE) employees[27] and average wages of $25,000 or less per year.[28]
- The credit phases down linearly and is no longer available once the number of FTEs reaches 25 or average annual wages reach $50,000.[29]

In the absence of the individual mandate (i.e., before 2014), the employer tax credit alone (at a lower 35% maximum rate) is not likely to induce many small employers that do not currently offer health coverage to begin doing so.

- Researchers at the Center for Studying Health System Change estimated that a 30 percent premium subsidy program targeted at employers with fewer than 50 workers that previously had not offered coverage would result in only about 3 percent of small-firm workers without offers of health insurance gaining coverage.[30] (The current credit targets an even smaller group of employers.) And previous state initiatives with similar uninsured-employer-only subsidies had little take-up.
- On the other hand, the individual mandate might motivate more small employers to offer coverage. RAND predicts a significant increase in small-employer offer rates for this reason

[26] The employer contribution used to calculate the credit cannot exceed what the employer would have contributed if the premium for each enrollee equaled the statewide average in the small group market. (After 2013, this limit becomes the average within the applicable rating area.)

[27] A full-time-equivalent is 2,080 work hours per year. Hours in excess of 2,080 for any one worker are not counted.

[28] An employer's average annual wages are calculated as its aggregate wages paid during a taxable year, divided by the number of FTE employees, then rounded (if necessary) to the next lowest multiple of $1,000.

[29] The phase-out applies to both factors simultaneously so that, for example, a firm with 17.5 FTEs and average annual wages of $37,500 would receive no credit, while a firm with 20 FTEs and average annual wages of $25,000 would receive 1/3 of the maximum credit.

[30] James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief No. 46, Center for Studying Health System Change, December 2001.

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(even without considering the effect of the small-business tax credit).[31] If so, some of these businesses may choose to offer coverage through the SHOP Exchange (particularly if they qualify for the small-business tax credit).

- However, given the substantial individual tax credits available to low-income workers who are ***not*** offered employer coverage, we remain skeptical that very many currently non-offering low-wage small employers will begin to offer coverage.
  - » For example, Maryland's Health Insurance Partnership provides subsidies to small, low to moderate wage firms with fewer than ten employees that have not offered health insurance to their employees in the previous 12 months. The Partnership began enrollment in October 2008 but, as of December 2010, had enrolled only 315 businesses and 1,468 covered lives (including dependents). The participation rate among eligible workers is 70 percent.[32]

But the tax credit should enable some small businesses that would otherwise drop health coverage, because of increased costs or reduced revenues, to maintain it for their workers.

Significantly, regardless of the net effect of reforms on small-employer coverage overall, the small-business credit could play an important role in attracting a critical mass of small employers sufficient to launch the State's SHOP Exchange successfully.

➤ Currently offering small employers are unlikely to switch from the regular small-group market to the Exchange unless they have a strong financial incentive to do so. The tax credit could provide such an incentive.

Estimated Small-Business Tax-Credit Recipients

We present two estimates of the number of people associated with small firms that might take advantage of the small-business tax credit.

First, the Commonwealth Fund, based on work by Jonathan Gruber of MIT, estimated that, nationally, about 3.4 million workers are in firms that will take up the tax credit between 2010 and 2013.[33] California has about 12.5% of the national total of workers at private firms with fewer than 25 workers who have coverage through their own employer.[34] So the California equivalent of Dr. Gruber's national estimate would be about 425,000 workers.

There are usually about 0.75 dependents per covered worker among private-sector firms in this size range,[35] but it can be expected that many children of low-wage workers would qualify for

[31] "How Will the Affordable Care Act Affect Employee Health Coverage at Small Businesses?" RAND Health *Fact Sheet* RB-9557-DOL (2010). <http://www.rand.org/pubs/research_briefs/2010/RAND_RB9557.pdf>.

[32] [Maryland] Health Insurance Partnership Enrollment Update, January 1, 2011. <http://mhcc.maryland.gov/legislative/hlth_ins_partnership_20110105.pdf>.

[33] Sara R. Collins, Karen Davis, Jennifer L. Nicholson, and Kristof Stremikis, Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010, The Commonwealth Fund, September 2010 (pub. 1437).

[34] Author's calculations based on data from the federal government's 2009 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), a survey of employers.

[35] Data from the Census Bureau's Current Population Survey (CPS) show that the number of Californians with any employer coverage is 1.863 times the number of Californians with coverage through their own employer, suggesting

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CHIP (Healthy Families), so the 0.75 figure is probably at the high end of the likely range. A figure of 0.5 dependents per covered worker was used to establish the low end of the likely range. Using these parameters generates the following estimate:

- Estimate 1: Between 635,000 and 745,000 total lives would be covered by small firms expected to take advantage of the small-business tax credit (prior to 2014).

Second, IHPS made its own conservative estimate using special tabulations of the MEPS-IC that provided a distribution of businesses with fewer than 10 and with 10-24 employees by 3 average-wage groupings. Using this data, IHPS estimates that, in 2009, 290,000 workers were covered through small California employers that are likely to qualify for a substantial small-business tax credit. Applying the same ratios of dependents per worker as above:

- Estimate 2: IHPS estimates that between 435,000 and 510,000 total lives are presently (2009) covered through small firms that appear to qualify for a ***substantial*** small-business tax credit.[36]
    - The same number are currently covered through small firms that would qualify for a less-than-substantial small-business tax credit.

- Note that both of these estimates are "covered lives" estimates and ***not*** "participating businesses" estimates.
- ***Note also that neither of these estimates adjusts for currently offering small firms that might decide to drop coverage when the individual tax credits become available in 2014.***

Considering these two estimates, it seems reasonable to project that small firms covering between 450,000 and 650,000 total lives seem likely to participate in the SHOP Exchange in 2014 in order to take advantage of the small-business tax credit.

For context, based on MEPS-IC data, IHPS estimates that in 2009 about 2.2 million California workers and dependents had employer coverage through a private-sector business that employed a total of fewer than 50 workers.[37] The California Health Benefits Review Program estimates that about 3.3 million lives were covered through California's small-group market in 2010.[38] (In addition to private-sector workers, this estimate apparently includes workers employed by small units of government that use private insurers rather than CalPERS.)

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a ratio of 0.863 dependents per covered worker. But data from the MEPS-IC for California show that enrolled workers in private-sector firms with fewer than 25 employees are more likely to have single coverage and less likely to have family coverage than the average across all firms. The 0.75 dependent-per-worker estimate represents the author's adjustment of the CPS figure to reflect this reality.

[36] We did not directly define "substantial." We included workers and dependents covered by currently offering firms that qualify for the maximum credit, plus half of those covered by firms that fully met one of the two criteria (number of employees and average annual wage) but were in the phase-out range on the other criteria, plus one-quarter of those covered by firms that were in the phase-out range on both criteria.

[37] Author's calculation based on data from the 2009 MEPS-IC.

[38] California Health Benefits Review Program, "Estimates of Sources of Health Insurance in California, 2010," http://www.chbrp.org/documents/insur_source_est_2010.pdf.

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- Hence, the "core" enrollment for the SHOP Exchange—people covered through businesses receiving substantial small-business health insurance tax credits—would represent at least 13% and perhaps as much as 29% of California's current small-group market.

The greatest threat to a successful launch of the SHOP Exchange would be elimination of the federal requirement that (after 2013) small employers ***must*** buy coverage through the Exchange in order to qualify for the small-business credit. Since the credit is already available for traditional coverage through 2013, there could be strong pressure to eliminate that requirement.

Big Enough to Operate Efficiently?

Based on experience with the "Health Connections" program in Connecticut, as well as with California's former HIPC/PacAdvantage program, an Exchange with 75,000 covered lives should be large enough to operate efficiently. The PacAdvantage small-employer program enrolled in excess of this figure and was able to operate efficiently—its demise resulted from adverse selection, not from high administrative costs. The smallest of our estimates above is more than six times this figure.

SHOP participation could be even higher than our estimates for several reasons:

- Currently, about one-quarter of workers who are offered coverage by a small employer decline the offer. (However, given participation-rate requirements for small-employer coverage, many of these workers have coverage from another source, e.g., through a spouse's employer). Presumably, the individual mandate will increase the take-up rate for employer coverage, which should increase the number of covered lives associated with currently offering employers. But this will likely be a smaller increase among small employers than among large employers.

- As noted earlier, the individual mandate might motivate more small employers to offer coverage.

- The worker-choice feature of the SHOP Exchange might attract some small employers that are not eligible for the small-business tax credit.

Uncertainty about the Size of the SHOP Exchange's "Core Population"

On the other hand, SHOP participation could be smaller than the above estimates if many currently offering low-wage small employers drop coverage because their low-income workers can qualify for sizeable individual tax credits (premium subsidies) through the individual Exchange.

- Both CBO and Jonathan Gruber project modest declines in total employment-based coverage. Presumably, these declines would occur primarily among small employers that are not required to pay a penalty if their workers get subsidized coverage through the individual Exchange.[39]

[39] On net, employers in Massachusetts did ***not*** drop coverage after reform was enacted there in 2006. But, under the Massachusetts reforms, only Medicaid plans, not regular commercial-market plans, were available to the subsidized population. Thus, the difference in provider networks and perceived access between Medicaid and commercial plans

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To explore this possibility further, we examine the coverage choices facing small employers once Exchanges become available in 2014.

Coverage Choices Facing Small Employers Once Exchanges Become Available

Businesses with fewer than 50 employees but more than 25 full-time-equivalent employees are not subject to any penalty if they do not offer coverage. If they offer coverage, they do not qualify for the special business tax credit. If they choose to offer coverage, they may do so through the SHOP Exchange or by purchasing coverage directly from a health insurance issuer. There seems to be no strong incentive for such employers to use the SHOP Exchange, and therefore we do not consider them part of the SHOP Exchange's "core population."

Businesses with 25 or fewer full-time-equivalent employees also are not subject to any penalty if they do not offer coverage. They may:

1. Choose not to offer coverage, thus allowing their income-eligible workers to qualify for premium tax credits and cost-sharing subsidies for purchasing individual coverage through the Exchange. Their higher-income workers could obtain coverage through the Exchange or the outside individual market with no tax benefit or from another source available to them, such as their spouse's employer.
2. Choose to offer coverage through the Exchange, pay at least half the premium and, if their average wages are under $50,000, qualify for the time-limited small-business tax credit.
3. Choose to offer coverage to their workers by purchasing a health plan directly from a health insurance issuer.

The tax credit for small employers is not limited to employers that previously did not offer coverage to their workers. Thus, during the 2010-2013 interim period, it will provide a significant savings to small, low-wage employers that already provide coverage to their workers. As already noted, however, and particularly given the current economic climate, it seems unlikely that it will encourage more than perhaps a handful of such employers to begin offering coverage if they do not already do so.

Additional Uncertainties for the SHOP Exchange

Under current law, beginning in 2014 (when the Exchanges become operational), the small-business health insurance tax credit is available for only two consecutive years for any one employer.[40] This limitation has the following consequences:

- Tax-credit-eligible employers that do not now offer coverage are not likely to begin doing so, because that would create worker expectations that the employer will continue to do so when the tax credit expires—which might not be financially feasible for the employer without the

might have influenced employers' decisions whether or not to offer coverage. Under federal reforms, the Exchanges are expected to make regular commercial coverage available to tax-credit recipients, so the network / access issue will not be a consideration.

[40] While this two-year period could be extended, such an amendment to federal law seems unlikely before the Exchanges begin operation in 2014.

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tax subsidy. (And the availability of tax credits for individual coverage through the Exchange provides a ready alternative.)

- Some currently offering employers might be unwilling to switch to the SHOP Exchange in order to continue receiving the small-business tax credit. They might be convinced that it is better to retain their current, single-carrier plan. Or, as discussed in the previous section, they might use the availability of tax credits for individual coverage as a reason to get out of the business of contributing toward health coverage for their workers entirely.

- Carriers might be more reluctant to participate in (and help assure the initial success of) the SHOP exchange if its "core" tax-credit-recipient population can be dramatically diminished after two years.[41] Failure of popular carriers to participate would, in turn, make currently offering small employers less likely to come into the SHOP Exchange when it opens.

[41] As discussed in the main text, reluctance of carriers to participate in the SHOP Exchange might be addressed by requiring carriers to do so as a condition of participating in the individual Exchange—unless the carrier does not serve the small-group market at all.

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Appendix C: Wage Levels Don't Define Family-Income-Based Subsidy Levels

The main text notes that, while employers obviously know what they pay their employees, they generally do not know their workers' family incomes. Given possible spouse's earnings and other income sources, individual wages and family income are not perfectly correlated. Further, family income associated with a given percent of poverty varies by family size.

Exhibit 6 shows the distribution by family income relative to poverty of workers (who have employer-sponsored health insurance) at different individual income levels.[42] For example, a low-wage employee could be the secondary worker in a two-earner family with much higher family income. While this is not a frequent occurrence, it is also not uncommon—1 of 6 workers earning less than $20,000 per year is in a family with income above 400% FPL.

Thus, an employer will not normally know how many of its workers would be eligible for what level of individual health insurance tax credit, which will vary by total family income and family size.

Exhibit 6: Workers Covered by Employment-Based Insurance, by Individual Annual Income (proxy for individual wage/salary earnings) and Family Income Relative to Poverty

Workers Holding EBI By Individual Annual Income		Family Income Relative to FPL			
	Total	**<200%**	**200%-299%**	**300%-399%**	**400% +**
Less than $20,000	*100.0%*	55.1%	17.6%	10.6%	16.7%
$20,000 to $29,999	*100.0%*	26.5%	37.0%	15.0%	21.5%
$30,000 to $39,999	*100.0%*	7.9%	30.3%	30.4%	31.4%
$40,000 to $49,999	*100.0%*	3.1%	14.4%	30.0%	52.5%
$50,000 or more	*100.0%*	0.2%	3.8%	8.8%	87.2%
All Workers w/ EBI in Own Name	*100.0%*	11.0%	16.1%	16.6%	56.3%

Source: Institute for Health Policy Solutions analysis of the March 2009 Current Population Survey (CPS).

[42] Due to limitations of the online tabulator used to generate this data, the individual incomes shown here represent total income received by the individuals, not just their earned income. But the data is sufficient to illustrate the point.

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