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SMALL BUSINESS MAJORITY

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SHOPping Around

Setting up State Health Care Exchanges for Small Businesses: A Roadmap

Terry Gardiner and Isabel Perera July 2011

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Introduction and summary

A significant amount of focus on the Affordable Care Act—comprehensive health care legislation that Congress passed last year—revolves around the requirement that each state establish an American Health Benefit Exchange that can help individuals who do not have access to employer-provided health insurance purchase qualified health plans.

Perhaps less attention has been paid to the provision of the Affordable Care Act that also calls for states to establish a Small Business Health Options Program, referred to as a "SHOP exchange." The fundamental mission of SHOP exchanges is to create a well-functioning health insurance marketplace providing an array of affordable, high-quality health insurance plans for small businesses and their employees.

The Affordable Care Act requires each state to create its exchange by January 1, 2014. If the state fails to set up an exchange by then, the federal government will create one for it.

States can also choose to combine the individual and small business or SHOP exchanges—an option with many proponents, because expanding the pool would create more competition among insurers, which would mean more choice and should result in better pricing for consumers.

SHOP exchanges can help the large number of small businesses and their employees who continue to struggle with escalating health costs. Health insurance premiums for these employers have grown 113 percent over the last decade. But because of their smaller scale and thinner margins, they are less able than other employers to absorb these increasing costs.

These costs lead to high uninsured rates among this population. Nearly 23 million of the 45 million Americans without health insurance in 2007 were small-business owners, employees, or their dependents, according to Employee Benefit Research Institute estimates. In other words, about 50 percent of uninsured Americans are part of the small-business community.

SHOP exchanges can help these businesses find the best care—if they're set up right. It will be up to the states to implement them, and there are many issues to consider in this process. The exchanges will be competing with insurance offered in the outside market, so they'll need to offer health plans that are high quality and cost competitive. They'll also need to be able to maximize participation from the beginning to gain scale, avoid adverse selection (the upward price spiral that occurs when one plan or market disproportionately attracts high-risk employees), and succeed.

This report provides a roadmap for states, policymakers, health reform advocates, and small-business leaders as they begin to create these exchanges. It starts with an overview of the problems small businesses face affording health care and then addresses the details of the SHOP exchange and how it will help.

The report then examines the implementation process, beginning with some basic principles policymakers will need to consider when creating an exchange. These include:

- Knowing the state's small-business market
- Shooting for maximum participation
- Paying attention to cost concerns

Next, the report focuses on five key decisions states will need to make at the outset that will determine the shape, structure, and character of the exchange. These include:

- Will the exchange be an active purchaser or a passive purchaser?
- What role will brokers play?
- Which structure should the exchange adopt to best serve individuals and employers in the state?
- Should employers or employees pick their plans?
- Should the exchange offer additional services to small employers?

The final section delves into the variety of issues states will face as they set up exchanges. These are in no particular order but are all critical issues states will need to confront:

- Designing exchanges with small employers in mind
- Maximizing small-business participation
- Deciding whether to establish separate individual and small-employer exchanges or merge them

- Determining which services the exchange will provide to attract small employers
- Deciding whether small-business employees should be able to choose their own health plan or if the employer chooses a single plan for all employees and the necessary mechanisms
- Determining the role of, compensation, and services for insurance brokers for exchange health plan marketing and sales
- Providing cost-effective coverage so small employers have high-value, low-cost choices
- Making sure the exchange will be competitive with the outside insurance market and attract enough small businesses to succeed

Throughout the paper we also include numerous examples of public and private exchanges for small employers that are already up and running. These can offer lessons for states as they begin the process.

We cannot stress enough how important it is for policymakers to think about the topics covered in this paper before they start setting up the exchanges. If they fail to take into account such issues as maximizing participation or making the exchange cost competitive, based on the history of small-employer exchanges and pools, they risk low enrollment and potential failure.

We believe the recommendations in this report will help states begin to design exchanges that suit their unique small-business populations and help provide these businesses and their employees with the high-quality, affordable care they need and deserve.

High health costs are hurting small businesses and their employees

Small businesses, which employ 42 million Americans, continue to struggle with the rapidly escalating costs of health insurance.[1] Over the past decade, small-business owners have watched their health insurance premiums rise 133 percent—the same kind of premium growth large businesses have experienced. But because of their smaller scale and thinner margins, they are less able than larger businesses to absorb these increasing costs.

Consequently, the percentage of small businesses offering coverage fell from 68 percent in 2000 to 59 percent in 2009. Fifty-four percent of businesses with three to nine employees offered coverage in 2000 and only 46 percent offered coverage in 2009. Many employees at these businesses do not take the benefits offered, as only 63 percent of employees at small firms are covered by their employer.[2]

Other factors make it more difficult for small businesses to offer coverage than large businesses. For instance, on average, small businesses pay 18 percent more than big businesses for the same coverage—often due to high broker fees, fixed administrative costs, and adverse selection, which is the upward price spiral that occurs when one plan or market disproportionately attracts high-risk employees.[3]

These dynamics have a profound impact on small-business owners and their workforce. Nearly 23 million of the 45 million Americans without health insurance in 2007 were small-business owners, employees, or their dependents, according to Employee Benefit Research Institute estimates.[4] Put another way, about 50 percent of uninsured Americans are part of the small-business community. Similarly, 28 percent of the nation's 22 million self-employed entrepreneurs are uninsured. As a result, many of the employed are also uninsured.

Small Business Majority released an analysis in June 2009 of the costs facing American small businesses under the status quo. For this work, MIT economist Jonathan Gruber estimated that:

- Small businesses (with fewer than 100 employees) would pay nearly $2.4 trillion over the next 10 years in health care costs for their workers.

- Health care costs would lead to a loss of 178,000 small-business jobs, $834 billion in small-business wages, and $52.1 billion in profits.

- Nearly 1.6 million small-business workers would continue to suffer from "job lock," where they are locked in their jobs because they can't find a job with comparable benefits. This represents nearly 1 in 16 people currently insured by their employers.[5]

It should come as no surprise, then, that small businesses were of utmost concern to policymakers as Congress considered and ultimately passed comprehensive health care reform legislation in 2010. The president signed this legislation, known as the Affordable Care Act, into law on March 23, 2010.

The Affordable Care Act and the SHOP Exchange

The Affordable Care Act requires each state to establish an American Health Benefit Exchange that can facilitate the purchase of qualified health plans for individuals who do not have access to employer-provided health insurance.

The Affordable Care Act also requires states to establish a Small Business Health Options Program, referred to as a "SHOP exchange." The law requires each state to create its exchange by January 1, 2014. If the state fails to set up an exchange by then, the federal government will create one for it.

The fundamental mission of SHOP exchanges is to create a well-functioning health insurance marketplace that provides an array of affordable, high-quality health insurance plans for small businesses and their employees. A well-designed SHOP exchange can:

- Reduce the extra premium paid by small businesses and reduce the volatility (year-to-year changes) in health premiums by pooling small-business buying power and gaining economies of scale
- Offer employers and employees choices of multiple insurers, providers, and delivery systems, and—by allowing portability of health coverage—reduce employee recruitment barriers
- Help small employers and consumers shop for insurance and make it easy for them to compare options by providing clear and comparable information regarding insurers, provider networks, and benefit plan options available to them
- Greatly reduce the burden on small-business owners of administering health benefits
- Drive innovation and improvements in affordability, quality, and customer service resulting from healthy competition among both insurers and providers

The SHOP exchanges can initially serve firms with up to 100 employees. But if a state chooses, it may restrict SHOP exchange eligibility to employers with 50 or fewer employees through 2016.

States may allow employers with more than 100 employees to purchase health plans through the exchange beginning in 2017, and they may choose to establish a single exchange that serves both individuals and small employers or to operate separate exchanges to serve these markets.

SHOP exchanges must abide by the Affordable Care Act's requirements for American Health Benefit Exchanges. Both types of exchanges, for example, must:

- Implement procedures for certifying, recertifying, and decertifying qualified plans
- Provide standardized comparative information on participating plans
- Offer assistance via a toll-free telephone hotline
- Manage enrollment periods in compliance with requirements established by the Department of Health and Human Services

Beyond these requirements the new law gives states significant flexibility to design and implement a SHOP exchange. This flexibility enables states to determine how they would organize and operate a SHOP exchange and choose which types of products and services it might offer.

What is a health insurance exchange?

A health insurance exchange is an independent entity that creates a more organized and competitive market for health insurance. An exchange creates a competitive marketplace for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help small-business owners and consumers better understand the options available to them.

The Henry J. Kaiser Family Foundation also has an explanation and FAQ on health insurance exchanges available at http://healthreform.kff.org/faq/what-is-a-health-insurance-exchange.aspx.

SHOP exchanges can increase health coverage among small businesses

Two separate studies confirm that the market reforms and new, competitive marketplaces included in the Affordable Care Act will give small businesses better access to good coverage. Together, these analyses—one by RAND Corporation and the other by The Urban Institute—suggest that the new health care law will reduce small employers' premium contributions and increase insurance-offer rates among small firms.[6]

The Urban Institute researchers estimated that small employers' premium contributions would fall 8.2 percent following implementation of the new law—a decline that is largely attributable to the introduction of the SHOP exchange. The RAND researchers estimate that insurance-offer rates among small businesses will rise significantly. Between 2010 and 2016, offer rates among businesses with 10 or fewer employees will rise from 53 percent to 77 percent. For businesses with 11 to 25 employees, offer rates will rise from 71 percent to 90 percent. Finally, offer rates among businesses with 26 to 100 employees will rise from 90 percent to nearly 100 percent.

A recent national survey of small-business owners by Small Business Majority also found support for the new insurance market promised by the SHOP exchange.[7] One-third (33 percent) of respondents who currently do not offer insurance said the exchange would make them more likely to do so, and 31 percent of small-business owners who already offer coverage said the presence of the exchange would make them more likely to continue offering health benefits.

Small-business owners were devastated by the Great Recession and hammered by double-digit health care premium increases. They were likely encouraged to learn about the SHOP exchanges and how they can work for small businesses.

Small-business owners and their employees can benefit from the new opportunity to obtain high-quality, low-cost health insurance if state officials properly implement the provisions of the Affordable Care Act. States, therefore, are responsible for creating a well-conceived SHOP exchange that competes with the outside market to provide these opportunities.

The rest of this report offers a roadmap to help states effectively set up the exchanges to meet the needs of their small-business communities. We'll start with some basic design principles.

SHOP exchange design principles

Small-business exchanges can provide high-value, low-cost opportunities for small employers to purchase health insurance. But these exchanges will likely compete with small employers' other health insurance purchasing options. For instance, small-business owners could purchase coverage inside the exchange or maintain their grandfathered health plans outside of it. In fact, small-business health insurance pools and exchanges have historically struggled to grow and compete with other health insurance options for this market.[8]

In other words, "build it and they will come" isn't good enough. It needs to be built right.

To succeed, SHOP exchanges must provide high-quality, low-cost health insurance that compares favorably to insurance offered in the outside market. Exchanges can also improve their market position by offering a robust range of products and services, and by providing comparison tools that facilitate employer and employee choice across available health plans.

States can use the following three principles to decide whether to design a SHOP exchange or to build a strong foundation if they choose to create their own:

- Know your small business market.
- Shoot for maximum participation.
- Put cost first.

These principles are drawn from the authors' extensive research into this area, which includes case studies, critical literature, and expert input.

Know your small-business market

Understanding small businesses is fundamental to gaining trust and building market share. Small groups have distinct health insurance needs. They are particularly sensitive to cost, have limited administrative capacity, and often need in-depth education about

their health insurance options. To successfully meet these needs, states will want to develop mechanisms for receiving input and feedback from small businesses.

Further, exchanges must consider small businesses' existing pathways for purchasing coverage. Small businesses often rely on intermediaries, particularly brokers, to help them sort through their health insurance options. Competitive exchanges should therefore carefully consider how to incorporate these intermediaries and how to use these resources for both outreach and feedback.

Shoot for maximum participation

The exchanges' success hinges on maximizing participation. Without sufficient enrollment, exchanges will not be able to compete with the outside market, adequately spread risk, and obtain favorable premiums. SHOP exchanges must therefore fully support small-business participation.

The key is aggressive outreach from the beginning: It will promote a successful launch and drive early small-business participation in the exchange.

Typically, the most competitive exchanges start strong. The initial launch is an important indicator of the exchange's long-term success. If exchanges begin by reaching out to small employers, brokers, and other intermediaries, they are more likely to achieve maximum participation. On the other hand, if small employers are not aware of the exchange or do not understand how it operates, they may default to their existing insurance arrangements.

Put cost first

Small employers list cost as the number one barrier to buying health insurance, according to opinion polling conducted by Small Business Majority.[9] Exchanges should therefore be particularly sensitive to cost concerns. Here's how.

First, plans must be cost effective, and they must meet the needs of employers and employees. Exchanges should incentivize participants to choose lower-cost plans.

Second, administrative cost should not excessively burden the price of premiums. Exchanges should develop pricing incentives that drive competition among plans.

These incentives can range from competitive broker commissions to benchmarks for administrative expenses.

Competitive commissions make the exchange a viable alternative for the value-conscious broker and employer. Lower administrative expenses reduce the overall cost of sustaining and financing the exchanges, so ultimately these expenses are also reflected by the cost of employer premiums.[10]

Lastly, exchanges can promote the small-employer tax credit—which is only available for coverage purchased within the exchange after 2014—as a tool for reducing employer costs. For in-depth information about the tax credit, visit Small Business Majority's page at http://www.smallbusinessmajority.org/hc-reform-faq/index.php#1a.[11]

These cost considerations, when effectively implemented, work cyclically. They attract small businesses, build size, and achieve economies of scale.

The next section will focus on specific decisions states will need to make when implementing the exchanges.

Key decisions

Five key decisions made at the outset—choices that may differ depending on a state's insurance market and other variables—will largely determine whether an exchange succeeds:

- Will the exchange be an active or passive purchaser?
- What role will brokers play?
- Which structure should the exchange adopt to best serve individuals and employers in the state?
- Should employers or employees pick their plans?
- Should the exchange offer additional services to small employers?

Let's review each of these decisions in turn.

Will the exchange be an active purchaser or a passive purchaser?

Policymakers must determine how the exchange selects participating health plans. Exchanges that follow the active purchasing model choose high-value plans to meet the specific needs of small employers and their employees. Exchanges that are passive purchasers try to maximize plan options—and therefore employer and employee choice—by allowing any qualified carrier to participate in the exchange.

Experts believe that active purchaser exchanges—such as CBIA Health Connections in Connecticut, HealthPass in New York, and the FEHBP program for federal employees—provide better value and choices of health plans for employers and consumers.[12] Consumers know they are making an informed decision when choosing their health plan. Based on our research, many experts believe this focus on value is the first step toward long-term cost containment.

Passive purchasers, on the other hand, are similar to national companies such as eHealth Insurance or HealthPlanOne that try to attract a maximum number of

insurers to uncompetitive markets. An exchange might passively purchase insurance when it serves a market dominated by only a few carriers. This strategy may attract new insurers to this market, thus enabling the exchange to provide small employers with new choices.

Policymakers should also consider the preferences of small employers when deciding which approach to take. Small employers and their employees generally value administrative simplicity.[13] They prefer comparable, consumer-centered plan options. And they cannot make meaningful choices without a comparison tool.

What role will brokers play?

Brokers help their clients obtain and manage health products. The vast majority of small businesses purchase their health insurance through a broker. Brokers vary in size from individual brokers to larger brokerage firms. They also widely vary in terms of the products they offer. Some specialize in health insurance while others offer the full spectrum of insurance products an employer may need.

Brokers can and should continue helping their clients through health reform implementation.[14] State law, however, will clarify the brokers' specific role in the exchanges. Policymakers must consider several important dynamics regarding brokers.

The first is that brokers are likely to be needed more in the small group exchange than the individual exchange. Some have argued that individuals will have less need for a broker because they can fulfill their needs simply through the website and a help call line. Even today the role of the broker is less with individuals than employers (part of this may be that brokers can earn more from employers).

The needs of small employers are also greater than individuals. First, the employer of a small firm is very busy and not an expert on insurance. The employer is also making a decision for a wide range of employees. He or she needs advice, analysis, and someone to answer his questions. It is a very complex decision of costs, benefits, trade off, and alternatives.

Second, employers are used to having a broker.

Third, brokers help the employer with the employee issues once the employer has chosen a plan. Small employers are usually just that, small, and they do not have a human resources department to do this.

And finally, the brokers will fight tooth and nail if there is an attempt to cut them out since they have relationships with employers. This has happened before, and new exchanges typically run into problems when they try to push brokers out.

The second dynamic is that brokers influence their clients' insurance choices, and they can use this influence to steer small businesses to purchase coverage inside or outside the exchange. Brokers may steer clients toward other coverage options if they cannot obtain a commission on coverage purchased inside the exchange. Alternatively, they may influence whether small firms that are good insurance risks choose to purchase exchange coverage or look for coverage outside the exchange.

Collaborating with brokers

Tips from Washington state

In Washington state, the Health Insurance Partnership, or HIP, was a small-employer health insurance exchange that offered a lower employer contribution rate and subsidies for eligible employees. It closed enrollment in June, and will officially shut down on August 31, 2011.

The Washington State Legislature established HIP in 2007. With the help of a federal grant, HIP was fully implemented in 2010 and coverage began in 2011.

Administrators noted that, "The HIP partnership with brokers is critical because brokers are often the main source of information about health insurance for small employers."[15] To collaborate with brokers, HIP developed a training program that included:

- Information about the benefits of HIP
- Training on the enrollment process
- Program updates
- Notices of upcoming events and important dates

Once brokers completed the training program, their contact information was placed on the HIP website. This way, employers could determine which brokers were HIP preferred. All HIP-preferred brokers were licensed through the Washington State Office of the Insurance Commissioner.

Carriers paid commissions directly to the brokers at the same rate as the commercial market. Recently, HIP carriers cut commissions for the smallest employers to control overhead costs, an action that affected brokers enrolling employers in HIP. Brokers were less willing to provide typical broker assistance without proper compensation. Some employers then lost the opportunity to receive typical assistance. In response, HIP connected the employer with a broker that supported his or her needs.

These steps helped HIP build a strong relationship with brokers, and administrators emphasized that partnerships were the key to successful outreach. Partnerships with carriers, small-business organizations, and state agencies supported HIP's comprehensive goals and promoted its sustainability. For instance, the largest small-employer group insurance companies participated in HIP. Also, state agencies agreed to share data with HIP, which helped target potential enrollees. Together, these tools promoted HIP and support enrollees' needs.

Brokers can therefore influence whether an exchange experiences adverse risk selection—which will occur if people with higher medical costs enroll in the exchange while lower-risk individuals get coverage through plans outside the exchange that offer cheaper rates, thus creating significantly higher rates for all those buying insurance inside the exchange. This means the brokers can also influence the premiums for exchange coverage.

The third dynamic is that brokers are critical to building scale during the exchange's launch. The exchange will face greater challenges reaching a viable scale if brokers shun exchange coverage and take their clients elsewhere.

Lastly, brokers' compensation must be carefully negotiated. If the exchange lowers brokers' compensation rates, it will lower overall costs for participating employers and employees. The brokerage costs are paid by the employer, not the insurance company. They are added to the premium costs employers pay in the exchange. So if you lower brokerage fees, employers and employees ultimately get lower-cost insurance. But brokers may not bring their clients to the exchange if the exchange does not offer competitive compensation, which would threaten the exchange's ultimate viability.

In sum, brokers serve as small-business insurance navigators. Policymakers must consider the market role of brokers and include them in the exchange's outreach and educational efforts.

Which structure should the exchange adopt to best serve individuals and employers in the state?

The Affordable Care Act allows states considerable flexibility on how to structure exchanges to serve individuals and employers, both small and self-employed. Traditionally, an exchange normalizes premiums to the pool's overall risk. That is, participants will pay rates that are largely determined by who's in the exchange. Premiums will rise if the exchange comprises mostly high-risk (ill) participants. Premiums will fall if the exchange comprises mostly low-risk (healthy) participants. A robust pool of high- and low-risk participants will help spread the risk across a population and make premiums more affordable.

Exchange design determines how risk spreads. States can merge the individual and small-group pools and form one exchange, separate the two pools and form two exchanges, or separate the two pools and administer them under one exchange.

Exchange administrators should commission actuarial analyses and projections to determine which design option is best suited to the state market. The projections should consider the following variables and outcomes, taking into account the many changes that will occur as the Affordable Care Act is implemented:

- State demographics
- Projected pool sizes
- The spread of risk
- Administrative expenses
- Premium rate impact in all markets

Administrators should consider the totality of these effects on the exchange to decide if merging the markets is appropriate.

Should employers or employees pick their plans?

Small employers who offer health coverage typically select their employees' plan. Only larger employers are able to offer multiple insurance plans to their employees. In the individual exchange—much like the individual market today—enrollees will be able to choose among multiple health plans. Small-group exchanges, on the other hand, may turn this choice over to either the employer or the employee.

Under one scenario, the employer picks a single plan for their employees, who must enroll in this plan to obtain coverage. The employee-choice model, however, provides a new opportunity for many small businesses. This model has been successful in New York, Connecticut, and Massachusetts.

Since several existing exchanges test these models, policymakers may design new exchanges with the help of real-world experiences. (See table on page 17 for a comparison of how these exchanges deal with employee choice and other issues.)

Should the exchange offer additional services for small employers?

Successful exchanges and small-business health insurance programs that have been in operation for many years have all responded to the needs of small employers by providing additional services and programs to meet their customers' needs.

New York: HealthPass

HealthPass was born out of a public-private partnership. It is now a self-sustaining, private entity. This snapshot highlights the role of administrative services in user-friendly exchanges.

Implementation date: December 1999

Status: Open

Lives covered: 32,000

Plans offered: 25+

Participating small businesses: 4,000

Total number of small businesses in New York City metro area (<100 employees): 236,812

See full details of the exchange on page 46

Breakdown of small-business exchanges

Type of purchaser, role of brokers, structure, choice type, and additional services

	HealthPass	CBIA Health Connections	Commonwealth Choice	Utah Health Exchange	PacAdvantage (formerly, HPIC)
Type of purchaser	Active	Active	Active	Passive	Active
Role of brokers	Very involved	Very involved	Becoming more involved	Very involved	Inititally, not involved (later re-engaged by PacAdvantage)
Structure	Small-group market only	Small-group market only	Merged individual and small-group market	Small-group market only	Small-group market only
Choice type	Employee choice	Employee choice (within the employer's selected "suite")	Business express: employer choice; voluntary plan: employee choice; contibutory plan: employee choice (within the employer's selected "benefit tier")	Employee choice	Employee choice
Additional services	Single-page enrollment, consumer hotline, HR services	HR services (includes a wellness program, COBRA administration, Section 125 service, and HRA administration)	Call center, transparent online shopping experience, HR services	In developmental stages	HR services

For instance, most small employers—particularly those with fewer than 10 employees, which comprise 80 percent of American small businesses[16]—have no human resources department. Exchanges may provide a variety of administrative services that can help small businesses cope with the administrative work of providing health benefits and address their other human resources needs. Simple payment arrangements, call centers, and other supports that reduce the employer's administrative burden can also help.

Exchanges should be empowered to meet the needs of small employers, seek the input of their customers, and adapt services as needed.

Selected issues for states in setting up SHOP exchanges

This section outlines the many different issues likely to arise as states begin building their exchanges. The list is not exhaustive but it covers the key questions, design concerns, and hurdles states will face based on our research. Several of these items flesh out previous sections of the paper:

- Designing exchanges with small employers in mind
- Maximizing small-business participation
- Deciding whether to establish separate individual and small-employer exchanges or merge them
- Determining which services the exchange will provide to small employers
- Deciding whether small-business employees should be able to choose their own health plan or whether the small business chooses a single plan for all employees
- Determining the role of insurance brokers for exchange health plan marketing and sales
- Providing cost-effective coverage so small employers have high-value, low-cost choices
- Making sure the exchange will be competitive with the outside insurance market and attract enough small businesses to succeed

Designing exchanges with small employers in mind

How will states receive input from small businesses as they design exchanges?

Advisory boards. Small businesses and consumers should have significant input into exchange design and ongoing operations. Policymakers and exchange administrators should routinely solicit this input, and they can set up a regular mechanism for stakeholder feedback by creating one or more advisory boards for consumers, businesses, insurers, brokers, and medical providers.

Market research. Successful exchanges have also used focus groups and surveys of small employers during the design stage to ensure small-employer exchanges, plan offerings, and services meet the needs of small employers.

Brokers. Brokers often have strong, longstanding relationships with small employers as well as a background in insurance. Their strong relationship with small businesses enables them to understand the issues, concerns, and needs of small employers. They also can be a good source of information and feedback.

Website. The exchange website should be designed to elicit feedback from small employers and their employees on a continuous basis.

How will employers cover employees in other states?

Many of our largest urban areas span two or more states, and as a result small employers frequently have employees in multiple states. Small employers understandably do not want to deal with the complexity of needing to purchase health coverage for their employees from multiple state exchanges.

Exchanges such as CBIA Health Connections in Connecticut and New York HealthPass have established health plans that provide coverage for out-of-state employees. HealthPass reports that their employers draw workers from four different states. Their health plans include networks that cover multiple states, but premiums are based on the home state for all employees—New York in this case.

To increase the availability of more health plan choices, the health reform law requires the Office of Personnel Management—which manages federal employees' health benefits—to offer two multistate health plans in each state health insurance exchange. These health plans will provide coverage beyond the borders of a single state.

The reason OPM is instructed to do this is because they have the market clout and historical relationships to accomplish this goal. The state insurance regulators and new exchanges will not have this ability. OPM has been operating for 40 years, negotiates with insurers annually for 8 million covered lives, and does it in all 50 states and territories. They have experts, knowledge, and experience. They are in position to go to the existing insurers they deal with and offer them a plan through the new exchange. That insurer will feel compelled to comply.

It is not possible to prescribe one method that will work for all state exchanges due to varying state insurance regulations. Each state exchange will need to review the health insurance regulations of their home state and adjoining states and discuss with insurers how to meet the need for multistate insurance plans.

Connecticut: CBIA Health Connections

A business and industry association has operated CBIA Health Connections for over 15 years. This snapshot considers how tightly focused exchanges remain competitive over time.

Implementation date: Jan. 1995

Status: Open

Lives covered: 88,000

Plans offered: 4

Participating small businesses: 6,000

Total number of small businesses in the state (<100 employees): 71,805

See full details of the exchange on page 39

Will self-employed individuals access health plans and individual tax credits through the individual exchange, small-employer exchange, or have the option of either?

States have the option to direct self-employed individuals to the individual or SHOP exchange, or allow them both options. Some policymakers are concerned about the scale of the SHOP exchange and they have proposed that states allow the self-employed to enroll. Their enrollment could lead to a broader risk pool and therefore lower costs.

Currently, 12 states allow self-employed individuals to purchase insurance in the small-group market as a "group of one." COSE in Ohio, which has offered health plans to its 15,000 members for decades, successfully allows self-employed individuals in their small-business health insurance program.[17]

Twenty-eight percent of the 22 million self-employed individuals in this country are uninsured. Demand for coverage among this group will increase as the requirement for all individuals to have health insurance—as well as individual tax credits and insurance reforms—is implemented in 2014.

State policymakers need to consider that self-employed individuals, like other individuals, will be eligible for premium tax credits and cost-sharing subsidies, depending on income. The individual exchange will offer policies that qualify for individual premium tax credits and cost-sharing assistance.

In contrast, self-employed individuals will not be eligible for the small-employer tax credits that can be used to purchase policies in the SHOP exchange. If a self-employed person is not eligible for individual tax credits or cost sharing, they would benefit from setting up a section 125 plan to allow payment of health costs with pretax dollars that are deducted and set aside.

One option is to allow self-employed individuals the option of accessing either the individual or SHOP exchange. It is possible that rates and plans will be different in the two exchanges. A web-based calculator or decision matrix designed especially for self-employed individuals could be very beneficial for them in deciding.

How will the exchange website be built to meet the needs of individuals, the self-employed, small employers, and brokers?

The administrators of existing exchanges universally emphasize the importance of website design. The exchange's website is its online storefront. But it is also a mechanism to ensure effective outreach and feedback. A user-friendly design is fundamental.

Some exchanges allow for anonymous browsing, but small employers, employees, and brokers generally identify themselves. They next proceed through the shopping experience, which is tailored to their needs. Shopping for health insurance is a similar experience to shopping on airline or hotel price comparison websites. But some employers and consumers may not be familiar with the health insurance purchasing process.

The following information therefore must be available on the website:

- **Cost and value of plans.** Employers will be able to maintain a grandfathered plan and buy in the outside market. They will need to objectively understand and weigh these choices before they choose to access the exchange for their company and employees.
- **A comparison tool.** This should offer reliable and objective ratings of the quality and efficiency of available plans on the exchange's website.
- **Federal and state employer tax credits.** As of 2014, the small-employer tax credit will only be available through the exchange. The website should estimate the credit, as well as link to qualified sources such as the IRS.
- **Information on the full array of services that the exchange offers.**
- **Direct contact information for exchange personnel and support staff.**
- **Secure browsing with a notification, which builds trust with consumers.**

Some additional information should be made available on SHOP exchange websites that offer employees a choice of plans:

- **Additional costs incurred by the employees based on their choice of plan.** Employees covered by employer plans will not be eligible for individual tax credits and premium sharing.
- **Information regarding other coverage options.** Sites should also refer participants to relevant programs.

The exchange can customize navigation by recognizing the distinct needs of each group. These efforts help make the purchasing process straightforward, which all groups expect.

Maximizing small-business participation

An exchange's launch is fundamental to its long-term success. But reaching 22 million self-employed individuals and 6 million small employers can be challenging. Which outreach and educational tools strengthen the launching phase?

Small employers need to know about exchanges and how they will work. A national study by Small Business Majority in November 2010 found that only 43 percent of small employers were aware of the Affordable Care Act tax credits. Of that group, only a third were aware of exchanges.[18] A California-based study in February 2011 found that even though small employers are unaware of the law and their rights within it, many of them strongly support a state health exchange.[19] Taken together, these findings reveal the scope of misinformation that pervades American small businesses.

Exchanges must establish tools for communication, such as a customer support desk and a system of navigators, that effectively reach the small-business community. These tools are especially important during the first phase of implementation because the launch phase will need to attract a significant number of employers and increase the scale of its pool. These outreach and educational mediums are a two-way street, as well. They attract employers to the exchange but they also serve as vehicles for feedback.

States should communicate with the following key groups during the design phase to help draw in small employers:

Navigators. The Affordable Care Act requires navigators, which are essential to promoting the exchanges before they go live in 2014. Before the launch, navigators will share information to eligible consumers and small employers regarding the choices and benefits that are available within the exchange. These groups and individuals must be knowledgeable, trustworthy, and timely, and they must be well informed about the needs of small businesses across the spectrum (self-employed, micro-businesses with fewer than 10 employees, and larger small businesses with between 10 to 100 employees).

Community navigators

The experience of the fishing partnership health plan

Massachusetts fishermen looked for an opportunity to pool risk and obtain affordable health coverage in the 1990s. Forty-three percent of fishermen were uninsured at the time. They developed the Fishing Partnership Health Plan, or FPHP, along with the Massachusetts Fishermen's Partnership, or MFP.

The health plan launched a demonstration in 1997 that the Massachusetts health reforms later used as a template. The plan grouped fishermen together and provided subsidized coverage on a sliding scale. After the demonstration was implemented, the rate of uninsurance among fishermen dropped to 13 percent from 43 percent.

Organizing a highly competitive industry proved to be difficult, particularly because of the fishing industry's characteristically inaccessible fishermen. Literally at sea during their workday, this group also lacks traditional human resources capability. Many of the fishermen are self-employed, older, and speak a foreign language. They work in one of the country's deadliest industries, and they have trouble finding good, if any, health insurance.

In response to these limitations, the FPHP organized MFP members into a single risk pool. It also contracted with MFP "navigators" to reach out and promote the health plan. Fishermen are among the most difficult-to-reach self-employed individuals. The navigators needed to understand the nuances of the fishing industry. Consequently, fishermen's wives and daughters proved to be the most successful navigators.

Familial links proved apt. The navigators placed signs in the most social bait houses. They organized events at optimal hours and on bad weather days when fishermen were home. They communicated with the workers in their own language.

By the end of the plan's launch, the fishing community navigators had conducted nearly all of FPHP's outreach efforts. Approximately 2,000 fishermen enrolled. FPHP did not pursue traditional marketing methods, yet polls indicate that 90 percent of the Massachusetts fishing community knows FPHP.

Today, the community navigators are the program's centerpiece. Each navigator manages a caseload of 70 to 100 fishermen. Following the 2006 Massachusetts health reforms, FPHP has begun to incorporate their group into the Massachusetts Health Connector, the state exchange that provides health coverage options to small employers and individuals. To do so, the plan has doubled its team of community navigators.

FPHP will develop intermediary services, such as personalized advice on health coverage options, as the plan transitions its enrollees into the Connector. These services will cater to fishermen's health needs. Again, navigators are the centerpiece of this effort. Some of their responsibilities include:

- Tracking all calls with participants in a database
- Expanding their knowledge of supplemental health care resources, such as charitable foundations
- Providing shoreside support to fishermen
- Developing a navigator training program that is specific to the fishing industry
- Advising FPHP's burgeoning initiatives, which include a research agenda and a wellness program

The president of the Fishing Partnership Health Plan, JJ Bartlett, notes that "Navigation is the first step towards wellness." Fishermen, and other individual contractors such as farmers and forestry workers, often fall through the cracks of the health system.

Community navigators effectively liaise between the health plan and the fishermen, and they are consequently invaluable to consumers. Bartlett asserts that the navigators, FPHP's signature effort, are invariably thanked after each call.[20]

Brokers. Many small employers have existing relationships with brokers, who help them find and choose appropriate health plans and other products. In particular, brokers are a key source of information for micro-employers (those with 10 employees or less), half of whom do not currently provide coverage.[21] Consequently, the launching phase will need to incorporate brokers. Existing exchanges have reached out to brokers by coordinating trainings and info sessions. These meetings link the exchange, brokers, and small employers, and therefore build avenues for communication between the three entities.

Business groups. Exchanges can also use business groups to educate small businesses about the exchange. But 50 percent of small employers do not belong to any business group. Also, no single business group can be relied on to provide information or speak for all small employers. A national study by Small Business Majority found that trade and industry groups are the most frequent membership of small employers (34 percent), followed by the local chamber of commerce (28 percent).[22]

So exchanges should use business groups for outreach, but they should be aware that these groups will not reach all businesses and additional outreach methods will need to be used. An exchange could use a government business license list, for example. All businesses have licenses even if they don't belong to a business group.

Deciding whether to establish separate individual and small-employer exchanges or merge them

The law enables states to create separate individual and small-employer exchanges or to combine the two into a single exchange. States have additional flexibility to combine individual and small-employer risk pools.

Merging the individual and small-employer exchanges or risk pools may be an especially attractive option for small states. Merging could have the potential benefits of creating a larger market and thereby attracting more insurers, reducing administrative costs and increasing the competitiveness of the exchange, and reducing volatility by spreading risk among a larger group.

Policymakers must thoroughly study the existing state insurance market before deciding on merging given the wide variation in market structures, rates, and coverage. During the Massachusetts health reforms in 2006, for example, actuaries projected that a merged market would lower premiums by 15 percent for individ-

Massachusetts: Commonwealth Choice

Operated by a state agency, Commonwealth Choice is a product of the 2006 Massachusetts health reforms. This snapshot unpacks the implementation process of multilateral exchanges in the context of comprehensive reform.

Implementation date: July 2007

Status: Open

Lives covered (includes non-group and small group): 43,731

Plans offered: 73

Carriers: 7

Participating small businesses: 2,318

Total number of small businesses in the state (<100 employees): 135,284

See full details of the exchange on page 41

uals and increase premiums by 1 percent to 1.5 percent for small groups, such as businesses.[23] At the time, the individual market covered 66,000 lives (9 percent of the combined market). The small-group market covered 700,000 lives (91 percent of the combined market).

Actuaries in Maine perceived another scenario, however. The state's small-group market was three times the size of its individual market in 2007. Additionally, small-group plans were comparatively more generous (up to 50 percent richer) than individual plans. The study projected group rates would increase by an average of 3 percent and individual rates would decrease by 8 percent.[24]

The incongruities of state markets call policymakers to consider the following issues:

- Would creating a single exchange or risk pool prompt a sudden jump in premiums for some currently insured individuals or employers?
- Would merging the exchanges or risk pools substantially increase potential enrollment and make it more likely (but not guarantee) that the exchange would have a well-balanced risk pool?
- Would merging exchanges or risk pools several years after the 2014 implementation of the new law's major market reforms—particularly those related to premium rating rules—limit the premium rate disruption that might occur when the markets are combined?
- Do particular features of the state insurance market—such as whether self-employed "groups of one" can purchase plans in the small-group market—drive the state toward one approach or the other?

Determining which services the exchange will provide to attract small employers

Health insurance exchanges may offer services beyond the provision of and enrollment in health insurance plans. Eighty percent of small employers have fewer than 10 employees and most do not have human resources staff.[25] Successful small-employer exchanges and pools have therefore evolved to provide a wide range of services for small employers.

New York's HealthPass; Connecticut's CBIA–Health Connection; the Ohio Council of Smaller Enterprises, or COSE; the Small Business Association of Michigan; and SMC Business Councils of Pennsylvania provide health plans to thousands of small businesses and also provide a wide array of additional services to their members. State health insurance exchanges may wish to follow these examples.

Successful exchanges provide essential administrative services. These exchanges, such as HealthPass and COSE, have established themselves as a single point of entry for small employers and provide:

- Comparative plan information to help employers and employees make informed decisions on coverage.
- A single application for all plans/policies offered within the exchange.
- A single premium payment "aggregation" for each employer, with the exchange allocating premium amounts to insurers based on employees' plan choices. Ideally, this aggregation would take the form of a website, including a mechanism for incorporating subsidies. The employer registers the employees that qualify and determines the share of premium paid by the employer and employee. Essentially, the employer has a password-protected account like online banking, an online investment account, or a payroll service like ADP. Each month the funds flow from the employer (employer and employee share) to the exchange and then out to the multiple insurers. The employer writes one check and gets one billing showing all the details. But the exchange makes it happen.
- A detailed accounting to the employer of each employee's individual ratings, plan choices, family tier, and coverage additions for withholding purposes to help employers establish their employees' contribution.
- One point of contact in the exchange for enrollment changes.
- Guidance to employers about qualification and estimated calculation of the small-business tax credit.
- Facilitation of coverage for out-of-state employees for small employers including working with other state exchanges.
- Coordination of coverage of Medicare-eligible employees, dependents, and retirees.
- A clear method for communication, such as a call center, for obtaining additional information from the exchange.
- A software tool that allows the employer the option to "consolidate" the premiums for employees or to individually charge employees based on their individual ratings (age, tobacco use, geography, etc.).

State exchanges may also consider providing additional HR services to small businesses, as some successful exchanges have done, in order to compete with grandfathered plans and the outside exchange market. Such services include:

- COBRA administration
- Section 125
- Flexible spending accounts
- Wellness programs

This last service departs slightly from its category and therefore merits further discussion. Wellness programs are in high demand with small employers. In response, several successful small-employer health insurance programs and exchanges have developed robust wellness programs for their small employers and their employees.

Examples include:

- CBIA provides a wellness program with confidential employee health assessments, individual tools, educational materials, and incentives.

- COSE provides custom-designed wellness programs to help small businesses control health care costs by better managing chronic diseases, encouraging healthier lifestyles, and reducing unnecessary health care utilization.

- Commonwealth Choice plans in Massachusetts provide subsidies to small employers who participate in their wellness programs. Administrators hope this additional service will also bring more businesses to the exchange and spread risk within the pool.

Deciding whether small-business employees should be able to choose their own health plan or the small business chooses a single plan for all employees and the necessary mechanisms

Depending on administrative arrangements, exchanges can enable small-business employees, like individuals, to choose their own health plan (employee choice) or rely on small businesses to choose a single plan for all employees. Employee choice has proven to be an attractive feature in existing small-employer exchanges, such as HealthPass in New York, while other exchanges have chosen to forgo the additional complication of directing premium payments to appropriate plans.

HealthPass reports that employee choice has been a key factor in their success. The exchange cites several items such as self-sustainment—meaning they are not subsidized—and a "voluntary and very flexible" employer premium contribution system as the structural facilitators of this success.[26]

The larger implications of the employee choice design include:

Pros:

- Employers who are introducing health care coverage for the first time prefer to offer their employees a choice of plan.
- Employers won't need to assume responsibility for choosing specific coverage that may or may not meet the health and budget needs of all employees.
- Individual choice enhances satisfaction among employers and employees.
- Employees experience less year-to-year disruption and confusion associated with changing health insurance plans and/or carriers when they control this decision.

Cons:

- An employee choice model is more complex at many levels. Employers, brokers, and employees would have to learn about this new system. And the exchange would have to set up systems to administer it.

- It is a big change. Everyone is used to the system of employer choice where the small employer goes out, shops for different options, and picks for all employees one choice. The employees basically have to take that option. They have little or no say in which plan is chosen for them. But, on the other hand, they don't have to spend time shopping for plans.

- A potential downside is the billing, where each employee will have a different cost if they choose different plans. Under the employer choice model, with one insurer covering all employees, the insurer gives a lump cost to the employer, which essentially averages the entire employee population. The employer and employee are used to one average cost for all employees.

How an "employee choice" system works

Small employers typically pick a single health plan to meet all the needs of their employees (and themselves). An "employee choice" system is fundamentally different. Features include:

- A single premium payment for the employer, which the exchange then allocates across insurance plans according to employee enrollment decisions. Today a small employer buys a small-group plan, and therefore all employees have the same plan. The employer pays one check each month to that insurer for all employees of the firm. If the employer moves to an employee choice model, that means multiple insurers will provide coverage to the employees of the firm. So multiple checks need to flow each month to each insurer. The exchange must act as the aggregator, accountant, and intermediary—one check from the employer to the exchange—and then distribute checks to the multiple insurers. This is how payroll service companies work with employers with very sophisticated software. It keeps the process simple for the 4.8 million firms with fewer than 10 employees that have no human resources department.

- A detailed accounting of each employee's individual ratings, plan choices, family tier, and coverage additions, which are needed for withholding purposes and so the employer can make informed decisions regarding premium payments.

Brokers, employers, and employees will all have to learn how the new system of "employee choice" operates. Small-employer exchanges that use employee choice have made a concerted effort to educate and train insurance brokers in how this system works and the advantages it offers to their business.

Determining the role of, compensation, and services for insurance brokers for exchange health plan marketing and sales

Some exchanges chose to exclude brokers or pay brokers reduced rates. They reasoned that broker fees would simply drive up the cost of coverage and that the exchange could provide many of the services that brokers typically provide.

But experiences within these exchanges and others suggest that even within a health insurance exchange, there is still an important role for brokers for small employers. They ultimately found it is better to have brokers market the exchange plans versus competing against exchange plans from the outside.

There are several important reasons for this conclusion. First, brokers sell other nonhealth products to employers. Second, brokers are trusted advisors by small businesses, educating small employers about health plan options. Third, exchange-based coverage will be competing with several alternatives for small employers

California: PacAdvantage

PacAdvantage was initially a state-operated program and later privatized. This snapshot examines an exchange's responses to outside market dynamics.

Implementation date: July 1993

Status: Closed in December 2006

Lives covered: 110,000 to 150,000

Plans offered: 13 to 27

Participating small businesses: 6,200 to 10,000

Total number of small businesses in the state (<100 employees): 698,145

See full details of the exchange on page 36

including health plans sold in the outside market, employers' grandfathered plans should they exercise this option, and the option of not offering coverage at all should the employer have fewer than 50 employees.

So it will be important to keep brokers engaged in the exchange marketplace rather than pushing them to direct small employers toward other options.

If an exchange chooses to include brokers and distributors, costs and services must be carefully defined to ensure exchange plans remain competitive with those outside the exchange. In Connecticut and New York, commission rates are in the 3 percent to 4 percent range for the services performed by brokers and are competitive with outside markets.

If the exchange pays brokers a reduced rate, it must compete with plans in the outside market by offering additional services. Exchanges, for example, can offer to share administrative and outreach responsibilities with brokers. Exchanges should also be aware that some of its plans have twins in the outside market. In Utah, carriers may offer identical (or very similar) plans to customers both inside and outside the exchange. The outside market's twin plan may offer a higher commission rate for brokers and challenge the exchange's competitiveness.

If an exchange doesn't use brokers, it will need to hire, at a fixed upfront cost, additional in-house sales staff and provide them training on small businesses to perform broker functions for small employers and their employees.

Providing cost-effective coverage so small employers have high-value, low-cost choices

Should the exchange be an active purchaser?

States may empower their state exchange to be an active purchaser to restrict participation to plans that offer low premiums, high-quality coverage, or a combination of the two. This scenario is distinct from the passive purchaser model, which allows all qualified health plans to participate in the exchange. States can design their exchanges along one of these two models.

If they choose to use the active purchaser model, exchanges may establish specific criteria for plans that participate in the exchange, such as participation in payment reform efforts or compliance with particular consumer protections.

Or they may negotiate with plans to obtain lower rates. Exchange enrollees would have fewer plan choices. But those plans would offer policies with lower rates and potentially higher quality.

Exchanges could use various active purchaser strategies to achieve their goals:

- Limit participation to high-value plans that offer high-value, affordable coverage.
- Promote innovative health care delivery system reforms by requiring or encouraging insurers to adopt these reforms.
- Give preference to plans with a proven track record of well-coordinated, primary care.
- Create cost-control mechanisms that enable the exchange to negotiate with insurance plans or, if necessary, establish specific targets for premium growth.
- Rate participating plans on criteria such as quality, cost, enrollee satisfaction, and other measures to facilitate plan choice by employers and employees.

Alternatively, states may choose a passive purchaser model and require exchanges to allow all qualified health plans to participate in the exchange marketplace. This approach would maximize the number of plan choices for exchange enrollees but not allow the additional strategies of an active purchaser model.

Regardless of the option, exchanges should create and maintain a marketplace that enables small employers and employees to easily identify high-value, high-quality health insurance plans. Employers and their employees want a range of choices but not a bewildering range of options.

Further, exchanges cannot remain static. They will be functioning in an overall competitive insurance marketplace with a market outside the exchange and self-insured plans. Successful small-employer exchanges have learned to focus on the health plan needs of their customers and change over time in response to changes in the insurance market and changes among small employers.

Making sure the exchange will be competitive with the outside insurance market and attract enough small businesses to succeed

The real-world experiences of some small-employer exchanges and purchasing pools have led some analysts to worry that SHOP exchanges will not be sufficiently competitive with the small-group insurance market, which will continue to offer coverage outside of the SHOP exchange. Other experts fear SHOP exchanges would suffer from cost disadvantages and adverse selection, among other risks.

This is a very important issue and policymakers need to address these concerns head on. Also, there is no single policy that can answer this question. Rather, there is a series of policy provisions in the Affordable Care Act and policy options that enhance the ability of newly created SHOP exchanges to be more successful than past small-employer exchanges and pools.

Several features of the new health reform law will give small-employer exchanges new tools to compete with other options available to small businesses. First, the Affordable Care Act provides a small-employer tax credit to offset the cost of health insurance that will only be available through the exchange. Two, as the RAND micro-simulation and the Massachusetts experience have found, demand for and participation in employer coverage will increase when the individual mandate takes effect in 2014.[27] Third, full implementation of insurance reforms, inside and outside the exchange, and other strategies to reduce adverse selection will create a level playing field between the exchange and the outside market.

These features and others previously discussed all have the ability to contribute to the competitiveness of a SHOP exchange.

Exclusive tax credit

Starting in 2014, the small-employer tax credit will only be available through the exchange. This subsidy will also increase from 35 percent of premiums to 50 percent of premiums for for-profit employers and from 25 percent of premiums to 35 percent of premiums for nonprofit employers. Employers who wish to take advantage of this new benefit will need to purchase coverage through the exchange.[28]

Individual mandate

Small-business employees, like all Americans, will be required to have health insurance that meets minimum coverage standards beginning in 2014. These employees—particularly those without another source of coverage, such as a spouse or a public program—will look to their employer to be a source of this coverage. The requirement that everyone have insurance will therefore increase the demand for coverage in this labor market. Some experts suggest that small employers' demand for health insurance will increase by more than 20 percent. [29]

Adverse selection

Insurance market reforms and other strategies in the Affordable Care Act should limit the premium impact of adverse selection, which is the price spiral that occurs when one plan or market disproportionately attracts high-risk employees.

Insurance plans will be required to offer coverage to all applicants—without increasing premiums based on health history—whether they apply for coverage inside or outside the exchange. Further, risk adjustment and risk corridors within the exchange should limit the potential for one plan or one market to be irreparably harmed by adverse selection.

A risk adjustment mechanism administered by states will be an assessment on all insurers in that state selling insurance both inside and outside the exchange with a formula for sharing that assessment with insurers that end up with a greater percentage of high-risk enrollees.

This makes sure that all insurees are treated fairly for their risks and insurers are not trying to avoid covering high-risk individuals or employers.

This "Risk Corridor" program will be administered by the Department of Health and Human Services based on a similar system under Medicare Part D whereby insurers receive an adjustment up or down if their annual benefits costs (not counting administrative costs) are lower or higher than the "target amount." For instance, plans would be at risk for medical costs that are within the risk corridor of 97 percent to 103 percent and adjustment made outside that corridor.

States may make additional policy choices—such as tightening the outside insurance market—that will also help level the playing field between the exchange and the outside market.[30]

Utah: Health Exchange

The Utah Health Exchange is a public but low-budget entity. This snapshot sheds light on the ongoing implementation of a passive exchange.

Implementation date (pilot program): September 2009

Implementation date (second launch): September 2010

Status: Open

Lives covered: 2,880

Plans offered: 4

Participating small businesses: 100 (as of May 2011)

Total number of small businesses in the state (<100 employees): 57,118

See full details of the exchange on page 48

Employee choice

Exchanges will be able to offer an exclusive new benefit to small employers that only large employers have now: employee choice of health plans. By its very nature, when individual companies sell a small-group plan to an employer, there is only one choice: that insurance company's plan. Employers will now be able to let their employees choose which plan they want.

This has proven to be very popular with employers and employees in New York and Connecticut, where this employee choice model has been pioneered. It will keep the exchanges competitive with outside markets by giving small employers this option.

Exchanges can and must operate cost effectively

Exchanges must be cost competitive with outside plans to survive and succeed.

The experience of exchanges in Massachusetts, Connecticut, and New York demonstrate that exchanges can be managed to keep their costs low and provide value, thereby offering cost-competitive health plans to small employers. Providing services that small employers need can be another path to reducing costs for employers and providing value. The Massachusetts Connector has set a good benchmark of administrative costs by keeping their costs to 3 percent.[31]

Additionally, many states are also considering spreading the costs of operating the exchange across all health plans in their state, which would enhance the competitiveness of the exchanges.

Conclusion

The SHOP exchanges offer an exciting new opportunity for small businesses to obtain high-quality, low-cost health insurance if state officials effectively implement the provisions of the Affordable Care Act. The Affordable Care Act has built in many features based on the lessons of past small-employer exchanges and pools and enhances the ability of SHOP exchanges to succeed. It is incumbent upon states to create well-designed exchanges that can compete with the outside market to provide these opportunities.

By focusing on issues such as participation, cost, and their small businesses' unique needs, and by considering the lessons and experiences of past small-employer exchanges and pools, states stand to build successful exchanges that remain competitive with outside markets and allow small businesses access to affordable, quality health insurance when they need it.

Appendix A

California: PacAdvantage

Implementation date: July 1993
Status: Closed in December 2006
Lives covered: 110,000 to 150,000[1]
Plans offered: 13 to 27[2]
Participating small businesses: 6,200 to 10,000[3]
Total number of small businesses in the state (<100 employees): 698,145[4]

Overview

The Health Insurance Plan of California, or HIPC, was created in 1992. It started as a state-operated, voluntary, small-employer health insurance purchasing pool. This purchasing exchange was designed to give small employers collective purchasing clout, and it accompanied a number of additional small-group reforms, including guaranteed issue of coverage, limits on exclusion of pre-existing conditions, and restrictions on rate variations.

These marketing and underwriting regulations applied both inside and outside the HIPC. But insurers were allowed to charge different rates for the same plan inside and outside the exchange.

As per the enacting legislation for HIPC, the state handed off the plan to private management—the Pacific Business Group on Health, or PBGH—in 1999. PBGH renamed the pool PacAdvantage and wholeheartedly endorsed brokers and general agents, previously excluded from the exchange, to help attract new small businesses. Brokers and insurers were attracted to the potential of a large new market and the program grew.

Eventually, however, the exchange attracted an unbalanced amount of high-risk participants.[5] This process, known as adverse selection, caused rates to increase inside the pool, and employers began opting out. After all, participation was nei-

ther incentivized nor necessary. Only the riskiest groups remained, which raised premiums above those offered outside the exchange. The number of participating insurers dwindled as enrollment decreased, and PacAdvantage was forced to close in 2006.

Lessons learned

- Enrollment was low from the beginning due to the voluntary nature of the program. Participation was voluntary for plans, voluntary for brokers, and voluntary for small employers. Additionally, in the mid-to-late-1990s, less than a third of employers were well-informed of the exchange, indicating a need for more effective outreach.[6] Further, low enrollment numbers resulted in high per-capita administrative costs.

- Former PacAdvantage CEO John Grgurina knows that "brokers can steer enrollment."[7] HIPC did not pay brokers competitive commissions so that they could keep administrative costs low. In response, a poor relationship developed between the brokers and the exchange. Once privatized, the exchange attempted to reverse this relationship. But by that time the damage had already been done. Some brokers directed low-risk groups out of the exchange, while high-risk groups stayed and new ones entered the exchange. The risky groups raised premiums and dissuaded small employers from participating.

- These weak economies of scale led to less price advantage, which in turn made the exchange less attractive to employers and decreased its bargaining power against insurers. The lack of competitive premium rates inside the exchange caused healthy policyholders to opt out. These policyholders found better rates for the same plans outside the exchange. As they dropped out, only high-risk policyholders were left. This phenomenon (adverse selection) could not be remediated.

- Unlike the outside market, the exchange could not adjust premiums for individual firms up or down 10 percent, which tied rates in the exchange to the risk of its overall pool. Despite attempts by PacAdvantage to put together an effective risk-adjustment mechanism, health plans did not consider the mechanism strong enough to offset losses. Carriers did not see the value in the exchange and eventually pulled out.

California: PacAdvantage endnotes

1 The range represents total lives covered at both the program's peak and at its close.

2 Jack A. Meyer and others, "Business Initiatives to Expand Health Coverage for Workers in Small Firms" (New York: Commonwealth Fund, 2001), available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2001/Oct/Business%20Initiatives%20to%20Expand%20Health%20Coverage%20for%20Workers%20in%20Small%20Firms%20%20Volume%20II%20%20Case%20Studies%20o/meyer_business2_475%20pdf.pdf; Jill M. Yegian and others, "The Health Insurance Plan of California: The First Five Years," *Health Affairs* 19 (5) (2000): 158–165, available at http://content.healthaffairs.org/content/19/5/158.citation.

3 Business Wire, "PacAdvantage Pooled Health Care Coverage for Small Employers Will Cease Operations at End of this year," August 11, 2006, available at http://www.redorbit.com/news/health/612521/pacadvantage_pooled_health_care_coverage_for_small_employers_will_cease/index.html; Meyer, "Business Initiatives to Expand Health Coverage for Workers in Small Firms."

4 Bureau of the Census, "U.S. & states, totals," Statistics of U.S. Businesses (Department of Commerce, 2008), available at http://www.census.gov/econ/susb/.

5 Michael Hiltzik, "Will U.S. learn its healthcare reform lesson from California?", *The Los Angeles Times*, September 14, 2009, available at http://articles.latimes.com/2009/sep/14/business/fi-hiltzik14.

6 Jill M. Yegian and others, "Health Insurance Purchasing Alliances for Small Firms: Lessons Learned from the California Experience" (Oakland, CA: California HealthCare Foundation, 1998), available at http://www.chcf.org/publications/1998/05/health-insurance-purchasing-alliances-for-small-firms-lessons-from-the-california-experience.

7 John Grgurina, interview with author, Washington, D.C., February 4, 2011. Phone.

Appendix B

Connecticut: CBIA Health Connections

Implementation date: January 1995
Status: Open
Lives covered: 88,000
Plans offered: 4[1]
Participating small businesses: 6,000
Total number of small businesses in the state (<100 employees): 71,805[2]

Overview

The Connecticut Business & Industry Association, or CBIA, represents businesses of all industries and sizes. It advocates for the general business and industry community and it provides products and services for the benefit of its members. One of these benefits is a private-sector health exchange, CBIA Health Connections. The exchange serves businesses with 3 to 100 employees and requires that at least 75 percent of full-time employees participate.

Employers may choose one of two "suites," or plan design options—one more comprehensive than the other—and enroll in them by making a minimum premium contribution. The contribution must equal at least half of the lowest monthly employee-only medical rate, or half of the lowest premium that an employee can pay each month. Employees, then, may "buy up" or "buy down" to higher or lower benefit levels within the suite.[3] CBIA also offers small employers several add-ons, including life, disability, and dental insurance.

Best practices

- CBIA actively competes with the outside market. The exchange operates under the same underwriting rules, eligibility rules, and rating standards as the outside market. Like the outside market, CBIA's carriers also participate in the state-

wide Connecticut Small Employer Reinsurance Pool for high-risk employees. Officials credit this pool with ensuring a competitive small-group market.[4] Insurers within the exchange compete for customer satisfaction as they would outside the exchange. Consequently, the exchange remains competitive and it does not pose a disadvantage to small employers. In fact, its narrow focus on the small-group market actually makes participation attractive. CBIA is tightly focused on its niche and it can respond nimbly to market forces.

- Benefits across plans are standardized, so choices are made based on premium price, network design, and formularies. The exchange establishes benefit standards and purchases plans from carriers.[5] It actively negotiates with the carriers. This managed competition model incentivizes insurers to offer high-quality and low-cost plans.

- The exchange maintains a relationship with the rest of the private sector, including insurance companies and brokers. But it actively competes in the small-group market by offering extensive communications and human resources services. CBIA offers consolidated administrative services, so employers only see one bill. As a result, the exchange has become especially successful in the 3-to-25-employee market, where few businesses have human resources staff.

Connecticut: CBIA Health Connections endnotes

1 As of publication, CBIA offered four plans; however, two carriers were transitioning out of the exchange due to other priorities. CBIA reports that its subscriber retention rate has remained high. Ken Comeau, interview with author, Washington, D.C., February 17, 2011. Phone.

2 Bureau of the Census, "U.S. & states, totals," Statistics of U.S. Businesses (Department of Commerce, 2008), available at http://www.census.gov/econ/susb/.

3 Amy Lischko, "Health Insurance Connectors & Exchanges: A Primer for State Officials" (Princeton, NJ: RWJ Foundation, 2007), available at http://www.statecoverage.org/files/Health%20Insurance%20Connectors%20and%20Exchanges-A%20Primer%20for%20State%20Officials.pdf.

4 Created in 1990, the Connecticut Small Employer Reinsurance Pool was the first of its kind. All carriers must participate, though each chooses which high-risk small groups or particular employees/dependents to reinsure. Carriers must reinsure individuals within 60 days of plan enrollment. The pool provides coverage for claims of more than $5,000 per covered life. Nonsubsidized, the pool is funded by insurers' reinsurance premiums, as well as by an annual assessment based on their small-group market share. Janet L. Kaminski Leduc, "Backgrounder: Small Employers and Health Insurance in Connecticut," September 30, 2008, available at http://www.cga.ct.gov/2008/rpt/2008-R-0542.htm.

5 The exchange cannot negotiate rates because Connecticut's small-group market operates under adjusted community-rating regulations.

Appendix C

Massachusetts: Commonwealth Choice

Implementation date: July 2007
Status: Open
Lives covered (includes nongroup and small group): 43,731[1]*
Plans offered: 73*
Carriers: 7
Participating small businesses: 2,318
Total number of small businesses in the state (<100 employees): 135,284[2]

**Commonwealth Choice merges both the nongroup and small-group market (1 to 50 employees). Included in its membership totals are 7,216 who have enrolled in coverage through their employer.*

Overview

The Massachusetts legislature passed a series of health reforms in 2006 aimed at providing near-universal coverage. (The Affordable Care Act modeled some of its reforms after those of Massachusetts.) One of Massachusetts's unique market reforms was the merger of the individual and small-group markets.

The state formed the Health Connector, an agency devoted to lowering the rate of uninsured. Currently, the connector houses two programs: Commonwealth Care and Commonwealth Choice ("CommChoice"). The former is a subsidized program for low-income adults who are not offered insurance through an employer. The latter—the focus of this snapshot—is a nonsubsidized health insurance exchange, which serves the merged market.[3]

Insurance plans must meet a minimum set of standards, which require coverage for a broad range of medical services, to participate in the exchange.[4] Participating insurers have received the Health Connector's "Seal of Approval" to offer a range of health benefit plans to consumers and small businesses. These plans

are grouped, by price and benefit level, into "benefit tiers."[5] Special exchange-only products are available to young adults. In addition, as of the 2006 reforms, participating insurers must charge the same rate for the same plan both inside and outside the exchange.[6]

Small employers began enrolling in CommChoice in January 2009. In the pilot Contributory Plan program, employers selected a benefit tier and a "benchmark plan." They also determined how much to contribute to employee premiums. Next, employers chose their plan: either the "benchmark plan" or another plan within the employer-selected benefit tier. This program was launched to a limited number of small businesses, and it is not available to new enrollees.[7] CommChoice administrators have changed their focus to other small business programs, which they believe will raise enrollment in the exchange.

Currently, small employers may enroll in CommChoice in one of two ways. The Voluntary Plan program enrolls employers with part-time and temporary workers. This program, which does not require employer premium contributions, allows employees to purchase insurance on a pretax basis. The Business Express program follows the employer-choice model and allows employers to choose a health plan option for their employees. It targets small employers, particularly micro-groups (small businesses with one to five employees), by lowering their characteristically high administrative costs. These small business enrollment programs are separate from those that CommChoice offers individual subscribers.

Business Express boasts higher enrollment than both the Voluntary Plan and the Contributory Plan combined. But it only offers health benefit plans from three insurers, so only 21 health benefit plans are currently available.[8] Critics claim that the lack of key carriers, such as Blue Cross Blue Shield, has contributed to its low enrollment. All Commonwealth Choice carriers, however, recently agreed to participate in Business Express by the end of 2011.[9]

State legislators relieved premium rates for small businesses in 2010 by providing a discount of up to 5 percent for employers who participate in a wellness program. The connector will implement the new program in July 2011.

Lessons to date

- The connector's website promotes transparent shopping. A comparison tool helps consumers and small businesses shop and enroll in health insurance. The standardized products, marked by the connector's "Seal of Approval," simplify the "apples to apples" comparisons.

- CommChoice serves a merged market, which leads to lower rates for nongroup policyholders and higher rates for small-group policyholders.

  - CommChoice prioritized nongroup policyholders during its initial boom. Individual consumers had the highest rates of being uninsured, so leaders focused on reversing this trend. As a result, CommChoice developed in two stages. In the first stage, marketing efforts concentrated on the nongroup market, and the exchange developed unique products for individuals. In the second stage, CommChoice addressed small-group needs.

    - The first stage drove the overall success of health reform in Massachusetts. More individuals are insured, and more employers offer insurance. The exchange's rapid implementation contributed to making these successes possible.[10]
    - In regards to the second stage, critics noted the long lead time before information relevant to small employers and brokers was made available on the website, as well as the delay in launching a small-employer pilot program.[11]
    - States will launch the exchange in one stage, not two, under the Affordable Care Act. The connector's experience shows that if a state chooses to merge the exchange, it should not neglect the needs of small employers.

  - The connector's unique Young Adult Program helped lower the rates of uninsured individuals in the 18-to-26-year-old demographic. Small employers often rely on young adult employees, especially as part-time and temporary hires. The connector initially focused more resources on the nongroup market but it is likely that small employers indirectly gained from this particular nongroup product. It made health insurance available to a significant segment of small business employees, using creative outreach methods that included a promotional campaign through the Boston Red Sox.

– Most Massachusetts residents are responsible for obtaining health insurance, and they may be subject to a tax penalty if they do not.[12] Before January 2011 nongroup purchasers could join and drop coverage at will, which in turn led to the "jumper" phenomenon. Some nongroup jumpers purchased insurance only when they needed insurance to cover high health care costs, such as prenatal care. The high-risk "jumpers" may have contributed to a 1 percent to 1.5 percent increase in small-group premium rates.[13] A new law, which went into effect on January 1, 2011, implemented open enrollment periods to limit jumping. But some case studies suggest that the "jumper" problem will persist unless the "weak" penalty for being uninsured (a maximum of $1,212) is strengthened.[14] To sidestep these dynamics, states should carefully assess how enrollment behavior might affect the exchange.

- Some brokers have raised their concerns with regard to the implementation of CommChoice. The connector, for example, shared information about the program with small employers and the "intermediary" Small Business Service Bureau without first informing brokers. Some brokers suggest that these moves "alienated" them from the exchange.[15] Despite the alienation, the connector states that, "Over 70% of employers that provide their employees with health insurance coverage … use brokers."[16] This issue is a sensitive one as brokers, associations, and other industry professionals have relationships with small businesses. These existing relationships have affected how the exchange spreads the word to small employers. Exchanges should inform brokers of the new changes as well as leverage their outreach capacity.

Massachusetts: Commonwealth Choice endnotes

1 MA Health Connector, interview with authors, February 2011. Phone and email.

2 Bureau of the Census, "U.S. & states, totals," Statistics of U.S. Businesses (Department of Commerce, 2008), available at http://www.census.gov/econ/susb/.

3 Specifically, the merged market serves individuals and families who make more than 300 percent of the Federal Poverty Level, or FPL; young adults; part-time and temporary workers; and small businesses with 50 or fewer employees.

4 "Health Care Reform: Key Decisions," available at https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=MCC Benefits.htm&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/Health Care Reform/What Insurance Covers/MCC Background/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken (last accessed May 2011).

5 The benefit tiers are: Gold, Silver High, Silver Medium, Silver Low, Bronze High, Bronze Medium, and Bronze Low.

6 Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, "The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions" (New York: The Commonwealth Fund, 2009), available at http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/May/The-Massachusetts-Commonwealth-Health-Insurance-Connector.aspx.

7 The program is available to the groups that participated in the pilot program, on a renewal basis.

8 The Contributory Plan and the Voluntary Plan offer six plans, and house 55 and 635 small firms, respectively. Business Express offers three plans, but houses 1,564 small firms. MA Health Connector, interview with Sandra Bogar, Washington, D.C., February 17, 2011. Email.

9 Roni Mansur and Kaitlyn Kenney, "Commonwealth Choice July 2011 Seal of Approval," presented at Health Connector Board of Directors Meeting, April 14, 2011, available at https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-4-14/3%2520-%2520SoA%2520Board%2520Meeting%2520Presentation_final.pdf.

10 The Commonwealth Care program was enrolling members in October 2006, within six months of the passage of the law. The Commonwealth Choice program was established and selling coverage by May 2007.

11 Jim Stergios and Amy Lischko, "Health care fails small businesses," *The Boston Globe*, May 12, 2010, available at http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2010/05/12/health_care_fails_small_businesses/.

12 The maximum penalty for 2011 is $1,212.

13 Dianna K. Welch and Kurt Giesa, "Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets" (New York: Oliver Wyman, 2010).

14 Ha T. Tu and others, "State Reform Dominates Boston Health Care Market Dynamics" (Washington: Center for Studying Health System Change, 2010), available at http://www.hschange.com/CONTENT/1145/?words=boston.

15 Jeff Rich, "The Impact of the Massachusetts Connector on Brokers," available at http://massahu.org/. The Health Connector's broker commission schedule is $10 per subscriber per month for groups of one to five and 2.5 percent of premium for groups of 6 to 50. Insurers in the state have broker commissions that are in some cases higher, and other cases lower, depending on the specific insurer and group size.

16 MA Health Connector, interview with authors.

Appendix D

New York: HealthPass

Implementation date: December 1999
Status: Open
Lives covered: 32,000
Plans offered: 25+[2]
Participating small businesses: 4,000
Total number of small businesses in New York City metro area (<100 employees): 236,812[3]

Overview

HealthPass, now a private commercial exchange, was originally developed by the former mayor of New York City, Rudy Giuliani, and the New York Business Group on Health (now the Northeast Business Group on Health).

Small employers must be located in New York City, Long Island, or the Mid-Hudson Valley in order to participate. Additionally, an existing 75 percent of employees of each participating small business must be insured, either by the employer, a spouse, or otherwise. This requirement ensures robust participation in the exchange.

The employer may or may not choose a standard dollar amount to contribute to each employee's premium. The employer also has the choice of setting up a Section 125 premium-only plan, which allows employees to use their pretax earnings to pay for plans.

The exchange also uses the "employee-choice" model. Employees may purchase plans of their choice once their employer has enrolled in HealthPass. Much like the SHOP Exchanges will be able to do, HealthPass offers "add-ons" (such as dental and a bundled security product) to the employee.

Best practices

- HealthPass is a user-friendly program. It requires little administrative effort from the employer since most of its administrative and enrollment forms are one page. Similarly, it offers the employee a substantial number of benefit options and premium levels. The exchange provides both employers and employees with personalized small-group administrative support, such as human resources services and health consultation hotlines. In addition, Workable Solutions—a third-party administrator—provides back-end operational and communications support. These personalized services are especially attractive to the micro-group market. These are businesses with one to nine employees, and they comprise 80 percent of HealthPass enrollees. The exchange attributes its success with these groups to its robust support services.[4]

- Local authorities considered the exchange a long-term investment, so public support and funding helped get it on its feet. The mayor's office contributed to the program's startup costs and lent a member of senior leadership to act as HealthPass's first president. The public-private partnership set long-term, break-even goals, making short-term losses less of a public burden. Currently, HealthPass is a self-sustaining, private entity.

- The exchange maintains a good relationship with the broker community, which drives HealthPass enrollment. The exchange provides them with administrative support, which in turn facilitates brokers' small-group sales. A substantial portion of the HealthPass budget is devoted to broker outreach.[5]

New York: HealthPass endnotes

1 HealthPass serves New York City, Long Island, and the Mid-Hudson Valley.

2 The plans are offered through four carriers and belong to one of four categories (In-Network only, In- & Out-of-network, Cost-sharing, and High-deductible). Two dental plans and two bundled security products (long-term disability, accidental death & dismemberment, and term-life) are also available.

3 Bureau of the Census, "U.S. & states, totals," Statistics of U.S. Businesses (Department of Commerce, 2008), available at http://www.census.gov/econ/susb/.

4 Shawn Nowicki, "SHOP Exchanges: A Small Business Benefit," presented at the Families USA Health Action 2011 Conference, available at http://www.primaryimmune.org/advocacy_center/pdfs/health_care_reform/Small_Business_Health_Exchange_20101007.pdf.

5 Stephen N. Rosenberg, "New York's HealthPass Purchasing Alliances: Making Coverage Easier for Small Businesses," (New York: The Commonwealth Fund, 2003), available at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2003/Sep/New-Yorks-HealthPass-Purchasing-Alliance--Making-Coverage-Easier-for-Small-Businesses.aspx.

Appendix E

Utah: Health Exchange

Implementation date (pilot program): September 2009
Implementation date (second launch): September 2010
Status: Open
Lives covered: 2,880[1]
Plans offered: 4
Participating small businesses: 100 (as of May 2011)
Total number of small businesses in the state (<100 employees): 57,118[2]

Overview

Utah's health reforms have focused on private-sector initiatives since 2005. Legislators conceived a free-market approach to exchange design in 2009 and subsequently developed one of the nation's only passive purchasers.[3] The state legislature set aside a small budget to establish the Utah Health Exchange, which they described as a small-employer health insurance marketplace.

The pilot program

The exchange first operated as a pilot program. Any insurer that met a basic set of requirements could participate. Small employers could participate if they entered through a broker and if at least 75 percent of their full-time employees agreed to join the exchange. The employer chose a dollar amount to contribute to employee premiums—known as the "defined contribution"—and employees would purchase the health plan of their choice. The pilot exchange prioritized consumer choice and price competition but health plans were too costly and employers did not continue the application process.[4]

The second launch

In 2010 leaders responded to the pilot program's failures by addressing some key issues. First, they established a statewide prospective risk-adjustment mechanism to reduce the high cost of premiums inside the pool. Second, they developed a user-friendly health insurance application. These changes altered the small-business enrollment process.

The 2010 changes also removed the broker requirement. Small businesses can now enter either independently or with a broker. While the exchange no longer requires brokers, virtually all enrollees enter with one. Broker outreach is a priority and the exchange's administrators perform weekly educational "broker trainings."

How the program works

Once two randomly selected carriers establish a firm's eligibility, employees send their health status information to the same two carriers, who determine the group rate and adjust risk for individuals. Inside the exchange, carriers determine rates in the same way that they do outside the exchange. Rates are determined for the small group, not the exchange pool (carriers also may apply pre-existing condition exclusions). If employers choose to complete the application process (some leave after this step), this group rate will allow employees to enroll in any participating health plans.

The employer, however, also chooses a default health plan for the firm's employees. This default plan is not visible to employees as they shop for their health plan of choice. The default plan is only applied if the employee does not elect a plan. Eventually, the exchange hopes to aggregate employee premiums, as well as include large employers in the marketplace.[5]

Supporters tout the Utah Health Insurance Exchange as a low-cost design option for maximum plan participation. At the same time, critics draw attention to the exchange's low enrollment figures and question its overall effectiveness.[6]

Lessons to date

From the pilot program

- Many participating employees chose the same plan in the pilot program that they previously held outside the exchange. The employees viewed the choice as a renewal of their previous plans but insurers charged them expensive new rates. The high costs associated with the exchange discouraged potential enrollees.

- Eighty-nine of the 99 small businesses that participated in the pilot program dropped out.[7] They were moving through a complicated enrollment process and they left before the costs of plans were visible. Other employers eventually dropped out due to high costs.

From the second launch

- Many exchanges achieve lower average rates by pooling risk among all participating businesses. But the Utah Health Exchange bases an employee's premium on the group's risk factor. An employee's individual risk factor also determines the employee's premium quote. High-risk enrollees face especially high costs.

- Some high-risk enrollees might be drawn to different plans than low-risk enrollees. A risk-adjustment mechanism protects insurers from the losses associated with adverse selection. The exchange collects payments into a pool and pays it out to those insurers who bear the most risk. This tool encourages insurers to participate in the exchange.

- The exchange works to both collaborate and compete with industry players. To do so, it employs the following techniques:

  - Administrative costs are low. With an annual budget of about $600,000, three staff members operate the exchange. Since the exchange is a passive purchaser, it does not require a large staff.
  - As a passive purchaser, the exchange draws a variety of plan options (140).[8]
  - Insurers participated in the design process. They developed a prospective risk-adjustment mechanism to be used across all plans offered inside the exchange.

- Exchange staff members draw their knowledge of the market from their experiences as part of the brokerage community. Their professional backgrounds are in benefits administration outsourcing. They actively respond to external competition and hold weekly "broker trainings" to expand their industry outreach efforts.

- Brokers receive different commissions inside and outside the exchange. Inside, they receive a single commission regardless of which plan their clients choose. Outside, they receive different commissions for different plans. But similar plans may be offered inside and outside the exchange at different compensation rates. This difference challenges the exchange's competitiveness.

- To date, the exchange has not attracted many previously uninsured small businesses. The majority of participating employers offered health coverage in the past. Of participating employees, approximately one-third fall into the default plan, or the plan chosen by their employer in case the employee fails to choose a plan. And enrollment remains low. But administrators do not plan on closing the exchange.

- Here are some other recommendations that might boost enrollment:

  - Observers suggest that a good comparison tool is a vital part of a user-friendly purchasing process.[9] The exchange could use this to help employees find plans.
  - Utah-based advocates have demanded additional services, such as premium aggregation and eligibility screening for public programs.[10] The exchange expects to implement these services in its next phase.
  - The advocates also note that true risk pooling, and even the inclusion of the individual market, would reduce premium costs.
  - Observers note that most employers are unaware that federal reform law offers them a tax credit for providing coverage, though the exchange educates brokers about its availability.[11]
  - Lack of educational efforts can be detrimental to the exchange's long-term sustainability. Navigators and other outreach tools will help remedy this problem.

Utah: Health Exchange endnotes

1 Patty Conner and Michael Sullivan, interview with authors, February 16, 2011. Phone.

2 Bureau of the Census, "U.S. & states, totals," Statistics of U.S. Businesses (Department of Commerce, 2008), available at http://www.census.gov/econ/susb/.

3 Conner and Sullivan, interview with authors.

4 Utah Health Policy Project, "Utah's Exchange at the Crossroads: Time to Bring Utah's Health Exchange up to Federal Standards" (2010), available at http://www.healthpolicyproject.org/Publications_files/State/UtahExchangeAtCrossroads10-18-10.pdf.

5 The Utah Health Exchange's web portal provides individuals with information about health plan options in the outside market.

6 Utah Health Policy Project, "Utah's Exchange at the Crossroads."

7 Ibid.

8 Conner and Sullivan, interview with authors.

9 Shelly B. Braun, interview with author, February 28, 2011. Phone.

10 Premium aggregation is not yet available, though the exchange promotes its plans to make it so.

Endnotes

1 "Statistics about Business Size (including Small Business)," Table 2a, available at http://www.census.gov/econ/smallbus.html; Jessica Helfand, Akbar Sadeghi, and David Talan, "Employment dynamics: small and large firms over the business cycle," *Monthly Labor Review* 130 (3) (2007), available at http://www.bls.gov/opub/mlr/2007/03/art3full.pdf. Note these statistics represent all firms with zero to 499 employees.

2 The Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2010 Annual Survey" (2010), available at http://ehbs.kff.org/pdf/2010/8085.pdf.

3 Jon Gabel and others, "Generosity And Adjusted Premiums In Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs* 25 (3) (2006), available at http://content.healthaffairs.org/content/25/3/832.full.

4 Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey" (Washington: Employee Benefit Research Institute, 2008), available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3975.

5 Small Business Majority, "The Economic Impact of Healthcare Reform on Small Business" (2009), available at http://smallbusinessmajority.org/econ_research.php.

6 Bowen Garrett and Matthew Buettgens, "Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature: Timely Analysis of Immediate Health Policy Issues" (Washington: Urban Institute, 2011), available at http://www.urban.org/UploadedPDF/412295-Employer-Sponsored-Insurance.pdf; Christine Eiber and others, "Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses" (Santa Monica: RAND Corporation, 2010), available at http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR825.pdf.

7 Small Business Majority, "Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act," (2011), available at http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php.

8 The snapshots in this toolkit consider a range of exchange models. It should be noted that those models represent a sample, not the universe, of experiences. Other states, including Texas and Florida, have operated state-based exchanges. Several other private exchanges are also in operation. One journalist noted that private exchanges operate in more than 20 states. See: Julie Appleby, "Businesses Turn to 'Private Exchange' Health Insurance," *USA Today*, April 28, 2011, available at http://www.usatoday.com/money/smallbusiness/2011-04-28-small-business-insurance_n.htm.

9 "State Averages," available at http://smallbusinessmajority.org/small-business-research/opinion-research.php.

10 In Massachusetts, the Connector uses 3 percent as its administrative cost benchmark.

11 "Healthcare Reform FAQ: Small Business Tax Credit," available at http://www.smallbusinessmajority.org/hc-reform-faq/index.php#1a.

12 Alain Enthoven and others, "Making Exchanges Work in Health-Care Reform" (Washington: Committee for Economic Development, 2009), available at http://www.ced.org/images/library/reports/health_care/Exchangememohc09.pdf.

13 Ha T. Tu and others, "State Reform Dominates Boston Health Care Market Dynamics" (Washington: Center for Studying Health System Change, 2010), available at http://www.rwjf.org/coverage/product.jsp?id=68488.

14 This toolkit will use the term "broker," also known as an "agent" or "producer," for simplicity.

15 Kate Trickle, interview with author, April 21, 2011. Email.

16 "What's a 'Small Business'?", FactCheck.org, August 25, 2010, available at http://www.factcheck.org/2010/08/whats-a-small-business/.

17 Based in Cleveland, the Council of Smaller Enterprises, or COSE, represents 15,000 members and almost 40 years of member support. Beyond its role as a small-business advocate and resource center, COSE enables its members to participate in group-purchasing programs. One such program is its Health Insurance Benefits Program. Currently, one insurer offers 18 health plan options. COSE plays a role in designing these plans. Employers can offer up to three plan options to their employees. To support the enrollment process, COSE offers trained staff, simplified billing and enrollment procedures, and a wellness program.

18 Small Business Majority, "Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act" (2010), available at http://smallbusinessmajority.org/reports/SBM-Healthcare_Survey_010411.pdf.

19 "Final," available at http://www.pacificcommunityventures.org/media/pdf/PCV_small_businesses_and_health_care_toplines_0211.pdf.

20 JJ Bartlett, interview with author, April 15, 2011. Phone.

21 The Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2010 Annual Survey"; John Carroll, "Like Stock Brokers, are Health Care's Middlemen Losing Influence?", *Managed Care*, May 2000, available at http://www.managedcaremag.com/archives/0005/0005.broker.html.

22 "Small Business Majority," available at http://smallbusinessmajority.org/.

23 Gorman Actuarial, LLC; DeWeese Consulting, Inc.; Hinkcley, Allen & Tringale LP Health Strategies, "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets" (2006), available at http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf.

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25 "Statistics of U.S. Businesses," available at http://www.census.gov/econ/susb/.

26 HealthPass does not regulate employers' contribution. They may contribute a flat-dollar amount, a percentage of the employees' premium, or nothing at all.

27 Garrett and Buettgens, "Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature", Eiber and others, "Establishing State Health Insurance Exchanges."

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30 Timothy Stoltzfus Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues" (New York: The Commonwealth Fund, 2010), available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

31 Timothy Stoltzfus Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues" (New York: The Commonwealth Fund, 2010), available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.

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Small Business Majority is a small business advocacy group founded and run by small business owners to focus on solving some of the biggest problems facing small businesses today. A major area of concentration has been, and will continue to be, healthcare reform; our primary goal is to provide small business owners with information about the new law, and to educate policymakers about small business owners' needs and concerns as they move forward on implementation. We're also heavily involved in clean energy policy, as well as working on strategies to promote entrepreneurship and small business growth, including legislative provisions for job creation, tax credits and access to capital.

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