AN UPDATE ON THE SMALL BUSINESS HEALTH OPTIONS PROGRAM: IS IT WORKING FOR SMALL BUSINESSES?

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OF THE

COMMITTEE ON SMALL BUSINESS

UNITED STATES

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AN UPDATE ON THE SMALL BUSINESS HEALTH OPTIONS PROGRAM: IS IT WORKING FOR SMALL BUSINESSES?

THURSDAY, SEPTEMBER 18, 2014

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON HEALTH AND TECHNOLOGY,
Washington, DC.

The Subcommittee met, pursuant to call, at 1:00 p.m., in Room 2360, Rayburn House Office Building. Hon. Chris Collins [chairman of the subcommittee] presiding.

Present: Representatives Collins, Luetkemeyer, Herrera Beutler, Hahn, and Schneider.

Chairman COLLINS. I call this hearing to order.

I would like to thank our witnesses for appearing today on our Committee's second hearing regarding the implementation of the health care Small Business Health Options Program, which we all know as the SHOP program.

The SHOPs are marketplaces established by President Obama's health care law and are intended to assist certain small businesses in shopping for, comparing, and enrolling in health insurance plans for their employees. The Administration promised that the SHOP Exchanges would simplify the process of obtaining insurance, expand health insurance coverage options for small businesses, increase small business purchasing power to lower costs, and put consumers in charge of their health care.

Unfortunately, the reality of the program is far less than promised. Despite spending vast amounts of time and taxpayer dollars regarding the SHOPs, the program continues to be beset by operational delays and other problems that have undermined their utility as a tool for small businesses. These problems include the inability to utilize web-based portals, limited choice of plans, and a lack of insurance carrier participation in the SHOPs.

The Committee has sent multiple letters to then-Health and Human Services Secretary Kathleen Sebelius and Administrator of the Centers for Medicare and Medicaid Services Marilyn

Tavenner to express our ongoing concerns about the seemingly endless problems besetting this program and to get answers about small business participation rates.

Unfortunately, the answers have not been provided. Specifically, in January of this year, Chairman Graves sent a letter to the Department requesting enrollment figures for the SHOPs exchanges. This inquiry was followed by another letter in June. To date, the

responses the Department has provided have not included information on the data on SHOPs enrollment.

In addition, last year, the Committee commissioned the Government Accountability Office to undertake an examination of the Department's implementation of the SHOP Exchanges. This report found a number of challenges the Department would need to overcome in order to make the SHOPS operational by the Department's original October 1, 2013 deadline. It appears these warnings were not heeded and the predictions of problems accurate.

For small businesses, the lack of operational SHOP Exchanges is one in a long list of disappointments and challenges they face in the wake of the health care law's implementation. Small businesses also face cancelled health insurance plans, higher premiums, higher deductibles, smaller provider networks, more paperwork, and onerous reporting requirements—all the result of this misguided health care law.

Today, I hope we will hear some answers about what small businesses can expect of the SHOPs and when the health care law will start working for them.

Ms. Hahn is not here so we will let her make her opening statement when she arrives, but we will roll into the testimony of our witnesses.

First of all, to explain the lights, the lights will be green as you are speaking. You have five minutes to deliver your testimony. You will see them turn yellow and then red. We will not adhere completely to that, but that is how the lights work.

So now that Ms. Hahn is here, we will delay your testimony just a moment and let her set up and have her deliver her opening statement. Sorry that we went without you but with the tight time schedule we——

Ms. HAHN. I heard you went without me without consent.

Chairman COLLINS. Oh, everyone that was here gave consent.

Ms. HAHN. Okay.

Where is my opening statement?

I am ready.

Chairman COLLINS. Okay.

Ms. HAHN. Thank you.

Chairman COLLINS. I now turn it over to Ms. Hahn for her opening statement.

Ms. HAHN. Thank you, Mr. Chair. It is great to be here.

My opening statement is in 2010, Congress made history with the passage of the Affordable Care Act. And while this law is not perfect, it has benefitted families across the country. Families no longer find themselves at the mercy of insurance companies. People with preexisting conditions can no longer be denied coverage. And this year, millions of Americans signed up for health coverage through the healthcare.gov website. And the uninsured rate has dipped to the lowest level in over a decade.

But the Affordable Care Act has not just helped families; it has helped small businesses also. And while 96 percent of small businesses are not required under the ACA to purchase coverage, those that choose to are seeing more options and more savings. For years, small businesses in every sector have struggled with the rising cost of health care. In fact, in a study by the National Federa-

tion of Independent Business, small business owners cited health insurance costs as the number one problem facing their business in 2012.

Because of the Affordable Care Act, we are beginning to make some progress. In the period since the enactment of the health care law, we have seen the slowest health care price growth in almost 50 years. Employer premiums are now growing at less than half the rate of the previous decade.

Small businesses in particular are seeing benefits. Before the Affordable Care Act, small businesses paid 18 percent more in premiums than their larger competitors for the same benefits. They could see their premiums increase dramatically if an employee had an accident or was diagnosed with a serious illness. Small businesses could be charged more for employing women or people with preexisting conditions, or for operating in blue collar industries like construction or roofing. Now, for the first time, small businesses have an opportunity to leverage their buying power with other small businesses in the SHOP Marketplace. The businesses enrolled in the new marketplaces are finding quality, affordable coverage and many qualify for a tax credit that can cut their premiums by as much as 50 percent. Three hundred sixty thousand small businesses have already used the Small Business Health Care Tax Credit available through the SHOP Exchanges to help them afford health insurance for two million American workers.

Take Lorenzo Harris, for example. Lorenzo Harris is the CEO of Janico Building Services, a full-service janitorial company with 40 employees in California. This year he transferred Janico's full-time employees from their existing health plan to California's SHOP Exchange and saw his premium costs go down by 30 percent. He also qualified for a health care tax credit of more than $1,000. This is great news, and I expect we are going to hear even more success stories like this, particularly from California, as the shops enter their second year in business.

Now, I know the Affordable Care Act is not perfect, and I expect today that we are going to hear both about some of the successes of ACA, as well as some of the criticism of the health care law's implementation. This should prompt us in Congress to fix the areas that need improvement. Medicare was passed nearly 50 years ago, and we are still making improvements and refinements to that law. That does not mean Medicare was a bad law; it means the job of Congress is to preserve what works and fix what does not.

I am looking forward to hearing the testimony of our witnesses today and the opportunity to learn more about how we can work together to ensure that our small businesses have access to quality, affordable health care options.

And I yield back.

Chairman COLLINS. Thank you, Ms. Hahn.

I would now like to introduce our first witness, Mayra Alvarez, who serves as the Director of the State Exchange Group at the Center for Consumer Information and Oversight at the Centers for Medicare and Medicaid Services. Prior to assuming her current position, Ms. Alvarez also served as associate director of the Office of Minority Health at the Department of Health and Human Services.

She has served on the staffs of Senator Richard Durbin, former Congresswoman Hilda Solis, and then Senator Barack Obama.

Ms. Alvarez, thank you for appearing today, and you may now deliver your testimony.

STATEMENTS OF MAYRA ALVAREZ, DIRECTOR, STATE EXCHANGE GROUP, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT; ROGER STARK, HEALTH CARE POLICY ANALYST, WASHINGTON POLICY CENTER; ADAM BECK, ASSISTANT PROFESSOR OF HEALTH INSURANCE, THE AMERICAN COLLEGE OF FINANCIAL SERVICES; JON GABEL, SENIOR FELLOW, NORC, UNIVERSITY OF CHICAGO

STATEMENT OF MAYRA ALVAREZ

Ms. ALVAREZ. Good afternoon, Chairman Collins, Ranking Member Hahn, and members of the Subcommittee. Thank you for the opportunity to discuss the benefits of the Small Business Health Options Program (SHOP) for small businesses and their employees.

Since last fall, SHOP has been working to provide small employers a new way to shop for health insurance coverage, and we look forward to offering even more with the addition of online functionality this fall. In the past, although many small employers have wanted to offer health benefits to their employees, they have faced many challenges. Historically, small businesses have been charged 10 to 18 percent more than large employers for the same benefits. Small businesses employing women or workers with high cost illnesses have faced higher premiums. Because small firms have fewer employers to pool than larger firms, premiums often vary dramatically from year to year due to changes in just one or two workers' health status or because of small changes in the ratio of male to female employees.

Because the law limits the factors insurers can use in determining the cost of premiums, small businesses can now count on more predictable rates, and many qualified small employers purchasing coverage through SHOP can receive further help keeping costs down through the availability of the Small Business Health Care Tax Credit. The SHOP provides a streamlined way for small businesses to offer health coverage to their employees. Similar to the individual marketplaces, the SHOP allows small businesses to easily compare and select plans that best meet the needs of their employees.

In 2014, the SHOP opened to small employers with 50 or fewer employees. In 2016, the program will be open to businesses with up to 100 employees. Unlike the individual marketplace, eligible employers can begin participating in the SHOP at any time and may purchase coverage for their employees at any time during the year. They are not limited to a single open-enrollment period.

This past year, small employers offered coverage to their employees through the SHOP Marketplace by enrolling in coverage through an agent, broker, or issuer. During this year, HHS has worked to create a seamless, online experience for enrollment through SHOP, and we have added key new features for the SHOP Marketplace for the 2015 plan year. New features include offering

many employees a choice of health plans; enabling employers to write just one check regardless of the number of plans that employees choose, a feature that is generally referred to as premium aggregation; and a dedicated online system for agents and brokers to assist their SHOP small business clients. Starting this fall, the online, federally-facilitated SHOP Marketplace will offer new health coverage options to small employers and make it easier for them to shop for, select, and offer employees high-quality health plans. And employees will be able to enroll in their employer plan online, helping reduce an administrative burden for their employers.

As we move to make online functionality for the SHOP available this November, CMS is committed to acting on lessons learned and continuously improving the user experience. One way that we are doing this is to give small employers, as well as agents and brokers in five states, the opportunity to experience key features of the new online SHOP Marketplace in advance of the full launch nationwide. During SHOP Early Access, small employers in these states will be able to establish a marketplace account, assign an agent and broker to their account, fill out an application, obtain an eligibility determination, upload their employee roster, and then when available in early November, browse available plans and pricing and complete the enrollment process. Early Access will also allow for targeted consumer testing before the SHOP functions are made available online in all federally-facilitated SHOP Marketplace states. This consumer testing will add to the rigorous performance and security testing completed prior to going live.

Beyond the opportunity for online enrollment, we are also making important progress in offering small business employees additional choices for their health coverage. In the past, most small employers were only able to offer a single health and dental plan for all of their employees. Now, through the Employee Choice option, small businesses in most states will have the option to allow employees to choose any health plan available at the coverage level selected by the employer. This provides significant benefits to both employers and employees, including lessening the administrative burden on employers, while allowing employees to select the plan that best fits their needs.

In addition to choice, we know how important affordability is to small businesses. The law created the tax credit to help small employers of lower wage workers afford a significant contribution towards workers' premiums. Qualified small employers can receive a tax credit worth up to 50 percent of their contribution towards employees' premium costs, and since the tax credit first became available in 2010, it has provided hundreds of thousands of small businesses more than $1.5 billion in tax credits. For too long, small business owners have struggled to keep up with the ever-rising costs of providing health insurance for their employees. The SHOP, combined with new insurance reforms and tax credits, enables more employers to provide their employees with high quality, affordable health coverage.

I look forward to continuing to work with you to improve the health care options for America's small businesses, families, and communities, and I am happy to answer your questions.

Chairman COLLINS. Thank you, Director Alvarez.

At this point, I would like to yield to my colleague, Congresswoman Herrera Beutler so she may introduce our next witness.

Ms. HERRERA BEUTLER. Thank you, Chairman and Ranking Member Hahn. I would like to thank you for the work the Subcommittee is doing.

I am excited to highlight what is happening with the SHOP and to see whether or not we are meeting the needs of small businesses and to see what we can do about that.

It is my pleasure to introduce a retired physician and accomplished health care policy analyst from Washington State, Dr. Roger Stark. Dr. Stark practiced thoracic surgery in Washington State for 20 years and was one of the cofounders of the Open Heart Surgery Program at Overlake Hospital in Bellevue, Washington. He graduated from the University of Nebraska, College of Medicine, and completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. Currently, Dr. Stark is a health care policy analyst for the Washington Policy Center. He is the author of two books and numerous in-depth studies on health care policy. We are lucky to have Dr. Stark here as a valuable resource, who understands the intricacies of the medical system as a physician, as well as the intricacies of the Affordable Care Act as an analyst, specifically the workings of SHOP in Washington State and the exchanges intended for small business owners.

So Dr. Stark, welcome. Thank you for being here. Thank you for making the very long trip across the country. We appreciate it.

STATEMENT OF ROGER STARK

Dr. STARK. Thank you very much, Chairman Collins, Ranking Member Hahn. Thank you very much, Representative Herrera Beutler.

Officials in Washington State chose to establish a state-run health insurance exchange, including a SHOP Marketplace. Coverage began in 2014. Only one carrier, Kaiser Permanente offered plans, and only offered those five plans in two counties in southwest Washington. Although 4,300 small businesses created online accounts, only 11 companies with a total of 40 people actually purchased insurance on the SHOP Exchange this year.

A second insurance company, Moda, has applied to offer 14 plans statewide starting in 2015.

The director of the Washington State SHOP Marketplace, Catherine Bailey, stated that many of the carriers were not interested in expending additional resources to be in the Small Business Exchange right away.

The Government Accountability Office has speculated that the use of tax credits and the SHOP enrollment are so low nationally for several reasons. The first reason is the complexity of doing all the paperwork.

The second reason that GAO reports is the tax credit is not a large enough incentive for many small employers.

And third, the majority of small businesses have never offered health benefits to employees.

In addition, insurance companies are seeing a drop off in employer-sponsored health insurance for small businesses. The CEO

of Well Point, Joseph Swedish, is on record earlier this month stating that small employers are shifting employees to the individual exchange or are dropping coverage completely.

From a policy standpoint, although the employer mandate is a critical part of the ACA, the SHOP Marketplace for small businesses seems to be almost an afterthought in the law. There is no clear evidence of interest on the part of small companies to provide health insurance through a marketplace with tax credits. Small businesses are typically startup or low margin companies where the added costs of employee health insurance can mean the difference between success and failure. The paperwork and regulatory burden in the SHOP Exchange are definite hurdles for small business employers.

There is no real free market in the individual exchanges or in SHOP. Proponents will claim that competition exists.

Yet, all insurance plans offered in the exchanges must contain the 10 government-mandated essential benefits. Insurance premium prices must be approved by the government. Consequently, individuals and employers only have government-approved plans and not meaningful choices or real competition. Narrow provider networks further limit choices.

The incentive of tax credits has not been significant enough to encourage employers to use SHOP. Obtaining the credit is so complicated that small businesses are unwilling or unable to spend the time and effort to complete the necessary forms.

The SHOP Marketplace duplicates the private insurance marketplace with an added burden to taxpayers. Private association health plans, for example, have flourished for years without government financial support. Since employer interest and utilization of the tax credit is so small, the benefits of the SHOP Marketplace are unclear.

So where to go from here? Designing an insurance exchange, whether it is private or government run, offers each state, like Washington State, the opportunity to reform health care delivery by starting with a clean slate and moving toward a patient-oriented consumer-driven system. The exchange can be a transparent, information-based market where individuals and small businesses can select the plan most appropriate to their needs. Done right, the exchange should be easy to use and should promote decreased health care costs. Insurance rates and benefit levels should be set by the insurance market and not by government regulations.

Washington State has 57 benefit and provider mandates that overlap the federal benefits. Ideally, an exchange should be able to offer an array of mandate-free or mandate-light insurance plans that satisfy market needs. Exchanges should not replace existing programs that work, such as association health plans.

Any subsidies in the exchange should flow to and be controlled by the patient. Tax credits or premium supports to purchase health insurance could also be offered in an exchange.

Each state should be able to function as a laboratory to design the most efficient, cost-effective exchange for small businesses and individuals with real choices and competition.

Thank you very much. I look forward to your questions.

Chairman COLLINS. Thank you, Dr. Stark.

Our next witness is Adam Beck. Mr. Beck serves as assistant professor of Health Insurance at the American College of Financial Services. Prior to his current position, he practiced law in Philadelphia, Pennsylvania.

Mr. Beck, thank you for appearing today, and you may now deliver your testimony.

STATEMENT OF ADAM BECK

Mr. BECK. Thank you, Mr. Chairman, Ranking Member Hahn, Members of the Subcommittee, for the opportunity to appear before the Subcommittee today.

Small businesses and the people who work for them, they combine together to constitute the backbone of the American economy. Health insurance is a tremendously valuable and often lifesaving financial product, which our tax code affords special status. And therefore, it is an important and essential goal to allow small business owners the opportunity to offer quality, affordable health insurance coverage to their employees.

The Small Business Health Options Program, or SHOP Marketplace, was designed by the 111th Congress to lower costs for small business, increase competition, and therefore, choice for business owners, and simplify the process of offering health coverage. These are laudable goals. However, it is my opinion that the SHOP Marketplace as it is currently structured and presented, falls short of these goals.

I believe that the SHOP Marketplace will remain inadequate and continue to enroll relatively few companies so long as three factors remain—the existing tax incentives, the lack of engagement of agents and brokers, and shortcomings in information technology infrastructure.

First, the tax incentives are too small, or indeed for most small employers, nonexistent. Without substantial and long-term tax credits, the cost of plans through the SHOP Exchange has been for most employers similar to the cost outside of SHOP and prior to the implementation of the Affordable Care Act. While most small employers have the desire to offer health coverage, the costs, both direct and opportunity, have been prohibitive for many. The Small Business Health Care Tax Credit created by the ACA does nothing to alleviate the cost burden for most employers. It is a complicated tax credit that is available only to a select number of very small businesses with few qualifying for the full 50 percent credit, and even then, they are only able to claim it for two years.

The Government Accountability Office estimates that up to four million small businesses could qualify for the credit, but this requires that the small business know about the credit and go through the difficult process of determining eligibility. Further, even by the GAO's own admission, advocacy groups identify that four million figure as the likely high point of potentially eligible businesses, with some estimating that as few as 1.4 million employers would qualify.

Data from the first year of the tax credit in 2010 indicate that the overwhelming majority of employees who are eligible for any credit were not eligible for the full credit. Only 17 percent, in fact, were eligible for that full credit. The greatest obstacle, according to

the GAO analysis, was the annual wage requirement. In the first year, 68 percent of businesses who received less than the full credit would have qualified for the maximum percentage based on the number of full-time equivalent employees but failed to qualify based on their wages.

Second, the SHOP Marketplace has not sufficiently engaged or compensated the agents or brokers who are so often the conduit to the small business community. Many brokers have encouraged their small group clients to consider purchasing plans off the SHOP Exchange because it requires about half the time of the broker and the compensation structure is the same whether the plan is on or off shop. States have required training of brokers to be SHOP certified, that many brokers have reported to be unhelpful and inaccurate. Overall, the SHOP Exchange has been very poorly marketed to both businesses and brokers alike.

Third, and hopefully most obviously, the delay by the administration of the federal-facilitated SHOP Marketplace and the accompanying website limited the ability of small businesses and the 32 states relying on the federal marketplace, but it also created confusion for business owners, brokers, and navigators in the states that had functioning shops. Additionally, states that were operating their own SHOP Exchange in 2014 experienced IT problems of their own that hindered enrollment.

I would compare the existing SHOP Marketplace to a new restaurant that despite offering some very good entrees, is struggling because of a poor location, minimal advertising, and prices that for many are simply too high. It has much potential but it needs much to change in order for that potential to be realized.

Small businesses want to offer health coverage. It simply needs to be more affordable, simpler, and facilitated by an experienced insurance broker. The Small Business Health Options Program has the potential to offer just that, but marketing, tax credits, information technology, and the agent-broker involvement need to be dramatically increased in order for the program to achieve wider popularity and demonstrate markers of success.

I thank you for the opportunity to testify, and I look forward to your questions.

Chairman COLLINS. Thank you, Mr. Beck.

I will now yield to Ranking Member Hahn so she can introduce our next witness.

Ms. HAHN. Thank you, Mr. Chairman.

It is my pleasure to introduce Jon Gable, the Senior Fellow at the National Opinion Research Center at the University of Chicago. He has more than 35 years of experience and is a nationally-recognized expert on the private health insurance and has authored more than 135 articles in scholarly journals. He is also an adjunct professor at the George Washington University in the Health Policy Department. He received an M.A. in Economics from Arizona State University and an A.B. in Economics from the College of William and Mary.

Welcome, Mr. Gabel.

STATEMENT OF JON GABEL

Mr. GABEL. Thank you. Thank you, Chairman Graves, Ranking Member Hahn, Members of the Committee. Thank you for the opportunity to discuss the promise and challenges of Small Business Health Options Program or SHOP. I am John Gabel, senior fellow at NORC at the University of Chicago.

NORC is an independent, nonprofit, nonpartisan research organization, whose mission is to conduct objective research in the public interests. The views I express are mine and not those of NORC.

Today, I will discuss factors promoting and inhibiting the success of SHOPs. Now, let me, given the time, I want to start off going through some graphics. So first, if you can turn to page four. What I want to point out—this is data from the Kaiser Family Foundation—that we are going through a period of price stability according to the Kaiser Foundation Survey. In fact, last year there was actually a decline in premiums.

Just a brief history of SHOPs and purchasing pools. Exchanges are not a new idea. Over the last 25 years, states attempted to build what was termed "health insurance purchasing co-ops" (HIPCs), but none enjoyed widespread success. Among the states to build HIPCs were California, Connecticut, Washington, Florida, Kansas, Colorado, and Kentucky. Connecticut got an 8 percent market share and that was considered successful. Massachusetts invested more than a million dollars in research and marketing in 2012–2013 and enrollment is less than 10,000.

I am going to allude later to the lessons learned of these earlier HIPCs, but just note that the authors of the ACA addressed many of these earlier shortcomings of the HIPCs.

Now, if you will turn now to number four, which is on page nine, this is a study we did for CCIIO. Here we compare the price of plans sold on the SHOP compared to those sold off the SHOP by the same metal tier. And what you see is the plans on the SHOP are lower cost than those off the SHOP. This may be due to narrow networks. This could be due to more nonessential benefits. But in any case, the costs are lower on the SHOP.

If SHOPs are to succeed where HIPCs fail, they must demonstrate added value over the traditional market. Shops can offer lower prices, tax credits not available off the SHOPs, wider employee choice, and a defined contribution that reduces the risk of future price increases. The authors of the ACA wrote into legislation provisions that would address major problems of earlier HIPCs.

Specifically, they made inside and outside the market played by the same underwriting rules. Administratively, CCIIO has tied large carriers to participate in the SHOPs. The promise of SHOPs is they operate under fair market rules. Prices on the SHOPs are lower than off the SHOPs. Lower prices are attributed to maybe narrow networks, but for employers seeking lower premiums, SHOPs are the place to shop.

Multiple carriers are participating in the SHOPs in all but one state. With the Employee Choice Model, employees can choose from multiple carriers and in some multiple tiers. Carriers on the competitive fringe of the small employer market, as well as nonprofit,

vertical, integrated organizations such as Kaiser Permanente see SHOPs as a way to build their market share.

If SHOPs and fully ensured plans are to survive, they must stand off threats by other insurance systems, such as self-insurance. To paraphrase Lincoln, a house divided cannot stand. Two insurance systems, one risk rated and the other not, will lead to a system with disproportionate share of bad risk and one with favorable risk. Such a system will live to the demise of the non-risk rated system.

I want to close with an observation from nearly 40 years of research. Many times I have written why are we making—may I proceed?

Many times I have written, why are we making such a big deal out of HMOs, PBOs, HRAs, and HSAs? They have only X percent enrollment. Why are we giving them so much attention?

All in due time became prominent insurance products, but it required many years of growth. So to paraphrase John Lennon, give SHOPs a chance.

I would be delighted to answer your questions.

Chairman COLLINS. Thank you very much.

Here is what we are going to do because our first vote series really does not end in nine minutes like that says. We have an extra 10, and I would like, in deference to Congresswoman Herrera Beutler, allow her to ask her questions, at which point we will adjourn for about 20 minutes. It is only two votes. And then Ms. Hahn and I will come back and continue.

So, I yield to Ms. Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Mr. Chairman.

I have a few different questions and thoughts.

I understand, Mr. Gabel, what you were talking about in terms of giving things a chance. I think some of the challenges that we are seeing in Washington State may allude to a bigger problem.

A little bit of background for folks. Washington State has called successful its implementation of ACA based on the number of individuals it has added to the Medicaid state roles. And regardless of whether or not you believe shifting from the private market to the Medicaid market is success or not, that is a separate issue.

On the SHOP-specific exchange, I am gravely concerned because we do have association health plans. We do have some other options for the small businesses who want to offer insurance, but those are being—I think the screws are being tightened on those in favor of the shops; yet, there is only one insurance provider in Washington State that partakes of the SHOP. And actually, it is only in two of the 39 counties. Next year, there will be one for all of the counties, and then those two counties may have a second option, but still that is a major, major challenge because, as you noted, premiums increasing, these small business owners do not have a lot of options except for push people into the individual market.

So I guess my first question I would like Dr. Stark to speak to, as you mentioned, the SHOP Exchanges were supposed to provide these business owners with choice and that was going to push down the prices. In my view, this has failed. The SHOP has failed. But what are you hearing from small businesses? Are you hearing

hopefulness? Am I being too critical? You are working with a lot of these folks.

Dr. STARK. Yeah, I do not believe you are being too critical, Congresswoman. Our two big business associations in the state of Washington are the Association of Washington Businesses (AWB) and the NFIB chapter there in Washington. And both of those organizations are in a watch-and-wait mode. I think the individual employers are looking to see will SHOP expand? Will there be choices? Will there be competition in the SHOP in the state of Washington? As it is now, as you alluded to, the association health plans are very popular in the state of Washington. The screws are being tightened on those. The qualifications are being tightened and a lot of business owners are very fearful that those are going to go away and they will be left with either putting their employees in SHOP or in the individual market. So there is a lot of concern on the part of small employers in the state.

Ms. HERRERA BEUTLER. What do you think if the association plans are on their way out and even for next year we do not really have much choice for the small businesses, what do you think is going to start to happen? What have you seen numbers-wise in terms of whether they are offering coverage, not offering coverage, or just closing down? Where are they supposed to go?

Dr. STARK. Well, we have three major employers in the individual market, or three major carriers in the individual market in the state of Washington, and so far none of those three have opted or elected to participate in SHOP, and we do not see them participating. Certainly, in 2015, it is doubtful; 2016 and 2017, they are going to have a product available for SHOP. So I think employers are going to be looking at either doing away with coverage and putting individuals—their employees in the individual exchange or the individual market, and I think that is probably the biggest option that they are going to—or getting out of the health insurance business completely.

Ms. HERRERA BEUTLER. Do you think that this is going to make it—so one of the things I heard I think from Mr. Gabel and from Ranking Member Hahn—I cannot remember everybody's titles—is that marketing could be a piece of this. It is my understanding that for the SHOP Exchange that the state has had about $1.4 million to market, and I think your numbers were 11 employers with 40 employees?

Dr. STARK. Yes.

Ms. HERRERA BEUTLER. How much would it take?

Dr. STARK. Yeah, I do not know. I am not a marketing person, so I really do not understand. I know our state exchange has been marketed fairly heavily, especially in the Medicaid population. We have been very successful at signing up Medicaid patients, but I am not aware of any big organized campaign on the shop aspect of the exchange.

Ms. HERRERA BEUTLER. So I wonder if that means that part of the goal is just to get folks—and my time is up—to get them out of group markets all together. But that is just for thought.

With that I will yield back. Thank you.

Chairman COLLINS. Thank you very much.

What we are going to do is adjourn for about 15-ish minutes, maybe 20. We will go and cast this vote and then when the second vote comes up, Ms. Hahn and I could quickly vote and be back up here. I apologize for that but it happens more than not and it is outside of our control.

So with that we will adjourn for about 15 or 20 minutes and then we will be back.

[Recess]

Chairman COLLINS. I call the hearing back to order.

So we will kind of jump into questions and I will ask some and then leave it to Ms. Hahn to ask a few, and then I may have some follow up, and she may have some follow up. So since this is a crazy day, I think we will take it from there.

So I guess, let me start with you, Director Alvarez. We have been trying very hard to get the hard data numbers from your group on how many businesses have signed up for the SHOP. Maybe the state exchanges and the federal, and how many—and we have not been successful. Is that data available yet? Do you have those numbers? And if not, when might we see it?

Ms. ALVAREZ. So just to provide some context, in 2014, small businesses had the opportunity to apply for coverage through the SHOP program, the paper application utilizing an agent and broker or directly through issuers. As a result of that, we are not the source of information as far as SHOP enrollment. CMS is not. We are working with issuers to get that information so that we can better understand the number of small businesses that enrolled in coverage through SHOP. And as soon as we get that information we will share it with you, as well as with the American public.

Chairman COLLINS. Is the same true of the state exchanges? Were they all paper-based or do we have data from the—what is it, is it 18 states that are providing their own? Do we have data from them?

Ms. ALVAREZ. It really does vary depending on the state. Some of them are working directly with issuers because they had a more manual process, while others are able to send numbers. As soon as we have a more accurate picture of what the enrollment in SHOP looks like, we will definitely give you that information.

Chairman COLLINS. There is a sign in my office. People actually take pictures of it, "In God we trust. All others bring data." It is the data that will tell the story. So to some extent now we are all supposing in doing that there is always a bias. The data takes the bias out of it, so I would encourage, certainly as you now move into the electronic piece and you are going to be rolling out your, across, what is it, five states, kind of an early enrollment piece?

Ms. ALVAREZ. Yes.

Chairman COLLINS. My concern has been, and I own a number of small businesses, is I sometimes think of the SHOP Exchange as a solution looking for a problem because the Chambers of Commerce across the United States did a marvelous job providing small businesses with health insurance—sole proprietorships and others. In fact, some would argue half the memberships at Chambers of Commerce signed up for the health insurance. And now that they are no longer in that, Ms. Alvarez, what would you say to those like me who would say we had an opportunity through the Cham-

bers of Commerce. It was working well and now we are into the SHOP Exchanges. Any comments there?

Ms. ALVAREZ. Definitely. It is important to consider that when we speak to small business owners, when I have talked to folks across the country, they want to provide coverage to their employees. They want the opportunity to give this as a benefit. And what we know is that we want to provide that opportunity through the SHOP program.

And when we talk about previous plans that were available to small businesses, we have to really talk about the quality of the coverage that the small businesses had access to and the risky environment that they were operating in. If one person got sick, premiums would go up. Sometimes if they needed hospitalization or treatment, it was not covered because it was not part of the defined package of services. What the Affordable Care Act is doing is providing access to health insurance coverage that is high quality, that provides a package of essential health benefits, that is going to be there when you need insurance the most. That is the reasoning behind ensuring that small businesses have access to these types of plans so that they know that their coverage will be there when they need it the most. Services like preventive care, hospitalization, emergency room care, cancer treatment. Services that we want and expect insurance to cover.

Chairman COLLINS. Sure. So what do you say to the patient who had a policy where their drug treatment for cancer was provided and now they have signed on to an exchange and it is not covered anymore and their formulary took it out? Or how about the person who was going to this hospital and all of a sudden under the restrictions of the insurance and the exchange, that hospital, they cannot go there anymore. Or their doctor is not in there. So I am just curious. Because I think you would agree there are cases where cancer coverage has been dropped from the formularies, hospitals have been dropped, and doctors have been dropped. Is that not an accurate statement?

Ms. ALVAREZ. I do not know the specifics of what cases you are referring to, Chairman, but what I can tell you is that what the marketplace has intended to offer is options for people.

Chairman COLLINS. Intended.

Ms. ALVAREZ. It does offer.

Chairman COLLINS. Okay. But you stated that they get all this coverage and I am saying that is just not so. I have had people call up and say, "I had my cancer drugs covered but now under Obamacare they have to provide prescription drugs but subject to their formulary." Am I wrong? I mean, does Obamacare require that every drug be covered under all the formularies?

Ms. ALVAREZ. Not every drug.

Chairman COLLINS. Right. So they dropped the most expensive ones.

Does Obamacare require that people can go to any hospital?

Ms. ALVAREZ. No, the networks vary.

Chairman COLLINS. Yeah. Sometimes so restrictive.

How about if you had your doctor you can keep it. Are all doctors in these plans?

Ms. ALVAREZ. The networks vary.

Chairman COLLINS. Yeah. In other words, it is, in many cases, a very bad day at the office when somebody comes home and says to their spouse, "We lost our hospital, we lost our doctor, and by the way, I just lost my cancer coverage."

So I think it is, again, the facts mean a lot, and I know you are sugar-coating it, but these have been very painful times for a lot of folks. As was pointed out, small businesses that had insurance, and you are right in saying in many cases without prescription drug coverage. What I have seen is prior to Obamacare, a lot of small companies with younger employees were able to provide that Affordable Health Care, and they did not offer prescription drug coverage. But in the younger populations, if most of your employees are under age 40, to a large extent that insurance was very affordable. Now all of a sudden, they have to provide prescription drug coverage so they lost all their insurance. So I would beg to differ with you when you again put this happy face on it.

If I am 35 years old with a young family and I have health insurance and now because the new policy I have to have has prescription drug coverage, which my family does not need because antibiotics are generic, a lot of pharmacies give them away for free. Most high blood pressure is generic now. Lipitor equivalents are generic now. That was not a good day for folks to come home and say I now have no insurance.

I guess maybe, Dr. Stark, I would ask you to comment on my—that is my bias but I have had it come firsthand—if you have heard similar things.

Dr. STARK. In the state of Washington, for example, we know at least 290,000 people lost the insurance plan they were on. We have no idea how many of those people then went into the individual exchange or how many people signed up on the individual market or went without insurance. So no, it is a significant issue, at least in the state of Washington; certainly nationally as well.

Chairman COLLINS. The other thing I have seen is higher deductibles. I have seen deductibles go up. So I guess, Director, when you talked earlier about small businesses now are comfortable now that they are not going to be penalized for having more women than men, they are not going to be penalized for having an older workforce, is that really true? Are you telling me that any company anywhere with a bunch of 65-year-old employees is going to pay the same insurance as somebody with 22-year-olds?

Ms. ALVAREZ. So premiums may vary, but they may vary only on a set number of factors. Age is one of them, but it is limited to three to one. Prior to the Affordable Care Act, older adults could pay 10 times more than a younger adult, so now we are limiting what that difference can be, as well as geographic area, and tobacco.

Chairman COLLINS. So men-women is not part of that anymore?

Ms. ALVAREZ. That is correct.

Chairman COLLINS. All right. But I know I have seen and heard where three to one is fine until they increase the individual, the younger. They increase the younger so that they are still getting the same on the older as opposed to keeping the younger the same. I mean, have you heard or seen of folks where the young are

being penalized now? Their premiums are going up more than ever?

Ms. ALVAREZ. I think it is important to consider what the health insurance market looked like before the Affordable Care Act. You saw health insurance premiums going up by double-digit increases, and no one had an understanding of why. What the Affordable Care Act does now is yes, insurance premiums can go up, but they are going up at a slower rate. In some states they are going down.

Chairman COLLINS. So is 20 percent a low rate?

Ms. ALVAREZ. It varies. Congressman, it varies.

Chairman COLLINS. There are 20 percent increases being announced all over because—well, let me again, what you know or may not know, is it not true that a lot of small businesses last year renewed their policies in October to lock in premiums last October where they were not subject to many of the mandates but now this October, as in a couple of weeks, they are getting their renewals and their renewals now compared to what they had are up 20 percent, 28 percent?

Ms. ALVAREZ. And the opportunity exists to have additional options in the marketplace. That is what the marketplace has intended to do, provide small businesses a choice. We have some preliminary information on 2015 rates for small businesses, and what we are finding is that there is going to be a decrease or only a modest increase in those premiums.

Chairman COLLINS. That is not so. That is just not so.

Ms. ALVAREZ. That is based on the preliminary information that we have, so we are happy to share that once it is available.

Chairman COLLINS. Once it is available.

Again, I mean, you are providing this without any data to support it. The data that we have supported is in New York State. Now, New York State is running its own exchange. All over the place, there is 18, 22, 24 percent increase for these companies all over the place. That is hard data. That is published data.

So again, I am just pointing out in my opinion, and we can agree to disagree, this whole SHOP experience is a solution looking for a problem. Small businesses that wanted to provide coverage, we are providing it. And granted, in many cases, perhaps not with prescription drug coverage, but that made it affordable. Now the easy thing for a lot of small businesses is just push people out, cancel it, and to some extent say, you know, go into the individual exchange.

Mr. Beck, I just wonder what experience—I am sharing some of mine. I am just wondering if you have any similar——

Mr. BECK. Well, the experience that I have seen speaking with independent agents and brokers from across the country is that a lot of them are concerned that they will lose their small group clients. I think from a policy perspective, the question then becomes is that such a bad thing for the marketplace or for the employees if they had previously had small group coverage and now are encouraged or even incentivized through their payroll to then go on to the individual exchange where they can—statistically they would have a likelihood of qualifying for tax credits. But I do definitely hear from agents and brokers that small group clients are nervous.

I think a lot of the early renewals had to do with uncertainty as much as they had to do with concerns about having to cover the 10 essential health benefits, but whether it is because of the SHOP Exchange or simply despite the SHOP Exchange, I think the nature of the small group market is going to change, and that probably has more to do with the availability of the individual marketplace with the tax incentives than it does anything else.

Chairman COLLINS. Thank you. I think I will reserve additional questions so we can hear from Ms. Hahn. And also, I think I saw Mr. Luetkemeyer get here, so Ms. Hahn.

Ms. HAHN. Thank you, Mr. Chairman.

Again, I think it is important to remember what our health care system was like before Congress passed the Affordable Care Act. It was a broken system. And fortunately, many of those folk were offering insurance plans that were bad plans. They did not cover what was needed. Many times you think you are young and you do not need certain prescription drugs or certain coverage, and you do not know what is going to happen. That is why it is an insurance plan. I do not think any of us can foretell what is going to happen to us, but we know a lot of people were wiped out financially in this country, many small businesses, because of a couple of catastrophic illnesses, bad accidents, unforeseen health challenges, and that is what Congress was attempting to fix with the Affordable Care Act. And we know that now a lot of individuals, even who work for small businesses, have the choice to get insurance. Your insurance does not matter who your employer is.

I was one of those whose insurance was tied to my employer and when I was laid off by a financial investment banking company, my only option was COBRA. And you want to talk about high premiums. I was a single mother at the time with three kids. It was impossible for me to pay that. So, and being a woman was a preexisting condition. And I know the communities I represent, you know, children have a higher instance of asthma because we live near big polluters in southern California, and many of those families could not get insurance because their kids already had a preexisting condition. So let us try to remember how bad our health care system was in this country. It was very much broken. And the Affordable Care Act is an attempt to remedy that.

Now, if there are places where we can do better, we should work together, you know, we should work together and try to do that. But certainly, wiping it away and going back to what we had is really not an option. And many people who have plans now that do not cover certain things, you know, those are plans that they chose. So these are plans people actually make the choice for, and you can look at all your options. You can line them all up, see what is available, see what the cost is going to be, and know. You never knew that before with insurance plans. You did not really know until you needed it whether or not it was going to be there for you.

So one of the things, Ms. Alvarez, I was going to ask, it was disturbing, Dr. Stark, to hear, you know, that a lot of insurance companies are not participating in the SHOP, and that is not good for consumers. We know that competition does drive down cost, and we know that is better. So I was going to ask you, what are you doing to ensure that insurance carriers do participate? How can we do a

better job? Is there something we can do here in Congress to encourage insurance companies to participate in the various SHOPs and exchanges?

Ms. ALVAREZ. We completely agree. We think competition does drive down cost for small businesses and individuals alike. And we are encouraged by some of the preliminary information we are seeing and participation in the SHOPs for 2015. Based on this preliminary information, we do anticipate that every state will have coverage in their SHOP market. And I do think it is a continual improvement process. The first year had some issues. The second year we are working on those issues and improving them, such as adding online functionality come November 15th, and that is the process of setting up this program, ensuring that we are learning from the lessons that we experience and improving for the next year. So 2015 is going to have online functionality come November 15th. We will learn valuable lessons this year and we will make it even better in 2016 and 2017. But yes, I agree that we are looking at better competition for small businesses across the country with greater participation by issuers.

Ms. HAHN. And just to follow up on that, do you think that is a long enough period to launch in October in five states and then in November a full launch? Is that enough time for us to look at this pilot launch and learn and make enough changes if need be? Is that a long enough time?

Ms. ALVAREZ. So just to clarify, we have done all of the necessary security testing and end-to-end testing in order to have a nationwide launch come November 15th for online functionality of the SHOP program. What we are doing at the end of October is providing early access to five states and, based on their market, based on on-the-ground agent and broker participation and a network of small businesses to give us their feedback of what the SHOP online marketplace looks like. They will be able to upload their employee roster, fill out an application, get an eligibility determination, and be able to access that website and identify any glitches or issues that we can then turn around and address for November 15th.

And, coupled with that, we are reaching out to agents and brokers to ensure that they have the opportunity to access a new portal that is established for agents and brokers to, again, be able to fill out their information so small businesses can assign themselves to this agent and broker, and be able to monitor activity once open enrollment begins. It is intended to identify any last minute glitches or issues so that we can be ready when we launch nationwide on November 15th.

Ms. HAHN. Right. Because we cannot afford another bad rollout of this.

Mr. Gabel, I was just was going to—it looked like you wanted to respond earlier, which you are welcome to do. But I know you sort of talked about some of the features, like getting one bill, writing one monthly insurance check, comparing plans that were positive benefits. Did not know if you could give us some more of your findings that you are hearing that are positive benefits from SHOP Exchanges.

Mr. GABEL. Okay. Just for the record——

Ms. HAHN. Is your mic on?

Mr. GABEL. Just for the record, we studied 26 states. Washington is the only state with one carrier. Some states, like Maryland, have 10 carriers. There are too many—it is in my testimony—too many have two carriers, but Washington is not typical.

And also, for the record, about 45 percent of small employers do not offer coverage, but that number is not declining. That number stayed relatively constant over the last couple of years. So, so far we do not see a movement towards individual exchanges.

What we can say, we did a survey for the Commonwealth Fund, and it is in my testimony. We asked small employers what you are looking for, and what we found was many of the attributes of SHOPs are what small employers are looking for. For example, if you will go to page seven, you have about 41 percent say it is very important to have more plans choices, and 34 percent say somewhat important. Ability to compare plans, 68 and 23 percent. That is very important. These are firms offering coverage. Having a third-party payer as a go-to or to answer questions, that is very important to about 40 percent roughly. And even for firms that do not offer coverage, the most important item basically is—well, two items—costs less than it does today. And as I showed you, the SHOP plans cost less than the plans off the marketplace. And another one is sick employee will not increase the cost.

Being a small employer in the pre-ACA days was a risky business because you never knew if you are offering coverage now and all of a sudden one of your employees gets cancer and then the next thing you know nobody wants to ensure your group. Or they will give you a prohibitively high premium. So I think those are aspects that will appeal to small employers.

Now, let me just also say the history of—this is not a new concept. Health insurance purchasing pools were really thought of as the solution back in the late '80s and the '90s, and a number of states sponsored them. But nobody had succeeded. But the way the SHOPs are organized, they have addressed some of the problems that the previous health insurance exchanges faced and could not overcome.

Ms. HAHN. Thank you.

Chairman COLLINS. Thank you, Ms. Hahn.

I would like to yield to Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Mr. Chairman.

I would like to read to you a little statement from the folks that own and operate an animal hospital close to where I live. This particular business has nine employees and they say, "I am skeptical about whether the Affordable Care Act will help my employees in the long run, but the rollout is such a mess it may cost me thousands of dollars extra in the first couple of years. I am required to enroll in the SHOP program, not just an ACA-compliant program, which I already am enrolled in. Or I may stand to lose the tax credit. The problem is the laws change on a weekly basis so even the insurance companies cannot tell me what to do in advance to ensure I will make the correct decisions. The worst case scenario is I will lose the tax credit and my employees will lose their employer-provided health care. I am spending hours and days trying to figure out what the best route is to take, but as mentioned

above, no one has the answers to what I need to do to make the best business decision. At this point, I am planning on sticking with the plan I recently enrolled in after hours of research by myself and my financial advisors and let the government tell me later whether this is the correct plan or not."

This is the dilemma that many of my small business folk have. And so the question I have for you, Ms. Alvarez, is will the temporary or limited tax credit be available to businesses outside the SHOP Exchanges in a situation like this gentleman due to the delay online and/or when the administration starts allowing or continues to allow certain individuals to obtain the taxpayer subsidies outside the individual exchange?

Ms. ALVAREZ. The tax credit is available for SHOP plans that are available through the SHOP Marketplace.

Mr. LUETKEMEYER. So if he shops outside it, he does not get it?

Ms. ALVAREZ. It depends, honestly. For the state of Washington, in the first year of enrollment in the SHOP program, we actually worked with Treasury to ensure that small businesses in the state of Washington still had access to the tax credit.

But one important point of clarification is that no small business with less than 50 employees is required to offer coverage to their employees. The SHOP program is intended to provide options for small businesses if they want to provide their employees coverage.

So for this veterinary hospital, while I do not know the specifics, I would want to clarify to them that they are not required. But I would expect that, like many small business owners, they want to offer this coverage and we want to get them answers to the information that they need. So we have a dedicated SHOP call center to provide answers. We have many partners on the ground willing and able to answer those questions, and we are more than happy to work with you, Congressman, to get them that information.

Mr. LUETKEMEYER. Okay. Next question, HHS and IRS decided last year that employees could no longer provide tax-free contributions to standalone reimbursement arrangements so that employees could purchase their own individual coverage. There are a lot of employers that use this that cannot afford to pay full insurance but they will pay $100, $200, $300 per employee per month or per week, whatever their pay period is, to be able to do that. The continuous arrangement will result in $100 per employee per day penalty, and many folks are not aware of this strict fine. Do you not think that the SHOP program should be encouraging innovation like this to be able to make and support the employers to be able to help their employees afford health insurance rather than penalize them?

Ms. ALVAREZ. What the SHOP program is doing is giving options to small businesses to have access to quality, affordable coverage. What I think you are referencing is the Department of Treasury rule.

Mr. LUETKEMEYER. Right. HHS and IRS——

Ms. ALVAREZ. Right.

Mr. LUETKEMEYER.—together made the decision.

Ms. ALVAREZ. And the understanding for the SHOP program is intended to provide those options for small businesses. Before the Affordable Care Act, whatever available health plan——

Mr. LUETKEMEYER. So with the SHOP program they can pay only part of the premium?

Ms. ALVAREZ. They have to be willing to pay at least 50 percent of the cost of coverage.

Mr. LUETKEMEYER. Okay. So if they have 10 employees and they pay the cost per employee is $300 a month and they pay $150, they are okay is what you are telling me?

Ms. ALVAREZ. I am sorry. Say that one more time.

Mr. LUETKEMEYER. Okay. If the cost of the program is $300 per month per employee, and they then pay $150 towards that, that is okay? The employee picks up the rest?

Ms. ALVAREZ. If you are using "program" as the key word for health insurance available through the SHOP program, yes. What we are trying to do is incentivize small businesses who are offering coverage to their employees, and that is done so through this tax credit. It is worth up to 50 percent of the cost of coverage for these employers that are contributing to employees' coverage. And that is available. It has been available since 2010 at 35 percent. It is going up to 50 percent, and we will know more information about how many small businesses took advantage of this opportunity soon.

Mr. LUETKEMEYER. Published reports have got that the president has waived a lot of different businesses from having to have business coverage for their employees. Can you tell me the basis for those waivers?

Ms. ALVAREZ. What we have been able to do is provide flexibility to employers that may not have been ready to transition into this market. And that is what we have been doing based on feedback from businesses. That is what we are trying to do with implementation, is be able to better understand and reflect the needs of Americans where possible with implementation of the law. Through the health insurance marketplace, it was up and running in 2014, and millions of people were able to have coverage as a result of it. Today, we announced that 7.3 million people were enrolled in coverage and paid their premiums.

Mr. LUETKEMEYER. Can I ask that question again? Because I am not getting an answer for it.

I asked the question, on what basis were the waivers given by the president for certain businesses?

Ms. ALVAREZ. It was based on our authority as the assigned departments to implement the law.

Mr. LUETKEMEYER. Okay. You were able to do it based on the authority, but what was the basis for the decision on why certain businesses got the waiver and other businesses do not get the waiver?

Ms. ALVAREZ. Implementation of this complex law requires a lot of stakeholder engagement and feedback and that is what we listened to. And looking at the different provisions, where we had flexibility, based on our authority, we were able to do so.

Mr. LUETKEMEYER. So the business had to come in to you and make a case that we cannot afford this? Or it is going to bankrupt

us? Or I cannot compete anymore with my competitor? What was the basis for the decision?

Ms. ALVAREZ. Sir, the conversations with the secretary and leadership are not ones that I am privy to.

Mr. LUETKEMEYER. Yeah, but you are administering the program; right?

Ms. ALVAREZ. I can tell you that the changes that were made to the program——

Mr. LUETKEMEYER. So what were some of the businesses that were waived and why did they get those—you do not know why they were given the waivers?

Ms. ALVAREZ. It was done in order to be flexible with implementation and to be responsive to the needs of the market.

Mr. LUETKEMEYER. But you do not know the basis of the waiver?

Maybe she knows the basis of the waiver.

Ms. ALVAREZ. I can definitely get back to you with that information.

Mr. LUETKEMEYER. Oh, Mr. Chairman, Mr. Chairman, another day at the capital.

I yield back.

Chairman COLLINS. Thank you, Mr. Luetkemeyer.

We will now yield to Mr. Schneider. Five minutes.

Mr. SCHNEIDER. Thank you. Brad Schneider from Illinois.

I want to thank the witnesses for being here. I appreciate your input and time.

The Affordable Care Act is often a contentious issue, but I think many of us on the Committee can at least agree that the issues small businesses are facing, have been facing in the marketplace, are difficult. Cost was not the only rising—was not only rising at unsustainable rates for small businesses and employees, but it was also proving to be an efficient and effective coverage that many businesses and individuals working in those businesses were receiving.

Both of these problems have the effect of ultimately stifling economic growth and putting businesses and individuals unnecessarily at undue risk. I know that in the early '90s we were seeing double-digit increases routinely in my insurance agency. The SHOPs take steps to address these issues, but clearly the implementation has not been perfect.

I guess Director Alvarez or Dr. Stark, maybe to one of you, Dr. Stark, in your testimony you indicated that when the plan was introduced, when SHOP plans came online, there were upwards of a million potential businesses, but so far only 170,000 recipients took the tax credit in 2011. Delivery has been inefficient. With an estimate so much higher, what can we do to streamline the process to make it more efficient to help these small businesses take advantage of the SHOP?

Dr. STARK. I think there is a broader answer to your question, or maybe it should be a broader question, and that is what should the employer-employee model really look like? Is the SHOP an effective way really to provide the sort of health insurance that employees need?

First of all, it is unclear that employers should be in the health insurance market. Traditionally, they are. They have been since the mid-1940s. Should that be the model for the country? And quite frankly, I do not think it should be.

So then the second part to your question is, well, what can we do with SHOP? Well, again, if you really want to help employers, then you have to increase the competition and you have to increase choices that they are going to have in SHOP, and you have to get away from the 10 essential benefit mandates that really make every product sold in SHOP exactly the same. You have to get away from government pricing, which really limits what insurance carriers can charge, and I think that is the answer to it. Set up an exchange that is transparent, that offers people an array of products that they can use.

Mr. SCHNEIDER. Dr. Alvarez? Or Director Alvarez? I am sorry.

Ms. ALVAREZ. The biggest problem, I think, with that approach would be adverse selection and the fact that people that need more services are going to select the plans that have more services, and it will be more expensive for them. And that is not leveling the playing field for Americans across the country. What the Affordable Care Act does, with the essential health benefits package, is just that. Insurance has to pool risk. There have to be people who are sick and people that are healthy coming together in a pool in order to balance it out and have better access to competition which drives down cost. But that is the expectation because no one knows what is going to happen in their life, if there is going to be a car accident or a serious diagnosis or if we are going to need prescription drug coverage sometime. We do not know. We do not know what tomorrow holds for us, and insurance should be there when we need it the most. That is the premise.

Mr. SCHNEIDER. So, Mr. Gabel, I think you touched on this. By definition, small businesses do not have the numbers to pool risk to get the benefit of the law of large numbers. What are your thoughts?

Mr. GABEL. Most definitely, they do not. And I believe that you have to have a minimum benefit package because without a minimum benefit package, let us say all the people who do not think they have mental health problems will not have mental health benefits, and they will not cover it. And they will not cover it. Whereas, those with mental health benefits, people with mental health benefits will go in. This has happened historically. This will most definitely occur.

I do want to say this. The average plan before the ACA of a small employer was a little bit less than .80 or .79, something like that. So this is not like the individual market. Before the ACA, the individual market, 50 percent of the plans did not meet the actuarial .6 threshold.

Mr. SCHNEIDER. Okay.

Mr. GABEL. Most, almost all the small employer plans in the country had a .6 actuarial value before.

Mr. SCHNEIDER. Great. Well, thank you. I am out of time so I will yield back.

Chairman COLLINS. Okay. I guess to finalize where we are, maybe a couple of questions then, I guess.

Dr., or Director Alvarez, I am assuming the government has provided funding to the states, however many that is, the 18 or so states that are creating SHOP Exchanges. I am assuming that is correct. Can you tell us how much has been spent towards the SHOP Exchanges in those 18 states?

Ms. ALVAREZ. I do not have the specific figures in front of me, but just one point of clarification, Congressman. What we have done is give establishment grants to state-based marketplaces. We have not given specific money for the establishment of a SHOP Marketplace. It is related to the establishment of the state-based marketplace. And as one of their requirements of operating a state-based marketplace, it is also operating a SHOP.

Chairman COLLINS. So let us go back to the data piece. Now, today, Administrator Tavenner did say 7.3 million folks, individuals have enrolled in health plans. Are any of those SHOP enrollments or are they all on the individual side?

Ms. ALVAREZ. They are all on the individual market.

Chairman COLLINS. So we still do not have any numbers on the SHOP?

Ms. ALVAREZ. We are working to get that information for you.

Chairman COLLINS. Well, and so let me just conclude by encouraging anyone and everyone in your arena to get the data because I know as a business guy, I cannot even imagine flying blind the way we are. We would like to answer the question, how many businesses are taking advantage of it? How many employees are taking advantage of it? What is the cost? And then once you have got that benchmark, you can go quarter-to-quarter, month-to-month, because on the SHOPs they can sign up every month, so it is not like a snapshot which we may have on the individual, that anything we could do to have that data will let the taxpayers understand how their money has been spent. And without it there is a frustration that I have and others where we are supposing things. And I think you understand that frustration. So if you could just let us know, and sooner than later where we are.

So I was just wrapping up. I did not know if you had anything else to add or not, Ms. Hahn?

Ms. HAHN. No. Just thank you to all of you for coming and expressing your concerns. Director Alvarez, I really appreciated and was impressed by your knowledge of the situation and your ability to clarify and illuminate for us what the intended purposes are of the Small Business SHOP Exchange. And again, I would reiterate my opening comments that certainly we have already found out things are not perfect, but I am dedicated to and committed to, and I hope my friends across the aisle are as well, to fixing what we think needs to be fixed because ultimately I think this is a good law and a lot of it I think has helped we already know millions of Americans. So thank you for being here today.

Chairman COLLINS. I also would like to thank everyone for appearing and just concur that this health care debate is going to be continuing for some time to come. And the more data we have, the better the context can be. We do not have to talk over each other. The debate should be on the data, which then will lead us to see where we are going.

And I would like to point out though, I am a small business owner, and I probably visit in any given week when I am back in the district, 15 or 20 small businesses. And I can tell you universally that the biggest problem they bring up is Obamacare. The mandates on hours and the fact that they are cutting workers' hours to 28 hours, and I hear this prescription benefit cost which can be 25–30 percent, the cost of insurance, and some of these folks with young employees do not have any need for it. So what we are doing is penalizing the young and the healthy in order to provide for the old and the sick, and I understand that balance, but let us face it, the young and the healthy are not signing up at anywhere near the percentage that was put out, and partly as a result we are now seeing some of the costs go up because they have got a year of data and the young and the healthy were not there for it.

Ms. HAHN. May I just add one thing?

Chairman COLLINS. Sure.

Ms. HAHN. I also visit lots of small businesses in my district in Los Angeles. I have business roundtables all the time I make it a point to walk into, and universally, the biggest concern that my small businesses have are not with health care but with the economy. They want more customers, and their access to capital. Many of my small businesses, particularly my women-owned and minority-owned businesses, want to find out how they can access small business loans so that they can grow, expand, and hire people. That is what I hear universally.

Chairman COLLINS. We could have a whole discussion about Dodd-Frank and what that has done to the economy, but we will not be there today.

So again, you have all provided valuable insight and I appreciate your attendance.

I will ask unanimous consent that members and the public have five legislative days to submit supporting material into the record. And hearing no objections, so ordered.

The hearing is now adjourned.

[Whereupon, at 2:51 p.m., the Subcommittee was adjourned.]

APPENDIX

STATEMENT OF

MAYRA E. ALVAREZ

DIRECTOR, STATE EXCHANGE GROUP
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

AN UPDATE ON THE SMALL BUSINESS HEALTH OPTIONS PROGRAM: IS IT WORKING FOR SMALL BUSINESSES?

BEFORE THE

U. S. HOUSE COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON HEALTH AND TECHNOLOGY

SEPTEMBER 18, 2014

Statement of Mayra E. Alvarez on

"An Update on the Small Business Health Opti8ons Program: Is It Working for Small Businesses?"

U.S. House Committee on Small Business Subcommittee on Health and Technology

September 18, 2014

Chairman Collins, Ranking Member Hahn, thank you for the opportunity to discuss the many benefits that the Affordable Care Act is providing for small businesses. The Affordable Care Act has improved the insurance market for small employers, making it easier for them to find and purchase employee health coverage. Qualified small employers can now purchase coverage for their employees using the Small Business Health Options Program (SHOP), and small businesses are receiving a more generous tax credit in 2014 for offering their employees a qualified health plan through the SHOP in their states. Small employers will see even greater options this fall when the online functions of the Federally-facilitated SHOP Marketplace, and those of many state-based SHOPs, become available on November 15.

In the past, although many small employers have wanted to offer health benefits to their employees, they have faced many challenges. Historically, small businesses have been charged 10 to 18 percent more for the same benefits compared to large employers.[1] Small businesses employing women or workers with chronic or high-cost illnesses, or with pre-existing conditions, have faced higher insurance rates in most states. Because small firms have fewer employees to pool than larger firms, premiums varied dramatically from year to year due to changes in just one or two workers' health status or because of small changes in the ratio of male to female employees. The Affordable Care Act limits the factors insurers can use in determining what they charge small business and thus helps provide small businesses more predictable rates. In doing so, the law helps small employers provide their employees with high-quality, affordable health care coverage that cannot be priced so high that it's out of reach for businesses just because someone gets sick.

Affordable Care Act Implementation: Building on Progress in Affordability, Access and Quality

A new wave of evidence shows that the Affordable Care Act is working to make health care more affordable, accessible and of a higher quality, for families, seniors, businesses, and taxpayers alike. Thanks to the Affordable Care Act, consumers today enjoy better access to affordable health coverage, stronger protections in the case of illness or changes in employment, and a competitive

[1] *http://www.commonwealthfund.org//media/Files/Publications/In%20the%20Literature/2006/May/Benefits%20and%20Premiums%20in%20Job%20Based%20Insurance/Gabel_benefitspremiumsjobbased_925_itl%20pdf.pdf*

Marketplace that allows them to choose from and enroll in insurance coverage that is right for them. Millions of people—including many of the self-employed—have obtained private insurance coverage in the Marketplace, over seven million children, families, and individuals have gained coverage through Medicaid and CHIP, and more than three million young adults gained or retained insurance under the Affordable Care Act by staying on their parents' plan.

Recent years have seen historically low growth in overall health spending, and a variety of recent data show that very slow growth in health care costs is continuing.[2],[3] In fact, just last week, the Kaiser Family Foundation and Health Research and Education Trust reported the premiums for small businesses rose by just 1.7 percent from 2013 to 2014, the smallest increase since the organizations' survey began in 1999.[4] These increases are far below the double-digit increases small businesses experienced in the decade before the Affordable Care Act was enacted.

Several recent reports make clear that the Affordable Care Act is reducing the uninsured rate. A study published in the *New England Journal of Medicine* found that, as compared with the baseline trend, the non-elderly uninsured rate declined by 5.2 percentage points by the second quarter of 2014, a 26 percent relative decline from the 2012–2013 period, corresponding to 10.3 million adults gaining coverage.[5] These independent surveys point to the same overarching trend—the success of the Affordable Care Act in lowering the number of uninsured Americans.

The Affordable Care Act benefits Americans broadly, not simply those who are newly insured. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 16 to stay on their parents' insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance when someone gets sick. Preventive benefits, including wellness visits and certain cancer screenings with no cost sharing, as well as new incentives to pay doctors and hospitals for improving outcomes, are aimed at improving the quality of the health care that Americans receive. Now pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose their current coverage, they can purchase affordable coverage through the Marketplace—regardless of their personal health history—or have access to Medicaid in many states. Small business owners can be assured that they will not face wide variations and high volatility in premiums based on the type of work they do or the health status of their workers.

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[2] Council of Economic Advisers. 2014. "Recent Trends in Health Care Costs, Their Impact on the Economy, and the Role of the Affordable Care Act." *Economic Report of the President,* http://www.whitehouse.gov/sites/default/files/docs/erp_2014_chapter_4.pdf

[3] Jason Furman. "Good News on Employer Premiums Is More Evidence of a Dramatic Change Economic Change for the Better," *http://www.huffingtonpost.com/jason-furman/good-news-on-employer-pre_b_5798244.html*

[4] http://kff.org/report-section/ehbs-2014-section-one-cost-of-health-insurance/

[5] New England Journal of Medicine, Health Reform and Changes in Health Insurance Coverage in 2014.

The Affordable Care Act's reforms are effective because they have benefits across the health care system. Reductions in the uninsured rate should mean doctors and hospitals provide less uncompensated care, a cost that is often passed along to taxpayers, as well as consumers and employers who pay premiums for health coverage. And new pools of people buying insurance means insurers have an opportunity to grow by competing to provide better access to quality, affordable choices—the same advantages that consumers are used to in any competitive marketplace. The creation of a viable health insurance market benefits all Americans, no matter where they get their health insurance.

Small Business Health Options Program (SHOP)

The Affordable Care Act established the Small Business Health Options Program (SHOP) to make it easier for small businesses to obtain health coverage for their employees. Just as in the individual Marketplaces, the SHOP allows small businesses to easily compare and select plans that meet the needs of their employees. In 2014, the SHOP opened to small employers with 50 or fewer full-time equivalent employees. In 2016, the program will be open to businesses with 100 or fewer full-time equivalent employees. It is important to remember that unlike the individual Marketplace, eligible employers can begin participating in the SHOP at any time, and are not limited to a single open enrollment period. Just as they always have, small employers may purchase coverage for their employees throughout the year.

This past year, small employers have offered coverage to their employees through the Federally-facilitated SHOP Marketplace by receiving an eligibility determination from the SHOP, and enrolling in coverage through an agent, broker, or issuer. Some of these employers have also been able to claim the small business health care tax credit, which can cut their premiums by as much as 50 percent. Since August 2013, small employers have been able to contact a dedicated call center with questions about the Affordable Care Act and Federally-facilitated SHOP enrollment. HHS also added new small business online tools to HealthCare.gov earlier this year, including a consumer-friendly small business health care tax credit estimator that helps small employers determine if they qualify for the small business health care tax credit and how much it could be worth for a small employer.

Consistent with state law, agents and brokers are playing a vital role in the SHOPs, as they do in the small group market today. Agents and brokers act as trusted counselors, providing service at the time of plan selection and enrollment and customer service throughout the year. For the 2014 plan year, more than 79,000 agents and brokers trained to assist consumers in the Federally-facilitated Marketplace—including many who completed the SHOP-specific course. The SHOP Call Center is also available to help agents, brokers, Navigators, and other Marketplace approved assisters specifically working on behalf of small employers in states participating in the Federally-facilitated Marketplace.

HHS has worked to create a seamless online experience and add key new features for the Federally-facilitated SHOP Marketplace in 2015. New features include offering employees a choice of health plans, premium aggregation services, and a dedicated online system for licensed agents and brokers to assist their SHOP small business clients. Starting November 15, the online Federally-facilitated SHOP Marketplace on HealthCare.gov will offer new health coverage options to small employers with one to 50 employees, and make it easier for them to shop for, select and offer employees high quality health plans and dental plans, and allow employees to enroll online.

SHOP Early Access

As we move to expand online functionality for the SHOP this November, CMS is committed to acting on lessons learned and continuously improving the user experience. Thus, small employers, agents and brokers in five states—Delaware, Illinois, New Jersey, Missouri, and Ohio—will have the opportunity to experience key features of the new online SHOP Marketplace on HealthCare.gov, in advance of the full SHOP Marketplace launch nationwide on November 15. During "SHOP Early Access", small employers in these states will be able to establish a Marketplace account, assign an agent/broker to their account, complete an application, obtain an eligibility determination, upload their employee roster, and—when available in early November—browse available plans and pricing. Beginning on November 15th, small employers in these states and others participating in the Federally-facilitated SHOP will be able to complete their plan selection and enrollment and offer coverage to their employees that takes effect as soon as January 1, 2015.

Early Access will also allow for targeted consumer testing with small businesses, agents, brokers, and assisters before the SHOP functions are made available online in all Federally-facilitated SHOP Marketplace states. This consumer testing will add to the rigorous performance testing completed on the core software product and interfaces prior to Early Access and go-live.

SHOP Employee Choice

We are also making important progress in offering small business employees additional choices for their health coverage. In the past, most small employers were only able to offer a single health and dental plan for all of their employees. Now, through the "employee choice" option, small businesses in many states will have the option to allow employees to choose any health plan and dental plan available at the coverage level selected by the employer. Employee choice provides significant benefits to both employers and employees. It can lessen the administrative burden on employers and allow employees to select the plan that best fits their individual and family circumstances. Additionally, in 2015, all employers participating in the Federally-facilitated SHOP Marketplace will make their monthly premium payments directly to the SHOP Marketplace, which will disburse payments to all of the different

plans selected by employees when employee choice is offered, thus further reducing administrative hassle for employers.

In addition to expanding choices for consumers, employee choice has the potential to facilitate greater market competition in states—making it possible for smaller, less established issuers to break into small group markets and encourage all small group market issuers to compete based on price, customer satisfaction, and other quality measures.

HHS is aware that small business markets differ from state-to-state. To help smooth the transition to employee choice, HHS has allowed State Insurance Commissioners to request that the SHOP in their state defer implementation of the employee choice provision in 2015 if, in the Insurance Commissioner's expert judgment, doing so would be in the est interests of small employers and their employees and dependents. HHS is committed to implementing employee choice in a way that learns from early experience and ensures success. In total, 14 states with a Federally-facilitated SHOP Marketplace plus most State-based SHOPs will make employee choice available to small businesses in 2015, doubling the number of states offering this option. In 2015, nearly two-thirds of Americans will live in states where small business employees could be offered the option to choose a health plan rather than have their employer do it for them.

Small Business Health Care Tax Credit

In addition to choice, we know how important affordability is. The Affordable Care Act created the Small Business Health Care Tax Credit to help small employers of lower wage workers afford a significant contribution towards workers' premiums. An employer may qualify for a tax credit if it has fewer than 25 full-time-equivalent employees making an average of less than $50,000 a year (as adjusted for inflation beginning in 2014). To qualify for the Small Business Health Care Tax Credit, an employer must also pay at least 50 percent of the premium cost of employee-only coverage for each of its employees. For tax years starting in 2014, the tax credit can be worth up to 50 percent of for-profit employer's contribution towards employees' premium costs and 35 percent for non-profit employers, and is generally available only when employees are enrolled in SHOP coverage. The 2014 maximum credit amount for the Small Business Health Care Tax Credit is a significant increase over the maximum amount for the credit from 2010–2013, when it should be worth up to 35 percent of employer-paid premium costs, or 25 percent for tax-exempt employers. Since the Small Business Health Care tax credit first became available in 2010, it has provided hundreds of thousands of small businesses more than $1.5 billion in tax credits.

Conclusion

In conclusion, for too long, small business owners have struggled to keep up with the ever-rising cost of health insurance for their employees. The Affordable Care Act makes it easier for businesses to find better coverage options and builds on the current employer-

based insurance market. The SHOP, combined with new insurance reforms and tax credits provided by the Affordable Care Act, gives employers new options to provide their employees with high quality, affordable health care coverage. I look forward to continuing to work with you to improve the health care options for America's small businesses, families, and communities, and am happy to answer any questions you may have.

Testimony of Roger Stark, MD, FACS

House Small Business Subcommittee on Health and Technology

September 18, 2014

The Small Business Health Options Program

Background

The Patient Protection and Affordable Care Act (ACA) became law in 2010. The law is based on an individual mandate that requires every adult to own health insurance and an employer mandate that requires every employer with 50 or more full-time employees (FTEs) to provide health insurance to their employees.[1]

Under the ACA, states are allowed to expand their Medicaid entitlement program for the poor and are required to establish health insurance exchanges or utilize the federal exchange. These exchanges function as insurance brokerages where individuals can access insurance plans and potentially receive taxpayer subsidies to help them pay the insurance premium. Each exchange must offer at least four plans which must include t he ten essential benefits mandated in the ACA. Pricing must be approved by the government.

The ACA also attempts to establish an exchange marketplace for employers with less than 50 FTEs. The Small Business Health Options Program (SHOP) is designed to help "businesses provide health coverage to their employees."[2]

Small businesses with less than 25 FTEs may qualify for tax credits if they pay at least 50 percent of the total health insurance premium cost for employees and the average wage of their employees is below $50,000, The tax credit is determined by the number of employees and by average wages. Basically, the smaller a business is, the larger the tax credit it could receive.

Phase I of the employer tax credit began in 2010. Eligible employers may qualify for a tax credit of up to 35 percent of their contribution toward employees' insurance premiums. The employer must pay at least 50 percent of the employee-premium.

Phase II of the employer tax credit began in 2014. Eligible employers may receive a credit of up to 50 percent of their portion of premium costs. However, these employers must purchase coverage through a SHOP Marketplace, or qualify for an exception to this requirement, to be eligible for the credit. The credit is only good for two consecutive tax years.[3]

At least 70 percent of employers must be enrolled in the SHOP Marketplace for the employer to qualify for tax credits. Employees

[1] U.S. Department of Health and Human Services @ http://www.hhs.gov/healthcare/rights/law/
[2] What is the SHOP Marketplace @ https://www.healthcare.gov/what-is-the-shop-marketplace
[3] What You Need to Know About the Small Business Health Care Tax Credit @ http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers

who purchase their own health insurance count toward the 70 percent. Employees who have insurance through their spouse or who have government insurance, such as Medicare or Medicaid, do not count toward the total.[4]

Some state exchanges started accepting enrollees through a SHOP Marketplace this year. The federal exchange will start accepting online applications this November for coverage in 2015.

Employers with more than 50 FTEs will be able to access SHOP on November 1, 2015 and employers with more than 100 FTEs will be able to access the program in 2016.[5]

The demand and interest level of employers in an exchange such as SHOP was never determined. There is speculation and anecdotal evidence that SHOP was placed in the ACA for political reasons and convenience, rather than at the insistence of the law's architects.[6]

Enrollment in SHOP to Date

When the ACA became law in 2010, estimates showed that 1.4 million to 4 million employers were eligible for tax credits. Only 170,00, or 4 to 12 percent of employers, filed for credits that year.[7]

Individual state exchanges have had varying success at SHOP enrollment. New York state had nearly 1 million enrollees in its exchange, but only one percent were in the small employer market. California had a similar experience with 1.4 million enrollees overall, but less than 1 percent enrolled in SHOP.[8]

The federal exchange has delayed online enrollment until November, 2014.[9]

Officials in Washington state chose to establish a state-run health insurance exchange, including a SHOP. Coverage began in 2014, with SHOP having an open enrollment period. Only one carrier, Kaiser Permanente, offered plans and only offered those five plans in two counties in Southwest Washington. Although 4,300 small businesses created online accounts, only 11 companies, with a total of 40 people, actually purchased insurance on the SHOP exchange this year.[10]

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[4] It's Still Hard for Small Businesses to Shop Around for Health Coverage by Meir Rinde @ http://www.njspotlight.com/stories/14/04/29/it-s-still-hard-for-small-businesses-to-shop-around-for-health-coverage/

[5] Obamacare Small Business Facts @ http://obamacarefacts.com/obamacare-smallbusiness.php

[6] SHOP Flop: Obamacare for Small Businesses, by Brett Norman @ http://www.politico.com/story/2014/06/shop-sdmall-business-health-options-program-delay-107649.html

[7] Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity @ http://kstp.com/kstplmages/repository/cs/files/SMALL%20EMPLOYER%20HEALTH%20TAX%20CREDIT.pdf

[8] Why We Still Don't Know How Many Small Businesses Signed Up Through Obamacare by J.D. Harrison @ http://www.washingtonpost.com/business/on-small-business/why-we-still-dont-know-how-many-small-businesses-signed-up-through-obamacare/2014/07/10/773d0cb6-0859-11e4-a0dd-f2b22a257353_story.html

[9] Obamacare's Online SHOP Enrollment Delayed by One Year by Sarah Kliff @ http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/27/obamacares-online-exchange-for-small-businesses-is-delayed-by-one-year/

[10] With Statewide Insurance Options, Washington's Business Health Exchange Readies For Close-up by Gregg Lamm @ http://www.bizjournals.com/seattle/blog/health-care-inc/2014/09/with-statewide-insurance-options-washington-s.html

A second insurance company, Moda, has applied to offer 14 plans state-wide starting in 2015.

The Director of the Washington State SHOP Marketplace, Catherine Bailey, stated that "many of the carriers were not interested in expending additional resources to be in the small business exchange right away." [11]

The Government Accountability Office (GAO) has speculated that the use of tax credits and the SHOP enrollment are so low for several reasons. The first reason is the complexity in doing all the paperwork.[12] Conversations the GAO has had with tax preparers reveal that employers must spend from two to eight hours or possibly longer collecting employee data and tax preparers must spend an additional three to five hours calculating the credit.

Second, the GAO reports the tax credit is not a large enough incentive for many small employers.

Third, the majority of small businesses have never offered health benefits to employees. The Medical Expenditure Panel Survey (MEPS) estimated that 83 percent of small companies did not offer health insurance in 2010 when the ACA became law.

In addition, insurance companies are seeing a drop-off in employer-sponsored health insurance for small businesses. The CEO of Well Point, Joseph Swedish, is on record earlier this month stating that "small employers (are) shifting employees to the individual exchange or (are) dropping coverage completely." He goes on to say small employers are making "a very radical, fast shift to walking away from the so-called moral imperative" of providing health insurance.[13]

Policy Analysis

Although the employer mandate is a critical part of the ACA, the SHOP marketplace for small businesses seems to be almost an afterthought in the law. There is no clear evidence of interest on the part of small companies to provide health insurance through a marketplace with tax credits.

Small businesses are typically start-up or low-margin companies where the added cost of employee health insurance can mean the difference between success and failure. The paperwork and regulatory burden in the SHOP exchange are definite hurdles for a small business employer.

There is no real free market in the individual exchanges or in SHOP. Proponents will claim that competition exists, yet all insurance plans offered in the exchanges must contain the ten government-mandated essential benefits. Insurance premium prices must be approved by the government. Consequently, individuals and employers only have government-approved plans and not meaningful choices or real competition.

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[11] Ibid.
[12] See ref 5.
[13] But Small Employers are Walking Away From Coverage by Sarah Wheaton @ http://www.politico.com/politicopulse/0914/politicopulse15173.html

The incentive of tax credits has not been significant enough to encourage employers to use SHOP. Obtaining the credit is so complicated that small businesses are unwilling or unable to spend the time and effort to complete the necessary forms.

The SHOP Marketplace duplicates the private insurance marketplace with an added burden to taxpayers. Private association health plans, for example, have flourished for years without government financial support.

Since employer interest and utilization of the tax credit is so small, the benefits of the SHOP Marketplace are unclear.

Recommendations

Designing an insurance exchange, whether it's private or government-run, offers each state, like Washington, the opportunity to reform health care delivery by starting with a "clean slate" and moving toward a patient-oriented, consumer-driven system. The exchange can be a transparent, information-based market where individuals and small businesses can select the plan most appropriate to their needs. States can use the exchange as a mechanism to combine all existing state government insurance plans, such as Medicaid and Basic Health, into one administrative program.

Done right, the exchange should be easy to use and should promote decreased health care costs. Insurance rates and benefit levels should be set by the insurance market and not by government regulations. The administration of the exchange should be done through a nonpolitical, independent board, not by a politicized bureaucracy.

Under the ACA, all plans must contain the ten essential benefits that meet federal requirements. Washington state has 57 benefit and provider mandates that overlap the federal benefits. Ideally, the state exchanges should be able to offer an array of "mandate-free" or "mandate-light" insurance plans that satisfy market needs. Greater use of high deductable insurance plans coupled with health savings accounts can control costs and offer more choices for patients and employers without compromising quality.

Any subsidies in the exchange should flow to and be controlled by the patient, not by insurance executives or government officials. Tax credits or premium supports to purchase health insurance could also be offered in an exchange.

Each state can function as a laboratory to design the most efficient, cost-effective exchange for small businesses and individual. Although the ACA includes hundreds of new mandates and regulations, states should have an opportunity to overhaul their existing programs, start fresh and establish a meaningful patient-directed, market-oriented health care system. The alternative is to submit to more government regulation and central planning with the attendant bureaucratic inefficiencies which will not increase competition, improve access, or decrease costs to patients and employers.

Testimony of Professor Adam Beck to the Subcommittee on Health and Technology

Committee on Small Business

United States House of Representatives

Washington, D.C.

September 18, 2014

Good morning.

Thank you Mr. Chairman, Ranking Member Hahn and members of the Subcommittee for the opportunity to appear before you today. My name is Adam Beck and I am an assistant professor of health insurance at The American College in Bryn Mawr, PA. Since the College was founded in 1927, it has grown to become the nation's leading non-profit provider of higher education for professionals in the financial services industry. Today, The American College has the highest level of accreditation available and offers twelve professional designation and exam preparation programs, two master's degrees and a PhD in Financial and Retirement Planning. At The American College, I lead the Chartered Healthcare Consultant designation and teach courses focused on Health Care Reform for Employers and Advisers, Healthcare Consulting, Financing Long-Term Care for Seniors, and Life Insurance Law. I am the author of a textbook on the Essentials of Health Care Reform and the co-author of texts on healthcare consulting and long-team care financing. Additionally, I am an attorney with active licenses in New Jersey and Pennsylvania and advise medical and psychotherapy practices on matters relating to health insurance, Medicare, HIPAA and compliance with the Affordable Care Act.

Small businesses and the people who work for them comprise the backbone of the American economy. Health insurance is a tremendously valuable, often life-saving, financial product, which our federal tax code affords special status. Therefore, it is an important and essential goal to allow small business owners the opportunity to offer quality, affordable health insurance coverage to their employees. Prior to the implementation of the Affordable Care Act, half of the uninsured in this country were part of the small business community—owners, employees and dependents.[1] That is not for a lack of desire on the part of small business owners to offer health insurance coverage. The Small Business Health Options Program, or SHOP Marketplace, was designed by the 111th Congress to lower health costs for small business, increase competition and therefore choice for business owners, and simplify the process of offering health coverage. These are laudable goals, however it is

[1] Gardiner, Terry and Pereera, Isabel. "SHOPping Around" Report of the Center for American Progress and Small Business Majority. June 2011. http://www.smallbusinessmajority.org/reports/shop_exchange.pdf

my opinion that the SHOP Marketplace as it is currently structured and presented falls short of these goals. I believe the SHOP Marketplace will remain inadequate and continue to enroll relatively few companies so long as three factors remain: the existing tax incentives, the lack of engagement of agents and brokers, and shortcomings in information technology infrastructure.

I. The Small Business Health Care Tax Credit is Overly Complicated and Too Small

The Patient Protection and Affordable Care Act created the Small Business Health Care Tax Credit to be an accompanying incentive to participate in the Small Business Health Options Program. Prior to the launch of SHOP marketplace on January 1, 2014, the tax credit was available in a smaller form for most private market small group health plans enrolled in by qualifying business organizations during the tax years 2010 through 2013. For the initial four years of the tax credit's existence, the maximum credit available was 35 percent for for-profit entities and 25 percent for tax-exempt organizations. Beginning in 2014, the tax credit increased and became conditioned upon participation of eligible employers in a SHOP plan. The maximum available tax credit is today 50 percent for for-profit entities and 35 percent for tax-exempt organizations.

While a fifty-percent tax credit may sound like a substantial incentive—particuarly considering that employers may still use pretax funds to pay for employee health benefits—the reality is far more nuanced. First, there is the limited universe of eligible employers. The credit is only available to business organizations with 25 or fewer full-time equivalent employees and average annual wages below $50,000. While this undoubtedly includes a substantial number of small businesses, it requires employers to engage in tedious and somewhat complex calculations of how many full-time equivalent employees they maintain in a given year, continually monitor compensation and face a perverse incentive for limiting pay, should increasing pay lead to average annual wages exceeding $50,000. Second, there is the sliding scale nature of the tax credit. The maximum credit of 50 or 35 percent is available only to businesses with 10 or fewer full-time equivalent employees and average annual wages below $25,000. The credit is then available in diminishing percentage amounts as the businesses grow larger or pay more. This again requires a complex calculation just so employers can estimate the potential tax incentives they could achieve from purchasing plans through a SHOP exchange. Third, the credit is time-limited. Those who qualify may only claim the tax credit for two consecutive years.

The Government Accountability Office estimates that up to 4 million small businesses could qualify for the credit[2], but this requires that small businesses know about the credit and go through the difficult process of determining eligibility. Further, even by the

[2] "Small Employer Health Tax Credit: Factors contributing to low use and complexity." Report of the U.S. Government Accountability Office. May 2012. http://gao.gov/assets/600/590832.pdf (page 10)

GAO's own admission, advocacy groups identify the 4 million figure as the likely high point of potentially eligible businesses, with some estimating that as few as 1.4 million employers would qualify. Linda Blumberg and Shanna Rifkin of the Urban Institute analyzed this issue in a report issued last month that was commissioned by the Robert Wood Johnson Foundation.[3] They found that qualifying for the credit was particularly difficult in high cost-of-living areas, as the $50,000 limit in average annual wages applies uniformly nationwide. By way of comparison, someone earning $50,000 in Mason City, Iowa in 2014 would need to earn $73,104 annually to maintain the same standard of living in Los Angeles, California.[4] Data from the first year of the tax credit (2010) indicate that the overwhelming majority of employers who were eligible for any credit were not eligible for the full credit. Only 17 percent were eligible for the full credit.[5] The greatest obstacle, according to GAO analysis, was the annual wage requirement. In the first year, 68 percent of businesses who received less than the full credit would have qualified for the maximum percentage based on the number of full-time equivalent employees but failed to qualify based on wages.[6] According to the Urban Institute report, many employers reported that they felt they needed the assistance of an accountant just to determine eligibility for the credit, a cost that sometimes exceeded the actual value of the credit.[7] The GAO report offers a succinct summary of the degree of complexity involved in calculating the credit[8]:

> *On its Web site, I.R.S. tried to reduce the burden on taxpayers by offering "3 Simple Steps" as a screening tool to help taxpayers determine whether they might be eligible for the credit. However, to calculate the actual dollars that can be claimed, the three steps become 15 calculations, 11 of which are based on seven worksheets, some of which request multiple columns of information.*

Setting aside the studies and statistics, it is very difficult to find a small business that has actually claimed the credit. They indeed exist, as we know from tax filings, but apparently in such small numbers that even a media outlet with the reach of the *New York Tines* was unable to find one to profile.[9] When I teach my students about the tax credit, I always ask if any of the students—who are active brokers and financial advisers—have assisted any clients with this particular tax credit. No student has yet to answer in the affirmative.

While the cost of premiums for plans available on many state SHOP marketplaces have been comparable to—and in many cases

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[3] Linda Blumberg and Shanna Rifkin. "Early 2014 Stakeholder Experiences With Small-Business Marketplaces in Eight States." Report of the Urban Institute. August 2014. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414995

[4] http://money.cnn.com/calculator/pf/cost-of-living/

[5] GAO report, *supra*, at page 10.

[6] *Id*.

[7] Blumberg and Rifkin at page 3.

[8] GAO report, *supra*, at page 13.

[9] Robb Mandelbaum. "Why the Health Care Tax Credit Eludes Many Small Businesses." *The New York Times*. September 25, 2012. http://boss.blogs.nytimes.com/2012/09/25/why-the-health-care-tax-credit-eludes-many-small-businesses/

slightly lower than—similar plans prior to the opening of the SHOP, they generally remain higher than what many small businesses have determined they can afford to pay. This is where the tax credit is supposed to mitigate costs and increase the likelihood that a small business can actually afford to offer coverage. As expanded, simplified tax credit that is available for longer than two years would offer a real financial incentive for companies to either begin or continue offering health benefits.

II. The Inclusion and Empowerment of Brokers has been Minimal

For many small businesses that offer health insurance coverage to their employees, a health insurance agent or broker performs the bulk of the work necessary to facilitate benefit offerings. Small business owners frequently wear many (proverbial) hats, including that of human resources director, marketing director, and controller, among others. Thus, health agents and brokers play a critical role for small businesses. Many of these agents or brokers are comprehensive financial planners and advisers who work with small business clients on matters relating to life insurance and retirement benefits, investments and health insurance. The SHOP Marketplace will not succeed without a substantial buy-in from the agent and broker community. This much was readily acknowledged by John Arensmeyer, CEO of the pro-reform Small Business Majority, who said "at the end of the day, the success of the small-business exchanges is going to be very heavily dependent on brokers and agents." [10]

Health insurance, like any financial product, is complicated and its purchase often requires the advice and assistance of a licensed professional, such as an insurance agent or broker. Particularly for small group policies, where the health and financial well-being of multiple lives and families is at stake, there should be substantial involvement of agents and brokers to ensure that business owners make decisions that are in the best interest of both their company and their employees.

In its first year, at least in the states with fully or mostly functioning SHOP marketplaces, the marketing of the program to brokers, as well as the overall inclusion of brokers in the program, including empowerment, compensation and training, has been severely lacking. In short, even for those brokers who are aware of the SHOP marketplace in their state and the potential benefits available to clients, they must undergo state-mandated training and spend twice as much time on SHOP applications, all for the exact same level of compensation they would receive to sell a non-SHOP plan.

In the states that operate their own SHOP marketplace, brokers are required to be certified through a state-specific training process, which may either be in-person or delivered on the web. Brokers who went through the training program have indicated that

[10] Robb Mandelbaum. "Small Businesses Showing Little Interest in State SHOP Exchanges." *The New York Times*. December 23, 2013. http://boss.blogs.nytimes.com/2013/12/23/small-businesses-showing-litle-interest-in-state-shop-exchanges/

the materials were ineffective or even factually inaccurate. This included inaccurate exam questions and instructors who were required to teach material that was outdated. Further, many of the training programs covered SHOP only as part of a larger health care reform training, therefore requiring small business brokers to become educated upon issues unique to Medicaid, as opposed to more in depth discussion of SHOP.

Those issues only apply to the brokers who feel they were included in the SHOP process. The marketing campaigns for state SHOP exchanges have often failed to target or reach small business health brokers, instead focusing on the federally-funded navigators who primarily support individual exchanges. Additionally, and perhaps most importantly, the outreach to the business community about the existence of SHOP and the role that brokers can play in facilitating enrollment has been minimal. Many businesses remain unaware that they can turn to a local broker to discuss potential options under the Small Business Health Options Program.

The degree and structure of compensation for brokers has discouraged substantial involvement. A broker will earn the same commission or fee for selling a plan directly through an affiliated carrier as he or she would for selling a plan through the SHOP marketplace.

However, the time involved in enrolling a client in a SHOP plan is often double that required to enroll in a plan directly through a carrier. Some, including Lev Ginsburg of the Business Council of New York, estimate that the SHOP process is even more laborious, possibly as much as three or four times what it necessary to enroll in a non-SHOP plan.[11] The additional time is due to the complexity of the IT system and application interface necessary to complete the SHOP process, as well as the opportunity cost involved with the time that often must be spent explaining the new employee choice model to client companies.

The commissions are not the doing of CMS. In its May 2013 guidance, the Department of Health and Human Services clarified that broker commissions do not come from SHOPs, but rather from a negotiated arrangement between carriers and the brokers, but required that the rates be the same for a plan sold within a SHOP as it is for a plan outside of SHOP.[12]

This is not to say that either CMS or the state-run SHOPs have excluded agents or brokers. Indeed, they all have provided resource pages on their websites promoting the value of health insurance brokers and making materials available for the brokers themselves. It can be safely assumed that some broker perceptions are attributable to the focus during 2013 and 2014 on the individual health insurance exchanges, while SHOPs were delayed or given a lower priority. However, as the SHOP marketplaces fully launch later this year, CMS and the state marketplaces will prioritize the inclusion of brokers and the trade organizations that support them.

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[11] *Id.*

[12] Memorandum from the Centers for Medicare and Medicaid Services. May 1, 2013. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-brokers-5-1-2013.pdf

III. The Website Delay and IT Issues Increased Uncertainty, Hindering SHOP

Third, and hopefully most obviously, the delay by the Administration of the Federal Facilitated SHOP Marketplace and the accompanying website limited the ability of small businesses in the 32 states relying on the federal marketplace, but it also created confusion for business owners, brokers and navigators in the states that had functioning SHOPs. Additionally, states that were operating their own SHOP Exchanges in 2014 experienced their own IT problems that hindered enrollments.

On November 27, 2013, the Obama administration announced that the online enrollment component of SHOP would be delayed until November 2014, as opposed to launching in October 2013 as originally planned.[13] (An earlier delay, announced September 26, 2013, pushed back the October start to November.) While consumers were ultimately well aware of the online health exchanges, accessible through healthcare.gov, as evidenced by the 9.21 million online enrollments [14], small business owners who visited the site in one of the federal-facilitated states found themselves unable to browse and compare plans online, as promised. This delay had real effects on the efficacy of SHOP. Promoters of the law and brokers speaking with small business clients were unable to say "go to the website and explore your options." Further, the delays caused confusion among the small business community, which leads to uncertainty about SHOP as an effective means of obtaining insurance in the future.

The delays at the federal level were coupled with IT issues and a low prioritization in states that were running their own marketplaces. A thorough analysis of the impact of the Affordable Care Act in Pennsylvania was unable to draw meaningful conclusions about the efficacy of SHOP, as Pennsylvania did not have a functioning SHOP website.[15] A spokeswoman for CoveredCA admitted that the launch of the individual exchange was the priority, and the California head of the National Federation of Independent Businesses said that even in his state "the SHOP program has kind of taken a backseat." [16] In states with their own SHOP marketplaces, the low prioritization was often overshadowed by IT problems. Maryland and Oregon, for example, had online systems that were non-functional.

For brokers, there were IT issues that left many uncompensated for their work. Brokers would assist business clients with enrollment in a SHOP plan and then the online system would not record the involvement of the broker and the insurance carrier would not know to pay the broker. These IT issues discouraged both brokers and carriers alike.

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[13] Sarah Kliff. "Obamacare's online SHOP enrollment delayed by one year." *The Washington Post*. November 27, 2013. http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/27/obamacares-online-exchange-for-small-businesses-is-delayed-by-one-year/

[14] Charles Gaba. http://acasignups.net/

[15] "Beyond the Website." Fels Institute of Government, University of Pennsylvania. February 2014. https://www.fels.upenn.edu/sites/www.fels.upenn.edu/files/aca_final_feb_6.pdf

[16] Anna Gorman. "California's Small Business Health Insurance Exchange Off To Slow Start." *Kaiser Health News*. May 8, 2014. http://www.kaiserhealthnews.org/Stories/2014/May/08/Californias-Small-Business-Health-Insurance-Exchange-Off-To-Slow-Start.aspx

The most recent SHOP-related delay by the Administration will likely further hinder the program in 2015. On May 27, 2014 the Administration issued final rules on the Employee Choice model in SHOP, which including transition relief allowing states the option of delaying Employee Choice until 2016.[17] Eighteen states will delay Employee Choice an additional year. The Employee Choice model is an essential component of SHOP. In the past, small employees have been largely unavailable to provide choice or variety in health plans to their employees. While large firms overwhelmingly offer more than two plans to their employees, very few small employers were able to do so. The Employee Choice model will allow small businesses to offer employees a variety of plans within the same metallic tier or below a certain price point, which creates a real incentive for small employers to at least consider the options available within SHOP. An effective Employee Choice model, however, also requires a user-friendly information technology interface, which many states may not be fully prepared to offer.

While SHOP was supposed to be fully functional nationwide in 2014, what happened instead was a patchwork test run. In short, a key reason SHOP did not succeed in its first year was because its first year was postponed. A year with fully functioning structures and engaged players will be essential to truly judge efficacy.

IV. Other Factors Impacting the Fist Year of SHOP

Several other factors negatively affected SHOP during its initial year and will likely continue in the future. These include the many early renewals of small group plans in 2013, competition from private exchanges and the success of the individual marketplace.

Many insurers actively encouraged small business clients to renew (or "early-renew") their existing small group health insurance plans prior to December 31, 2013. Any plans renewed on or after January 1, 2014 were required to comply with a host of new requirements under the Affordable Care Act, namely to offer a package of ten essential health benefits and limit cost-sharing. Thus, businesses with these early-renewed plans had no need to purchase health insurance plans in 2014, at least not until later this year. As many as 70 percent of small businesses may have opted to early renew policies in 2013.[18] This dramatically limited the number of small businesses who otherwise may have been prime candidates for exploring plan options through the SHOP marketplace.

Private exchanges are likely to grow in popularity over the coming years. Because the ACA requires the pricing of plans to be the same within a SHOP exchange as it is outside, the free market can be expected to result in competition from private actors who feel they can provide a greater variety of plans or a better customer experience. Private exchanges have been increasingly popular among

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[17] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html

[18] Paul Demko. "Small Business Exchanges off to rocky start." *Modern Healthcare*. July 14, 2014.

larger companies, but the private exchanges are actively seeking to sell to small groups.

Finally, despite the well-publicized disaster that was the launch of healthcare.gov, the Health Insurance Marketplace ended up enrolling far more people than nearly anyone had anticipated and millions of Americans found health insurance at a lower rate than they had previously paid. If employees of small businesses have the option of obtaining affordable health insurance on their own, usually with the assistance of a federal tax credit, many small businesses who have not offered coverage in the past will likely simply direct their employees to the public marketplace, thus rendering an employer-based plan unnecessary and alleviating a prospective burden from the employer.

In conclusion, many small businesses want to offer health coverage. It simply needs to be more affordable, simpler and be facilitated by an experienced insurance broker. The Small Business Health Options Program has the potential to offer just that, but marketing, tax credits, information technology and broker involvement need to be dramatically increased in order for the program to achieve its laudable goals.

Statement of

Jon Gabel

Senior Fellow

NORC at the University of Chicago

The Small Business Health Options Program:

Its Promise and Challenges

Before the

U.S. House Committee on

Small Business, Subcommittee on Health and Technology

Statement of Jon Gabel

"The Small Business Health Options Program: Its Promise and Challenges

September 18, 2014

Chairman Collins, Ranking Member Hahn, Members of the Committee.

Thank you for the opportunity to discuss the promise and challenges of the Small Business Health Options Program (SHOP). I am Jon Gabel, a Senior Fellow at NORC at the University of Chicago. I am a nationally recognized expert on private health insurance with more than 35 years of experience. NORC is an independent non-profit, non-partisan research organization whose mission is to conduct objective research in the public interest. The views I present are mine, and not those of NORC.

Today I will discuss factors promoting and inhibiting the success of SHOPs. Some of the analysis will be based on recent research for CCIIO/CMS.

The authors of the ACA designed SHOPs to bring the efficiencies of the large group market to small employers. Historically, the small group market (firms with 50 or fewer workers) was characterized by higher premiums and administrative expenses, and greater volatility in premium increases from year to year. For coverage with identical financial protection the smallest employers (1–9 workers) paid premiums 18 percent more than large employers.[1] Whereas administrative expenses constituted less than 10 percent of the premium dollar for the nation's largest firms, administrative expenses accounted for more than 20 percent of the premium dollar for small employers. One reason that administrative costs were higher in the small employer market was that insurers competed through medical underwriting—a technical term meaning making sure that an insurer does not sell to small firms with very sick pe9ple, or alternatively, charging higher premiums to reflect expected expenses plus risk. Medical underwriting entailed examining the medical records and past insurance claims of the prospective new customers. Insurers did so not because they were "bad companies," but because the economic of health insurance dictated they do so. Medical expenses are concentrated among a few sick people. In employer-based insurance, the sickest 1 percent will account for 27 percent of claims expenses, the sickest five percent over 50 percent of expenses, and the healthiest 50 percent account for 5 percent of expenses. If an individual insurer unilaterally declined to medically underwrite, that insurer would attract the worst risks and be forced to price their products at non-competitive rates. The Affordable Care Act prohibits setting premiums based on the health status of the insured population. It does allow insurers

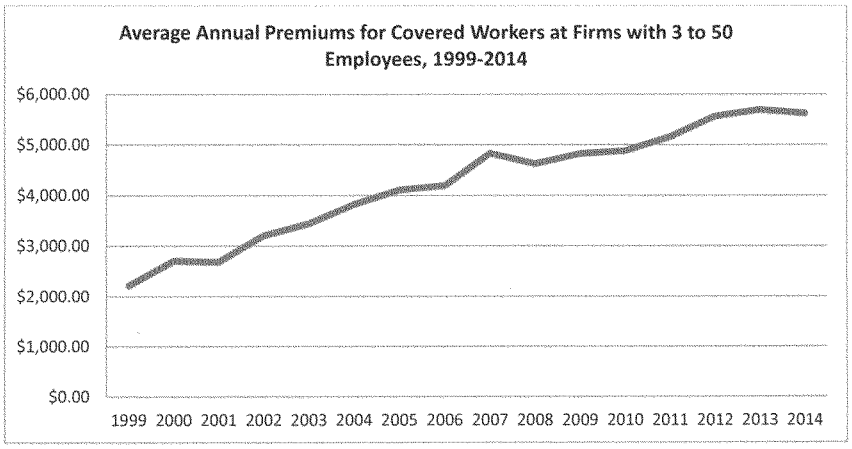
[1] J. Gabel, R. McDevitt, L. Gandolfo, J. Pickreign, S. Hawkins, and C. Fahlman, "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is up, Montana Is Down," *Health Affairs*, May/June 2006, 25(3): 832–843.

to set premiums based on the age of the population within limits, by geography, and smoking status. Thus, the ACA transforms the small group market so insurers no longer compete on their ability to identify and exclude high-risk individuals and small groups, but now must compete on price and quality.

Recent Trends in the Small Employer Market

SHOPs are aiming to establish itself at a time of relative price stability in employer-based insurance including the small employer market. Data from the annual Kaiser Family Foundation/Health Research and Educational Trust (KFF/HRET) Employer Health benefits Survey show that in 2013–2014 premiums fell 1.2 percent (Exhibit 1) for employers with 3–50 workers. In 2013 premium increases were 2.3 percent.[2] For all firms premium increases in 2013–2014 for family coverage were only three percent. Small employers, similar to consumers in general, would be more likely to shop for new plans when premiums are rising rapidly.

[2] Neither of these figures were statistically significant from the previous year.



Brief History of SHOPs and Purchasing Pools

Exchanges for small employers are not a new idea. Over the past 25 years many states attempted to build what was termed "health insurance purchasing co-operatives" (HIPCs), but none enjoyed widespread success. Among the states attempting to build HIPCs were California, Connecticut, Washington, Florida, Kansas, Colorado and Kentucky. Connecticut was perhaps the most successful

and attained an eight percent market share in the late 1990s.[3] Massachusetts invested more than a million dollars in research and marketing in 2012–13 to attract small employers to their "Connector." Enrollment today is less than 10,000 persons.

One clear lesson from earlier attempts to build HIPCs is that underwriting rules must be the same inside and outside the HIPCs.[4] Many states prohibited medical underwriting within the pools but allowed it outside the HIPCs. The inevitable result was that brokers sent their high risk groups to the HIPCs, medical claims expenses and premiums rose each year, risk selection worsened, and the HIPCs went into a death spiral. Another challenge to HIPCs was that large insurers often did not want to participate.

The authors of the ACA addressed many shortcomings of earlier HIPCs. Underwriting was prohibited on and off the Marketplace and plans offered on the Marketplace must also be offered off the Marketplace and are considered one plan. CCIIO requires carriers with market share of 20 percent or more in the state small employer market to participate on the SHOP. If a "tied" carrier refused to participate, the carrier was not allowed to sell plans on the individual exchange in that state.

Employee Choice and Employer Models

Other witnesses have described the structure and market rules of SHOPs, as well as operational issues encountered over recent years. I will not delve into those subjects, but will review the two SHOP models—the "employee choice" and "employer model."

With the "employee choice model," the employer contributes a fixed amount for plan offerings on the SHOP, regardless of which plan the employee selects. Although there is variation from state-to-state, in general employees can select plans from different metal tiers and carriers. If an employee picks a plan whose premium exceeds the employer's contribution, the employee pays out-of-pocket the difference between the contribution and the premium for the selected plan. Thus the employee model provides a strong incentive for employees to select lower cost plans, while offering a wide choice of plans. All state-based SHOPs but Massachusetts use the employee choice model, whereas states relying on the Federally-Facilitated Marketplace (FFM) used the employer model in 2014.[5] With the employer model, the employer chooses a single plan, and all employees that opt for coverage enroll in that plan.

Value-Added Features of SHOPs

If SHOPs are to succeed in enrolling significant numbers of small employers, they must provide value-added features not available in the current off-SHOP Marketplace. SHOPs have the potential to do

[3] Richard Teske, "How the Kansas Business Health Partnership Can Learn from Other Health Purchasing Cooperatives (HPC's)" Kansas Public Policy Institute, 2001.

[4] M. Hall, E. Wicks, and J. Lawler, "Health arts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed," *Health Affairs*, 20:1 (2001): 142–153.

[5] States may use different variations of the employee model—allowing different breadths of plan options to employees, such as requiring them to choose from plans within a metal tier or offered by a single carrier—but most supported only limited choice for plan year 2014. These variations could be incorporated into future multivariate analyses.

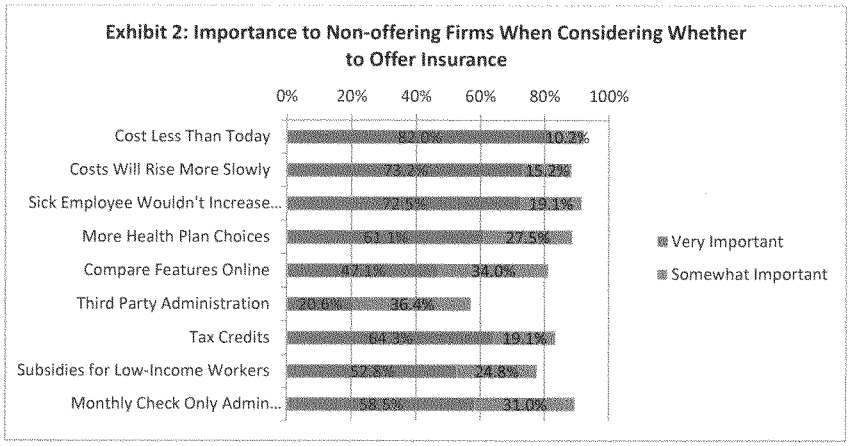
so. First, plans offered on the SHOP could have premium expenses lower than those plans only offered off the SHOP.[6] Second, employers seeking tax credits must purchase plans on the SHOP. These tax credits are linked to the size of the firm and the percentage of the workforce who are low-income workers. Third, SHOPs can enhance employee choice. When using the employee choice-model, employers can make a defined contribution, and employees can then select plans among multiple carriers, and in some states, multiple metal tiers—rather than having to choose one plan from one carrier. Fourth, the employee choice model is a defined contribution model, so employers reduce their financial risk against future increases in premiums. Note that two of these four features require the employee choice model.

A survey of small employers that my colleagues and I conducted with funding from the Commonwealth Fund and published in *Health Affairs*, found may potential "value-added" features are highly attractive to small employers—both firms offering and not offering health benefits.[7],[8] Exhibit 2 shows that among non-offering firms when considering whether to offer coverage, 82 percent say it is "very important" that insurance costs less than today; 73 percent indicate that it is very important that premiums don't go up when there is a sick employee; 61 percent say "more plan choice" is very important; 64 percent indicate that tax credits are very important and 59 percent consider the ability to send one monthly check very important. Similarly, Exhibit 3 displays that among small firms offering coverage that 41 percent thought it was "very important" to have more plan choice; 68 percent to have the ability to compare plans; 37 percent to have a third party to handle claims questions and another 37 percent to have a third party to answer questions.

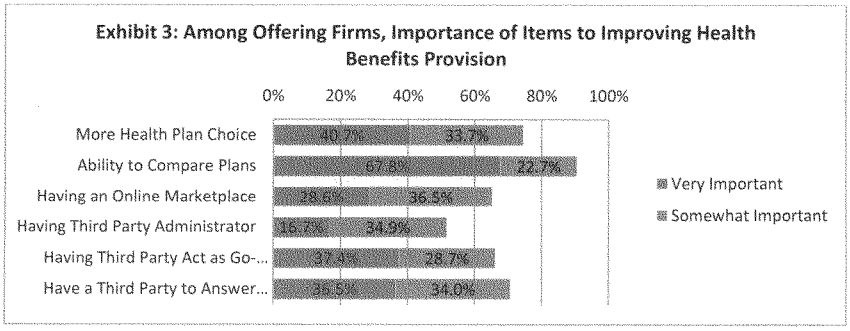
[6] If an insurer offers a plan on the SHOP, it must offer the same plan off the SHOP at an identical premium. On the other hand, insurers can offer a plan off the SHOP only.

[7] J. Gabel, H. Whitmore, J. Pickreign, J. Satorius, and S. Stromberg, "Small Employers' Survey: Premiums, SHOP Exchanges, And Self-Insurance Are Main Concerns With The Affordable Care Act," *Health Affairs*, Web Special, October 16, 2013 and November, 2013, 32:11, 2032–2039.

[8] About 45 percent of firms with fewer than 50 workers do not offer coverage, according to the Kaiser Family Foundations/Health Research and Educational Trust.



Source: J. Gabel et al, *Health Affairs,* Web Special, October 16, 2013



Source: J. Gabel et al, *Health Affairs,* Web Special, October 16, 2013

Availability of SHOP Plans

As noted previously, earlier HIPCs often encountered resistance from large plans. Aware of this history, CCIIO required carriers with 20 percent or more market share in the small group market to participate in the SHOP. In a study of 26 states, we found on average there were 4.3 carriers selling on the SHOPs in the 26 states, and 56 plans in total offered per state.[9] In these same states there is an average of three carriers selling to small employers off the Marketplaces only. But carriers selling on the SHOP also sell off-the-SHOP-only plans. In all there are about three plans sold off the SHOP only for every plan sold on the SHOP. Moreover, in many states only one or two carriers offer plans on the SHOP. Washington State has but one carrier. Hawaii, Vermont, Alabama, Florida, Kansas, Maine, and Tennessee have only two.

Tied carriers represent about 1/3 of the carriers participating on the Marketplace. In about 2/3 of those states, non-tied carriers offer more plans per state than tied carriers. We conducted interviews with nine employers who purchased coverage on the SHOP. A more common complaint was that there was too much choice rather than insufficient choice.

Cost of Plans on the SHOPs

One potential added value feature of SHOPs is to offer lower premiums than in the traditional small employer market. In the 26 states we collected data from state insurance websites and SHOP Exchanges. We used descriptive and multivariate analysis to compare the cost of coverage for a 40 year old non-smoker (a one employee firm) for plans sold on the Marketplaces with plans sold only off the Marketplaces i the same metal tier. In both descriptive and multivariate analysis we found that premiums were lower for plans on the Marketplaces (Exhibit 4) for the bronze, silver and gold tiers.

[9] J. Gabel et al., "Is There a SHOP Risk Premium in Employee Choice States?" NORC at the University of Chicago, June 2014, Contract with the Consumer Information and Insurance Oversight (CCIIO).

Average Premiums by Metal Tier for Plans Sold on and off the SHOP

Exhibit 4

	Plans Sold on the SHOP			Plans Sold Off the SHOP Only		
Metal Tier	Bronze	Silver	Gold	Bronze	Silver	Gold
Total	$298.98*	$351.60*	$413.90*	$313.62	$370.17	$431.01

* Difference between on- and off-SHOP premiums is significant at $p<0.05$.

Source: J. Gabel et al., "Is There a SHOP Risk Premium in Employee Choice States?" NORC at the University of Chicago, June 2014, Contract with the Consumer Information and Insurance Oversight (CCIIO)

In our multivariate analysis, we found, other factors held statistically constant, plans offered on the Marketplace on average have seven percent lower premiums that plans sold off the Marketplace only. Carriers not participating on the Marketplace have premiums two percentage points higher. One explanation for the lower premiums is that Marketplace plans are more likely to have narrower networks and thus obtain greater discounts from providers. Another possibility is the transparent and competitive market structure of Marketplaces leads to carriers offering lower premiums. A

third explanation is the actuarial values used to assign plans to metal tiers are calculated for the essential benefit package. Non-Shop Plans may offer more non-essential benefits.

Challenges to SHOP Success -- How Carriers View SHOPs

We conducted nine interviews with carriers—both tied and non-tied ones.[10] We found all carriers thought initial enrollment would be small, and it turned out to be smaller than they expected. The low set of expectations was largely based on the experience in Massachusetts and Utah. Most tied carriers would not have participated had it not been for the tying requirement, and would have preferred to watch and wait before entering. We interviewed one tied carrier that did not participate in the SHOP, and this carrier indicated that it was not planning to participate on the individual Marketplace, so the tying penalty was not the main issue.

Tied carriers and non-tied ones generally held divergent views about SHOPs. Non-tied carriers saw the SHOP as a means of entry or market share enhancement. The employee choice model offered an opportunity to enroll employees, whereas the tradition sale of one employer to one insurer would likely result in the dominance of traditional carriers. We spoke to Kaiser Plans and found that they were enthusiastic supporters of SHOPs. They viewed SHOPs as a useful way to reorganize the delivery of care and believed with employee choice they would be able to offer more value than the traditional fee-for-service insurers. We concluded that if SHOPs are to succeed, it will be due to the competitive fringe, not the current dominant insurers.

Challenges to SHOP Success-The Role of Brokers

Eighty percent of small employers use brokers or agents. Brokers often perform tasks that benefit managers do in larger firms. For example, among small firms using brokers, 84 percent responded that brokers select a health plan, 79 percent enroll employees, 59 percent provide customer service such as denied claims, and 31 percent decide employee contributions towards premiums.[11] Earlier HIPCs learned that broker buy-in was necessary for HIPC enrollment. Insurers reported in our interviews that brokers do not feel "plugged in" to the SHOP Marketplace and view SHOPs as competitors. Carriers stated that brokers believe they provide a valued service to small employers and that their role and income will be diminished if small employers purchase through SHOP. The dilemma for SHOPs is they need broker co-operation, but that SHOPs aim to reduce administrative expenses, and a major component of administrative expenses as brokers' fees that may constitute five percent of premiums or more.

Challenges to SHOP Success - Self-Insurance

[10] J. Gabel, A. Lischko, Analysis of SHOP Participation Requirement, NORC at the University of Chicago, Report to CCIIO for Contract, June 2013.

[11] J. Gabel, H. Whitmore, J. Pickreign, J. Satorius, and S. Stromberg, "Small Employers' Survey: Premiums, SHOP Exchanges, And Self-Insurance Are Main Concerns With The Affordable Care Act," *Health Affairs*, Web Special, October 16, 2013 and November, 2013, 32:11, 2032–2039.

As unintended consequence of the ACA is it makes self-insurance more economically attractive for small firms. Before the passage of the ACA self-insurance already had many regulatory advantages over full-insurance, ERISA pre-empts self-insured plans from state premium taxes, consumer protections, state mandated benefits, reserve requirements, and other state regulatory requirements. If an employer with a young and healthy workforce should self-insure, it would likely face lower premiums than if it were part of a larger pool of small employers as is the case with SHOPs. The foremost countervailing force to self-insuring has been the financial risk entailed with a catastrophic case, and the subsequent substantial increase in the cost of stop-loss coverage that would ensue. But the ACA eliminates medical underwriting so small firms can move into the fully-insured market if any insured workers or dependents were to experience catastrophic costs. Thus, self-insurance endangers both SHOPs and the traditional fully-insured market, and could repeat the experience of HIPCs. When there are two systems of insurance in the state, and one is risk-rated and the other is not, the risk-rated system will attract the better risks, and the non-rated system will attract the sick, and over time go into a death cycle. Data from the 2014 KFF/HRET Employer Benefits Survey does not show this happening yet.

Summary

If SHOPs are to succeed where HIPCs failed, they must demonstrate added value over the traditional small employer market. SHOPs can offer lower prices, tax credits not available off the SHOP, wider employee choice, and a defined contribution model that reduces the risk of future price increases. The authors of the ACA wrote into the legislation provisions that would address major problems of earlier HIPCs. Specifically, they required SHOPs and the off-the-SHOP market to play by the same underwriting rules. All plans sold on the SHOP must now be sold off the SHOP and priced as the same product. Administratively, CCIIO has tied large carriers to participate in the SHOPs.

The promise of SHOPs is that they operate under "fair" market rules. Prices on the SHOPs are lower than off-the-SHOP for the same metal tier. Lower prices may be attributable to narrow networks, a competitive market structure, or fewer non-essential benefits. But for employers seeking lower premiums, SHOPs are the place to shop. Multiple carriers are participating on the SHOPs in all but one state. With the employee choice model, employees can choose from multiple carriers and in some states multiple tiers. The defined contribution model limits the risk of future premiums increases. Carriers on the competitive fringe of the small employer market as well as non-profit vertically integrated organizations such as Kaiser Permanente see SHOPs as a way to build their market share.

Of course, the immediate and perhaps major challenge for SHOPs is information technology difficulties that others have discussed. But beyond IT problems, many challenges remain if SHOPs are to succeed where HIPCs failed. Dominant insurers have an eco-

nomic self-interest to see that SHOPs remain marginal. Along with established brokers and agents, they have a stake in maintaining the current delivery system where these groups have been so successful. The broker community poses a real dilemma. Health insurance is often too complicated and time consuming for small employers to master so small firms turn to brokers who are held in high regard. But SHOPs will perform many of the functions that brokers currently do. So to achieve broker buy-in, SHOPs may have to forfeit many potential savings.

If SHOPs and the fully-insured market are to survive, they must stand off threats by other insurance systems such as self-insurance. To paraphrase Lincoln, "A house divided cannot stand." Two insurance systems, one risk-rated and the other not, will lead to one system with a disproportionate share of bad risks, and one with favorable risks. Such a division could lead to the demise of the non-risk rated system.

I want to close with an observation from my nearly 40 years studying the economics of our health care system. Change does not come instantaneously. I can recall articles I read or wrote about HMOs, PPOs, HRAs and HSAs where it was observed, "What's the big deal over (fill-in the blank). They only have X percent enrollment. Why are we giving this so much attention?" All in due time became prominent insurance products, but it required many years of growth. So to paraphrase John Lennon, "Give SHOPs a chance."

I would be delighted to answer your questions.

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WEB FIRST

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Small Employer Perspectives On The Affordable Care Act's Premiums, SHOP Exchanges, And Self-Insurance

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ABSTRACT **Beginning January 1, 2014, small businesses having no more than fifty full-time-equivalent workers will be able to obtain health insurance for their employees through Small Business Health Options Program (SHOP) exchanges in every state. Although the Affordable Care Act intended the exchanges to make the purchasing of insurance more attractive and affordable to small businesses, it is not yet known how they will respond to the exchanges. Based on a telephone survey of 604 randomly selected private firms having 3–50 employees, we found that both firms that offered health coverage and those that did not rated most features of SHOP exchanges highly but were also very price sensitive. More than 92 percent of nonoffering small firms said that if they were to offer coverage, it would be "very" or "somewhat" important to them that premium costs be less than they are today. Eighty percent of offering firms use brokers who commonly perform functions of benefit managers—functions that the SHOP exchanges may assume. Twenty-six percent of firms using brokers reported discussing self-insuring with their brokers. An increase in the number of self-insured small employers could pose a threat to SHOP exchanges and other small-group insurance reforms.**

Small employers are generally defined as firms with three to fifty full-time-equivalent workers. In the United States more than 2.9 million small firms employ about 29.5 million workers, or about 25.4 percent of employed Americans. These firms could obtain health insurance coverage for their employees in the small-group insurance market.[1]

It is generally recognized that the small-group market does not perform as well for its customers as the insurance markets for midsize and large groups do for theirs.[2] There are a variety of reasons for the worse performance of the small-group market, including its higher administrative costs, rigorous medical underwriting (because coverage availability and premium costs are tied to the health status of a smaller number of employees), volatile pricing (with premium costs that can vary substantially from year to year), and the offering of lower-value products (in which premiums are high relative to the financial protection that they provide). Competition among insurers in the small-group market depends heavily on insurers' skill in medical underwriting—a logical consequence of spreading catastrophic costs among a few employees in a small firm.

To improve the performance of the small-group market, the Affordable Care Act made multiple changes in the rules for the insurance marketplace. An overarching aim of these reforms is to alter the small-group market so that insurers in it no longer compete on skill in medical un-

derwriting but on price and quality. Policy makers anticipated that a reformed market would improve access to insurance, better control the growth in the cost of coverage, and improve the quality of care.

The Affordable Care Act's small-group reforms are too numerous to list here. Some of the major ones are the establishment of the Small Business Health Options Program (SHOP) exchanges; an end to medical underwriting based on an individual's health status; and the setting of premiums based only on "community rating," in which costs can vary only by an individual's age, geography, family size, and whether or not he or she smokes. There are also tax credits for companies with high percentages of low-income workers; state-defined essential health benefits required of qualified health plans—those plans permitted to offer coverage in the SHOP exchanges; a requirement that to qualify, plans have an actuarial value of at least 0.6, meaning that the plans must pay out at least 60 percent of covered expenses; and pooling of small-group plans so that pricing and medical loss ratios (the portion of premium dollars spent on medical care) are done in the aggregate rather than for separate plans.

As of October 1, 2013, companies with fifty or fewer full-time-equivalent employees began signing up for insurance coverage through the SHOP exchange in their state. Seventeen states and the District of Columbia are operating their own SHOP exchanges, and the remaining exchanges are being administered by the Department of Health and Human Services. Coverage takes effect January 1, 2014.

SHOP exchanges are electronic marketplaces where company managers can obtain information on each qualified health plan sold in the exchange—including its benefits, premiums, networks, and actuarial value—and sign their company up for the plan of their choice. SHOP exchanges will perform administrative functions such as aggregating bills, participating in claims adjudication, and answering questions from consumers. Employers will make a fixed contribution for each employee according to the cost of the base plan and tier—or level of coverage—that the employer selects.

In the "employer model" used by the federally run exchange, the employer chooses one plan, and all employees who take up coverage through the firm are enrolled in that plan. The "employee model" used by seventeen of the eighteen state-based exchanges has many variations. One common element is that if an employee chooses a higher-cost plan than the base plan selected by the employer, the employee pays the difference in premiums out of pocket.[3]

Although many of the provisions of the Affordable Care Act are intended to make it easier for small businesses to obtain health insurance coverage for their employees, it is not yet clear how these companies will respond to the exchanges. To get a better idea of their interests and expectations, we first examine the state of the small-group market in 2013, the last year prior to the act's near-full implementation. Second, we assess the attributes of health insurance and features associated with the SHOP exchanges that do and do not appeal to small employers. Third, we examine the impact on small employers of aspects of the health care law that are already in effect.

Study Data And Methods

From January through June 2013, National Research LLP conducted telephone interviews with benefit managers of private US firms with three to fifty employees. Thirty-seven percent of the respondents were CEOs, 33 percent office managers, 4 percent executives responsible for human resources, and 7 percent chief financial officers; 19 percent had some other position. The sample frame, obtained from Dun and Bradstreet, was randomly selected and stratified by firm size, with additional controls for industry and geographic location. Of the 604 firms whose representatives completed interviews, 434 companies already offered health benefits, and 170 companies did not.

The survey instrument included questions for nonoffering firms on why they did not purchase coverage, their experience shopping for it, and what would make them more likely to purchase it. Offering firms were asked about their purchasing experience, factors that would improve their shopping experience, their views about selected attributes of the exchanges, how the health care law had affected them thus far, and whether they had considered self-insurance.

All of our analyses used statistical weights based on the inverse of the probability that the firm would be selected for the survey; this is the firm's employer weight. Employee-based weights were the product of the number of workers in the firm and the firm's employer weight. Two additional weights—eligibility-based weight and coverage-based weight—were the products of the employee-based weight and the proportions of eligible and covered workers in the firm, respectively. Most of the statistics presented in this article used employer weights.

When calculating standard errors, we use the statistical software SAS Callable SUDAAN, version 9.2, to adjust for design effects. Differences presented in the text are significant at the 0.05 level.

WEB FIRST

EXHIBIT 1

Differences In Coverage In Plans For Small Groups And For Midsize And Large Groups, 2013

	Small groups	Midsize and large groups
AMONG OFFERING AND NONOFFERING FIRMS, PERCENT OF:		
Firms offering coverage	60.1	93.3**
Employees eligible for coverage	56.6	74.8**
Employees covered by employer's plan	41.0	60.5**
AMONG OFFERING FIRMS, PERCENT OF:		
Employees eligible for coverage	81.1	76.0**
Employees taking up coverage	72.4	80.9**
Employees covered by employer's health plan	58.7	61.5
Employers offering coverage to part-time employees	17.2	34.2**
Employees working for a firm offering dependent coverage	80.9	—[a]
Employers offering more than one plan[b]	23.1	31.5

SOURCE Authors' analysis of data from: (1) Commonwealth Fund/NORC 2013 Survey of Small Employers; and (2) Kaiser Family Foundation and Health Research and Educational Trust. Employer health benefits: 2013 annual survey (Note 4 in text). **NOTES** A small group is a firm with 3–50 workers. Midsize and large groups are firms with more than 51 workers. Average monthly premiums for single coverage were $502 for small groups and $494 for midsize and large groups in 2013. [a]The Kaiser Family Foundation and Health Research and Educational Trust do not collect these data. [b]The Kaiser Family Foundation and Health Research and Educational Trust do not collect these data. Therefore, this percentage of employers offering more than one plan should be regarded as the minimum percentage of employers offering more than one plan. Given this difference, no statistical testing was conducted. **$p < 0.05$

Study Results

COST AND COVERAGE The average monthly premium for a single policy among small employers was slightly more than $502 per month, or about $6,029 per year, in 2013. Premiums were lowest for firms in the South; highest for companies with 10–24 workers; and—compared to companies with few low-income workers—lower for firms having larger proportions of younger, lower-income ($50,000 or less per year), and male workers.

Sixty percent of all small firms offered coverage in 2013 (Exhibit 1). Specifically, the shares were 53 percent for firms with 3–9 workers, 72 percent for firms with 10–24 workers, and 82 percent for firms with 25–50 workers. In contrast, 93 percent of all employers with 51 or more workers offered coverage.[4] Eighty-one percent of workers at small firms offering coverage were employed in firms that provided coverage for dependents. And among small firms offering coverage, 3 percent offered limited-benefit plans, also called mini-med plans. These plans typically have a low cap on the annual dollar value of covered services.

For offering and nonoffering small firms, only 57 percent of employees were eligible for coverage, and 41 percent obtained coverage from their employer (Exhibit 1). Some employees not covered by their employer's plan probably obtained coverage from a spouse's plan or from a public source such as Medicaid. Among small firms that offered health benefits, 72 percent of employees took up some coverage. Firms with more than 50 workers had significantly higher take-up rates. Similarly, midsize and large firms were significantly more likely than small firms to cover part-time workers.

VIEWS AND HISTORY OF NONOFFERING FIRMS When asked to choose "the *most* important reason why your firm does not currently offer health insurance to your employees," 75 percent of respondents chose the answer "cost of health insurance is too high," and 15 percent chose the answer "employees are generally covered under another plan." Only 0.4 percent of respondents at nonoffering firms said that their employees had no interest in health benefits. Ten percent of nonoffering firms had offered coverage within the past five years.

When respondents at nonoffering firms were asked what monthly premium for single coverage the firm could afford, they identified price points (that is, maximum prices that the firm would consider paying) considerably below the current market average of $502. Twenty-two percent of respondents indicated that their firm could afford $300 or more per month, and 15 percent said $200–$300. Fifty-six percent responded they could not afford monthly premiums of $200, and the remainder responded "don't know." Our survey data indicate that in the current small-group market, only 18 percent of plans cost less than $300 per month.

PURCHASING DECISIONS OF NONOFFERING FIRMS Thirty-seven percent of nonoffering firms reported having shopped for an insurance plan within the past five years. Firms in the East and Midwest were more likely to have shopped than those in the South and West.

We asked respondents from all small nonoffering firms, "How important would each of the following items be for your firm to consider offering health insurance?" Exhibit 2 displays the percentages of firms answering "very" or "somewhat important" and shows how closely purchasing decisions are linked to the cost of health insurance. For example, 82 percent of respondents said it would be "very important" "if health insurance cost less than it does today."

ROLE OF BROKERS FOR OFFERING FIRMS Insurance agents and brokers play major roles in small employers' purchasing decisions, often serving as de facto benefit managers. Eighty percent of offering firms use a broker or agent, and firms with 25–50 employees are more likely to use one than are firms with fewer workers. Small firms that use brokers have them perform various tasks: 84 percent use brokers to select a health plan, 79 percent to enroll employees, 59 percent to provide customer services such

EXHIBIT 2

Importance Of Various Items To Small Nonoffering Firms When Considering Whether To Offer Insurance, 2013

SOURCE Commonwealth Fund/NORC 2013 Survey of Small Employers.

as appealing denied claims, 57 percent to administer benefits through COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986), and 31 percent to determine employees' contributions toward premiums.

THE SHOPPING EXPERIENCE We asked small employers that offered a health plan, had offered a plan in the past five years, or had shopped for a plan in the past five years about the difficulty of different aspects of their shopping experience (Exhibit 3). Fifty-six percent responded that finding an affordable plan was "very difficult," and 26 percent said that it was "somewhat difficult." Employers found comparing premiums less difficult than other tasks, but 38 percent reported that even that comparison was "very" or "somewhat" difficult.

We asked small firms offering coverage, "How important would each of the following items be in making the process of providing health benefits easier, less expensive, and a better value?" (Exhibit 4). The most highly rated item was "ability to compare plans by cost, benefits, physicians in the network, and other features," which was rated "very important" by 68 percent of respondents.

APPEAL OF SELECTED SHOP FEATURES We asked small employers that offered coverage about their interest in a number of features that the SHOP exchanges will have and about various scenarios that could occur if they used a SHOP exchange. The survey questions did not specifically mention SHOP exchanges, instead describing their characteristics broadly.

Fifty-six percent of respondents said that they were more interested in "offering workers a choice of plans, with the employer paying a fixed amount, and the employee paying any extra cost for choosing a more expensive plan" (the "employee model") than in "offering workers one

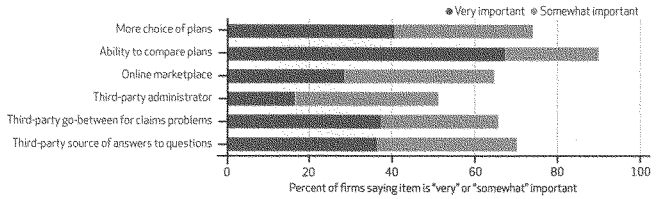
EXHIBIT 3

Difficulty Of Various Aspects Of Shopping For Benefits, Among Small Firms That Offer Benefits Or Bought Or Shopped For Benefits In The Past Five Years, 2013

SOURCE Commonwealth Fund/NORC 2013 Survey of Small Employers.

EXHIBIT 4

Small Offering Firms' Views On The Importance Of Various Items For Improving Health Benefits, 2013



SOURCE Commonwealth Fund/NORC 2013 Survey of Small Employers.

plan with less administrative work for your firm" (the "employer model"). Thirty-six percent preferred the employer model. In a related question, respondents were asked about their interest in the following scenario: Employees would be offered a choice of plans, with no change in cost to the firm, which would pay a fixed amount. Twenty-two percent said they would be very interested, and 45 percent would be somewhat interested.

When asked what is more important to their firm and its employees, being able to buy coverage from the dominant carrier in the state or having a "broader" (more extensive) choice of plans, 66 percent of respondents said that broader choice mattered more.

Small employers showed an interest in narrow-network plans, if using such plans would reduce costs. The survey defined *narrow-network plans* as those contracting with 25 percent of the doctors and hospitals in the community. If using a narrow network instead of a broad network—one with 80 percent of the doctors and hospitals in the community—would lower premiums by 5 percent, 57 percent of the respondents said they would opt for the narrow network. If the premiums were 10 percent lower, 77 percent would choose the narrow network, and with 20 percent lower premiums, 82 percent would do so.

One feature of the SHOP exchanges that has broad appeal is "getting one bill and writing one check each month." Seventy percent of employers indicated they would be "very interested" in such an approach.

If dental, vision, and other benefits such as disability insurance were part of an online marketplace, a sizable segment of small employers expressed interest in shopping for them. Thirty-two percent indicated they would be "very interested," and 36 percent would be "somewhat interested." Twenty-two percent said they would be "very interested" in shopping for wellness benefits through an online marketplace, but 40 percent would be "somewhat interested."

Impact On Small Employers To Date

Although most of the provisions of the Affordable Care Act take effect in 2014, the law has already affected many small employers in a number of ways. Half of all small firms were aware of provisions offering tax credits for small employers with substantial numbers of lower-income workers (those earning $50,000 or less per year). Small firms with large numbers of lower-income workers were no more likely to be aware of the tax credits than were small firms with fewer lower-income workers.

About one in six nonoffering firms that were aware of the tax credit considered offering health insurance because of it. Among all small firms that were aware of the tax credit, 61 percent had determined whether or not they were eligible for it. Firms with a relatively high percentage of older workers (those age fifty or older) were more likely than others to have made such a determination.

When asked if the firm's insurer had changed its benefit package because of the Affordable Care Act, 44 percent of employers said yes, 22 percent said no, and 34 percent said they didn't know. In fact, provisions that went into effect in 2010—such as prohibiting lifetime maximum benefits and requiring coverage of adult children up to age twenty-fix—have affected all plans.

Seventeen percent of small employers reported receiving a rebate from insurers. Seventy percent said they had not received one, and 13 percent were unable to answer the question. These rebates are a result of the medical loss ratio

One clear message from employers is that the cost of coverage is by far the most important factor in their purchasing decisions.

review provisions in the health care law. The medical loss ratio is the average portion of earned premiums an insurance company spends on medical benefits and quality improvements, as opposed to administrative activities. Under the law, in the small-group market this portion must be at least 80 percent, and an insurer must give its subscribers a rebate for the difference should its medical loss ratio fall below that level.

As a result of Affordable Care Act provisions, 22 percent of small employers offering coverage reported having at least one adult child (up to age twenty-six) enrolled in their health plan who would not have been eligible before health reform. On average, these firms covered two adult children. Based on survey findings, an estimated 725,000 adult children were covered by small employers because of the act.

Self-Insurance

An unintended consequence of the Affordable Care Act is that it may make self-insurance attractive for small firms. Even prior to health reform, there were many advantages to self-insurance. For example, self-insured plans were not subject to state-mandated benefits, state premium taxes, consumer protections, reserve requirements, and other state regulatory requirements. An employer with a young and healthy workforce could have lower premiums with self-insurance than with coverage obtained as part of a pool of employers. Currently, only 8 percent of firms with 3–50 workers self-insure.[5]

The major drawback to self-insuring has been the financial risk of having a covered person experience a catastrophic illness or injury, and the subsequent substantial increase in the cost for stop-loss coverage that would ensue. Stop-loss coverage is a form of reinsurance that limits the amount of money that employers must pay out for a claim or group of claims.

But self-insurance may become more attractive as the Affordable Care Act takes effect. Because the act eliminates medical underwriting, if one or more insured workers or dependents at a small firm were to incur catastrophic costs in a given year, the next year the firm could move into the fully insured community-rated market on or off the SHOP exchange.

We asked small employers using brokers if their brokers had discussed with them the possibility of self-insurance, and 26 percent said yes. (Firms with relatively older workers were more likely to respond positively, as were firms with relatively more high-earning workers.) For firms not using brokers, only 1 percent considered self-insuring. Among firms whose brokers had discussed self-insuring, or firms not using brokers but considering self-insuring, 9 percent said they were "very likely" to self-insure, and 14 percent were "somewhat likely." In all, roughly 5 percent of small firms offering coverage are either "very" or "somewhat likely" to move from full to self-insurance in the next few years.

Discussion

This survey of 604 small employers provides information on the current state of the small-group market during the year before the SHOP exchanges become operational. We found that just 57 percent of employees were eligible for coverage through their employer, and only 41 percent of employees obtained that coverage (Exhibit 1). The cost of a single policy now exceeds $6,000 a year—about 42 percent of the pretax earnings of a minimum-wage worker working full time.

The Affordable Care Act has already affected many small employers. Sixteen percent of them have received rebates from their insurers, and 725,000 adult children are covered by their parents' policies who would not have been eligible before the act's passage. About half of employers were aware of tax credits for small employers, and 60 percent of them had determined whether or not they were eligible for the credits.

The survey findings also provide information on aspects of the SHOP exchanges that may and may not appeal to small employers. One clear message from employers is that the cost of coverage is by far the most important factor in their purchasing decisions. The majority of employers not offering coverage identified price points (the highest premium amount they would consider) that were substantially lower than prices in the current market.

However, a sizable segment of nonoffering firms are close to purchasing health benefits: Nearly one-fourth of these firms reported price

22%

Covered an adult child

As a result of the Affordable Care Act, 22 percent of small employers offering coverage reported having at least one adult child enrolled in their plan who would not have been eligible before health reform.

points that were in the range of current plan prices. If tax credits were factored into the price of coverage, a larger segment of nonoffering small employers would have price points within that range. Moreover, 37 percent of nonoffering firms have shopped for coverage in the past five years.

Employers displayed their price sensitivity in other ways. Eighty-two percent of nonoffering firms indicated that it would be "very important" in their decision to buy health insurance for their workers if costs were lower than they are today. A majority of employers offering coverage were willing to select a plan with a narrow network of providers instead of one with a broad network if by doing so they could save 5 percent of their costs. If they could save 20 percent, 82 percent would select the narrow-network plan.

Many facets of the SHOP exchanges were very appealing to small employers. The most attractive feature was "getting one bill and writing one check each month." Seventy percent of small employers said they would be "very interested" in such an arrangement. About two-thirds believed that the process of offering health benefits would be "easier, less expensive, and better value" if they could compare costs, benefits, and physicians in networks among plan offerings. Substantial percentages of employers indicated that it would be "very important" to have a greater choice of plans than they do now and to have a third party that would act as a go-between in handling claims disputes.

Interestingly, having an online marketplace was not so highly rated. This may reflect the late Steve Jobs's observation that "customers don't know what they want until we've shown them."[6]

Small employers showed strong preferences for the "employee model" over the "employer model," even if the former involved higher administrative expenses than the latter. As noted above, seventeen of the eighteen state-based SHOP exchanges have chosen the employee model.[7] However, federally run exchanges will not offer that model until 2015.

Conclusion

We conclude by identifying two formidable challenges facing the SHOP exchanges. First, as states and the federal government implement them, it is imperative that the exchanges obtain a strong buy-in from brokers while simultaneously demonstrating superior value over what already exists in the small-group market.

Eighty percent of small employers use brokers, and these brokers perform most of the functions of a benefit manager, including selecting a plan, enrolling employees, and handling disputes over claims. The SHOP exchanges will perform many of the same functions, and with superior technology and economies of scale they will be able to do so at a lower cost than brokers can offer. This would suggest that brokers' fees would be reduced, leading brokers to oppose the exchanges. Historically, without broker buy-in, small-group exchanges tend not to succeed.[8]

The exchanges must obtain a strong buy-in from brokers while demonstrating superior value over what already exists in the small-group market.

Second, the survey quantified a much-discussed unintended consequence of the Affordable Care Act: a movement to self-insurance, which poses a threat not just to SHOP exchanges but to the entire small-group market. Under the act, self-insured firms do not have the same plan design requirements as fully insured firms. For example, self-insured plans do not have to meet essential benefit requirements of their state. Consequently, some brokers have suggested to small employers that they self-insure and purchase stop-loss coverage at attachment points as low as $10,000. (Attachment points are the dollar amount where stop-loss insurance begins paying for medical expenses.)

Moreover, should a small firm self-insure and incur catastrophic costs, instead of facing prohibitive stop-loss premiums the following year, it could simply move into the fully insured market through a SHOP exchange, where premiums are community rated (with adjustments for age of the workforce and geographic location). Among firms using a broker, 26 percent reported that their broker had already discussed the possibility of self-insuring in 2014.

Our calculations based on survey data suggest that 5 percent of firms are "very likely" and 7 percent "somewhat likely" to move from self-insured to fully insured status in "the next few years." These figures may underestimate the likely growth of self-insurance. After a few years of

converting to self-insurance, the small-group market could reach a tipping point that would leave the fully insured markets with greater risks, higher premiums, and eventually a so-called death spiral—in which costs become prohibitive for most people, so few people enroll except the sick, making per enrollee costs even higher. Based on the Urban Institute's Health Insurance Policy Simulation Model, without regulation of the stop-loss coverage market, the differences in premiums for fully and self-insured firms might reach 25 percent for single and 19 percent for family policies.[9]

To prevent this potential erosion of insurance, states need to reform their stop-loss markets so that stop-loss coverage is not de facto health insurance. Alternatively, if and when Congress is ready to make technical improvements in the Affordable Care Act, it should prohibit the sale of stop-loss coverage to small firms. If a tipping point were reached, then the many appealing features of the SHOP exchanges would be lost, and the small-group market would revert to the risk-based market it was prior to health reform. ■

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NOTES

1 The average number of workers per firm is from the survey whose results we report here. The number of firms with 3–50 workers is derived from Dun and Bradstreet's electronic database of businesses in the United States.

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By Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover, and Ethan Levy-Forsythe

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More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014

ABSTRACT **The Affordable Care Act creates state-based health exchanges that will begin acting as a market place for health insurance plans and consumers in 2014. This paper compares the financial protection offered by today's group and individual plans with the standards that will apply to insurance sold in state-based exchanges. Some states may apply these standards to all health insurance sold within the state. More than half of Americans who had individual insurance in 2010 were enrolled in plans that would not qualify as providing essential coverage under the rules of the exchanges in 2014. These people were enrolled in plans with an actuarial value below 60 percent, which means that the plans covered less than that proportion of the enrollees' health expenses. Many of today's individual health plans are below the "bronze" level, the lowest level of plan that can be sold through exchanges. In contrast, most group plans in 2010 had an actuarial benefit of 80–89 percent and would qualify as highly rated "gold" plans in the exchanges. To sell to ten million new buyers on the exchanges, insurers will need to redesign benefit packages. Combined with a ban on medical underwriting, the individual insurance market in a post–health reform world will sharply contrast with the market of past decades.**

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Aspiring to achieve near-universal coverage, the Affordable Care Act of 2010 ranks with the 1964 Civil Rights Act and the legislation creating Social Security and Medicare and as one of the most transformative, and controversial, laws of the twentieth and twenty-first centuries. Among its many objectives, the health reform law sought to improve the efficiency of the individual and small-group health insurance markets through the establishment of state-based insurance exchanges.

Starting in 2014 exchanges will allow individuals and employers of fewer than a hundred employees (or fewer than fifty employees if states choose a lower limit) to purchase coverage in Internet-based marketplaces. The exchanges will provide a choice of many plans and detailed information about them. The Affordable Care Act prohibits the use of preexisting conditions to deny health insurance to people and forbids insurers to set premiums based on a person's health status and medical history. People who buy coverage through exchanges and have household incomes of 133–400 percent of the federal poverty level will receive subsidies from the federal government.

The Affordable Care Act employs the technical term *actuarial value*, which is largely used by actuaries, benefit consultants, and economists. By estimating the percentage of the medical bill that a plan will pay for a standardized popula-

tion,[3] actuarial value measures the financial protection that the plan offers. If a plan has an actuarial value of 75 percent, the insurer pays three-fourths of the medical bills for that population, and the members collectively pay one-fourth out of pocket in deductibles, copayments, and other cost sharing. The Affordable Care Act sets up four tiers of health plans that people will be able to purchase through the exchanges, with each tier defined by its actuarial value. The value of the platinum tier is 90 percent or greater; gold, 80–89 percent; silver, 70–79 percent; and bronze 60–69 percent.

This paper addresses two research questions: First, what was the financial protection offered by plans in 2010 in the individual and small- and large-group markets? Second, do these plans from 2010 meet the 2014 standards that will apply to qualified health plans offered through state exchanges?

Our findings were based on simulated bill paying from a national sample of employer-based plans and a five-state sample of individual plans. Our primary finding was that most group plans on the market today fall into the "gold" range, and more than half of the enrollees in individual plans were in plans below the Affordable Care Act's 60 percent minimum threshold of actuarial value.

Study Data And Methods

DATA We used three major databases in this study. For employer-based health insurance, we analyzed data from the Kaiser Family Foundation/Health Research and Educational Trust 2010 Employer Health Benefit Survey.[2] In 2010 the survey included 2,046 randomly chosen public and private employers employing three or more workers. It collected extensive information about enrollment in the largest health maintenance organization, preferred provider organization, point-of-service plan, and high-deductible plan with a savings option. It also collected information about benefits and cost sharing in these plans.

Data on plans in the individual market in 2010 constituted the second major database. Five of ten states sampled in a previous study were randomly selected, with the probability of selection based on a three-year average of the number of individually insured people in the state.[3]

In the earlier study, we drew a stratified random sample from four regions, examining whether the state had restrictions on medical underwriting in the individual market—that is, the use of a person's health or medical information in evaluating his or her application for insurance and setting the premium price.[4] The probability of selection was based on the three-year average of individually insured people in the state. The five sampled states for this study were California, Pennsylvania, Florida, Utah, and Michigan. For the four largest carriers in each state, we copied short plan descriptions from the website eHealthInsurance.[5] From the short plan descriptions, we downloaded detailed data about covered benefits and patient cost sharing.

We collected data on enrollment in different individual insurance products through interviews with marketing managers of the carriers in each state. Products were defined by the type of plan—health maintenance organization, preferred provider organization, point-of-service plan, and high-deductible plan with a savings option—and deductible levels. This enrollment information was used to construct sample weights, as well as the probability of the state selection in the sample.

The Thomson Reuters MarketScan 2008 medical claims database[6] provided information on medical claims actually submitted for payment on behalf of fifteen million enrollees in employer-sponsored plans. We sampled a standardized population, inflated these charges to 2010, and used them as a basis for simulating payment of claims.

An alternative database sometimes used for actuarial analysis is the household file from the Medical Expenditure Panel Survey,[7] conducted by the Agency for Healthcare Research and Quality. This panel survey provides highly useful data collected through household interviews. However, it appears to understate charges and utilization by approximately 10 percent. High-cost families are particularly underrepresented.[8] In contrast, there is no attrition for very high users of health care services in MarketScan and other medical claims databases.

ESTIMATING PLAN GENEROSITY We simulated health plan and out-of-pocket spending for plans in the group and individual markets using the standardized population sampled from MarketScan. For each person in our claims database, we calculated the absolute payments by the plan and the enrollee.

To facilitate comparison with the Affordable Care Act's standards for 2014, we included all charges for the standardized population in calculating actuarial values, regardless of whether a given plan covered the full range of services for which there were charges. Summing estimates for individuals yielded an estimate for each plan in our two samples (group and individual plans). In the analysis, we calculated actuarial values and out-of-pocket expenses according to the percentile of spending.

An alternative method for estimating plan gen-

erosity is illustrated by Jessica Banthin and her colleagues.[9] Using data from the household component of the Medical Expenditure Panel Survey,[5] Banthin and coauthors added the out-of-pocket expenses for premiums and medical services for each household and then divided the sum by disposable household income. Households that spent more than 10 percent of disposable income on medical expenses were deemed households with a high burden of expenses.

Although this method is more intuitive than simulated bill paying, our simulation approach had the advantage of examining the effect of different features of health plans, such as deductibles, copayments, and limits on plan payments and out-of-pocket payments. Simulated bill paying also facilitates comparisons with the actuarial value standards that will apply in state exchanges in 2014.

ESSENTIAL BENEFITS The Affordable Care Act lists ten broad categories that must be included in essential health benefits and indicates that the intent of the law is to include services that are in a typical employer plan. The categories are as follows: ambulatory services; emergency services; hospitalization; maternity and newborn services; mental health and substance use disorder treatments, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services (those that provide medically necessary therapies to children with developmental disabilities and similar conditions) and devices; laboratory services; preventive and wellness services, including chronic disease management; and pediatric services including vision and oral care.[10]

From multiple surveys, analysts have a good understanding of which services employers currently cover, and the MarketScan medical claims database includes charges for these services. In this paper we assumed that all charges that appeared for the standardized population that we sampled from the MarketScan database were covered under the definition of *essential health benefits*.[11]

In the individual market, short plan descriptions identified what services were not covered among the Affordable Care Act's ten broad categories. For plans that did not cover a category, such as maternity and newborn services, we classified all related charges for that plan as out-of-pocket expenses. Behavioral health and maternity benefits were two areas commonly excluded or subject to internal limits in the individual market.

LIMITS ON OUT-OF-POCKET EXPENSES The Affordable Care Act requires that all health plans have a cap on annual out-of-pocket expenses that is no higher than the out-of-pocket limit that applies for high-deductible plans to qualify for a health savings account. Study plan data are from calendar year 2010, and the applicable health savings account out-of-pocket limits for that year were $5,950 for an individual and $11,900 for a family. Low-income families and individuals who buy coverage through an exchange will have lower caps. For example, low-income households earning 150–200 percent of the federal poverty level would have annual out-of-pocket caps of approximately $2,000 for an individual and $4,000 for a family, one-third of the standard caps.[12] Such households would receive coverage with a plan that has an actuarial value of at least 87 percent.

WEIGHTS AND STATISTICAL TESTING The standardized population included people enrolled in single coverage and family coverage with appropriate weighting to reflect the ratio of people with single and family coverage. Below we present statistics on households with coverage in the group and individual markets. Households can contain single or multiple persons. Multiple-person households have a policyholder and dependents. We use the term *family* as short for the technical term *insurance family*.

Employee weights were calculated as the product of the number of employees in the plan and the employer weight, which was the inverse of the probability that the firm appeared in the sample. In the individual market, overall weights were the product of plan or insurance product enrollment and the inverse of the probability that a state was selected for the study.

COMPARISONS TO PRIOR WORK The methods used in this paper to calculate actuarial value differed from those in our previous work, and this change precludes historical comparisons.[13,14] First, our prior studies assumed that some care was delivered out of network. This study assumed that all care was delivered in network. When beneficiaries use out-of-network providers such as in preferred provider organization plans, they incur much larger out-of-pocket expenses. Yet families greatly value having more choice of providers. Because we did not wish to downgrade the value of plans providing out-of-network coverage, we assumed that all care was provided in network.

Second, our prior studies used the individual as the unit of observation. In this study we included both families and single-person households.

Third, more extensive information on plan cost sharing and covered benefits was available for the current study. In the individual market, a major change from prior work was that actuarial values in this study reflected the absence of maternity benefits. In the previous study, maternity

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benefits were treated as other medical and surgical benefits, so even if the plan did not cover maternity or mental health benefits, the model treated such benefits as covered. For this article, if a plan does not cover maternity care, all expenses for such care are treated as uncovered services, and all medical expenses are borne by the beneficiary.

Fourth, in the individual insurance market the five-state sample in this study—as opposed to the ten-state sample in an earlier study[2]—did not include Massachusetts. The Massachusetts individual market is dominated by high-actuarial-value health maintenance organizations and thus differs greatly from the market in other states.[3]

LIMITATIONS We note a few limitations of this study. First, actual out-of-pocket spending is likely to be higher than our estimates, particularly for people who are extensive users of the health care system, use uncovered services, and obtain some out-of-network care. We did not separately estimate out-of-network spending because, as noted above, we wanted to avoid penalizing plans with such benefits.

Second, our sample for the individual market was only five states. However, these states accounted for approximately 31 percent of enrollment in the US individual insurance market.

Third, our methods for calculating actuarial value and out-of-pocket expenses have changed somewhat from previous studies, which precludes trend analysis.

Fourth, the analysis in this study did not take preexisting conditions into account.

Study Results

ACTUARIAL VALUE AND OUT-OF-POCKET EXPENSES

GROUP INSURANCE: The average actuarial value for a group health insurance plan in 2010 was 83 percent (Exhibit 1). As patients incurred higher medical expenses, their insurance paid a higher percentage of the cost. Thus, for families that incurred medical expenses that placed them in the top 1 percent of the population, plans paid 96 percent of allowed charges. For the bottom 50 percent of spenders, insurance paid only 64 percent of the charges.

For comparison purposes, we created a fifth category, plans of "tin" actuarial value, that captured those plans whose actuarial values were less than 60 percent (Exhibit 1). The range in actuarial values narrowed as patients incurred increased medical expenses, mainly because of required design features of insurance spelled out by the Affordable Care Act, such as annual

EXHIBIT 1

Actuarial Value And Out-Of-Pocket Spending In Group Insurance Plans, By Benefit Tier, 2010

	Tier					
Characteristic	**Tin**	**Bronze**	**Silver**	**Gold**	**Platinum**	**All tiers**
Number of employees enrolled (millions)	0.4	4.4	20.5	29.8	17.3	72.3
Percent of employees enrolled	0.5	6.1	28.3	41.2	23.9	100.0
AVERAGE ACTUARIAL VALUE PER FAMILY						
All families	59	67	76	85	93	83
Top 1%	91	94	94	96	98	96
Top 10%	78	83	87	92	96	91
Top 25%	70	77	83	89	95	88
Top 50%	63	71	79	87	94	85
Bottom 50%	25	31	47	68	86	64
AVERAGE OUT-OF-POCKET SPENDING PER FAMILY						
All families	$4,253	$3,427	$2,523	$1,565	$731	$1,765
Top 1%	15,346[a]	10,987	10,455	7,048	3,763	7,513
Top 10%	10,998	8,495	6,533	4,217	2,056	4,654
Top 25%	8,976	6,879	5,092	3,249	1,553	3,618
Top 50%	6,919	5,397	3,936	2,459	1,172	2,773
Bottom 50%	1,586	1,456	1,109	670	289	756
DEDUCTIBLES						
Percent of families with nonzero deductible	94	99	94	80	14	69
Average single-person deductible[b]	$5,376	$2,291	$1,209	$454	$224	$751

SOURCE Authors' calculations based on data from the Kaiser/HRET annual employer benefit survey and Thomson Reuters' MarketScan (Notes 2 and 6 in text). **NOTES** Actuarial values for tin, bronze, silver, gold, and platinum tiers are given in the text. Family includes single-person household. Percentages of families are by level of total health care spending. Out-of-pocket spending is determined before applying caps from the Affordable Care Act. [a]Out-of-pocket spending estimates would exceed the figure for families. [b]Excluding plans with zero deductibles.

and lifetime caps on consumers' out-of-pocket spending. For the top 1 percent of medical spenders, tin plans paid 91 percent of the bill, whereas platinum plans paid 98 percent. In contrast, for the bottom 50 percent of spenders, tin plans paid only 25 percent of the bill, while platinum plans paid 86 percent.

For an average family, annual out-of-pocket expenses were $1,765 (Exhibit 1). For the top 1 percent of spenders, the average out-of-pocket expense was $7,513, ranging from $15,346 for tin plans to $3,763 for platinum plans.

Deductibles strongly influenced actuarial values and out-of-pocket expenses (Exhibit 1). For example, only 14 percent of employees enrolled in platinum plans had deductibles, compared to 99 percent of enrollees in bronze plans. For plans with deductibles, the average deductible for a single person was $5,376 in tin plans and $224 in platinum plans.

▶**INDIVIDUAL INSURANCE:** The average actuarial value for an individual plan was 60 percent (Exhibit 2)—more than twenty percentage points less than that for group insurance (Exhibit 1). For families incurring the highest 1 percent of medical expenses, individual insurance covered 87 percent of the bill, compared to 33 percent for families in the lowest half of spending. There were no platinum plans in our sample of individual plans, and the majority of enrollees were in a tin plan.

Average out-of-pocket spending per family was $4,127 (Exhibit 2). Out-of-pocket spending for the top 1 percent of spenders ranged from $27,435 for tin plans to $6,383 for gold plans. For families in the bottom half of spending, the figures were $1,544 and $571, respectively. Ninety-six percent of families faced a deductible, which averaged $2,858 for single-person coverage.

DISTRIBUTION OF CURRENT PLANS

▶**GROUP INSURANCE:** In 2010 more than 60 percent of people enrolled in group plans were in either the gold or the platinum tier (Exhibit 3). About 28 percent were in the silver tier, and 6 percent were in the bronze tier. Fewer than 1 percent of enrollees were in tin plans, which would not qualify for the state insurance exchanges.

Health maintenance organization plans were disproportionately concentrated in the platinum tier (Exhibit 4). Although enrollment in these plans accounted for 20 percent of the employer-based insurance market, 45 percent of platinum enrollment was this category. Preferred provider organization plans were concentrated in the gold tier, and high-deductible health plans with savings options were more common in the bronze tier.

▶**INDIVIDUAL INSURANCE:** Fifty-one percent

EXHIBIT 2

Actuarial Value And Out-Of-Pocket Spending In Individual-Market Plans In Selected States, By Benefit Tier, 2010

	Tier				
Characteristic	**Tin**	**Bronze**	**Silver**	**Gold**	**All tiers**
Percent of beneficiaries	51%	33%	14%	2%	100%
AVERAGE ACTUARIAL VALUE PER FAMILY					
All families	52	64	74	85	60%
Top 1%	84	88	93	96	87
Top 10%	69	79	87	91	75
Top 25%	61	72	82	89	68
Top 50%	55	67	78	87	63
Bottom 50%	27	38	43	73	33
AVERAGE OUT-OF-POCKET SPENDING PER FAMILY					
All families	$4,905	$3,670	$2,666	$1,490	$4,127
Top 1%	27,435[a]	20,113[a]	11,804	6,383	22,478[a]
Top 10%	15,476[a]	10,750	6,856	4,330	12,523[a]
Top 25%	11,562	8,190	5,427	3,289	9,452
Top 50%	8,265	6,034	4,132	2,409	6,852
Bottom 50%	1,544	1,305	1,200	571	1,401
DEDUCTIBLES					
Percent of families with nonzero deductible	99	96	98	27	96
Average single-person deductible[b]	$3,881	$2,157	$1,054	$389	$2,858

SOURCE Authors' calculations based on survey of individual health plan provisions and Thomson Reuters' MarketScan database (Note 6 in text). **NOTES** Actuarial values for tin, bronze, silver, gold, and platinum tiers are given in the text. There were no platinum plans in our sample of individual plans. Family includes single-person household. Percentages of families are by level of total health care spending. Out-of-pocket spending is determined before applying caps from the Affordable Care Act. [a]Out-of-pocket spending estimates would exceed the figure for families. [b]Excluding plans with zero deductibles.

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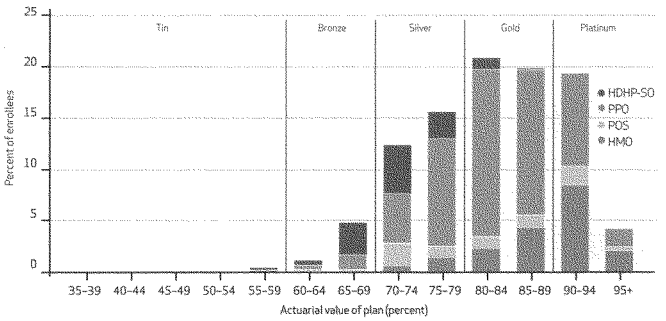
EXHIBIT 3

Percentage Of Group Policies, By Actuarial Value And Plan Type, 2010



SOURCE Authors' calculations based on data from the Kaiser/HRET annual employer benefit survey and Thomson Reuters' MarketScan (Notes 2 and 6 in text). NOTES Actuarial values for tin, bronze, silver, gold, and platinum tiers are given in the text. Account contributions by employers under high-deductible plans with savings options are treated as out-of-pocket expenses. HDHP-SO is high-deductible health plan with a savings option. PPO is preferred provider option. POS is point-of-service plan. HMO is health maintenance organization.

of the enrollment in individual insurance plans was in tin plans (Exhibits 2 and 5). Another one-third of individual enrollment was in bronze plans, 14 percent in silver plans, and 2 percent in gold plans. As noted above, our sample of individual plans included no platinum plans.

Preferred provider organizations held a predominant market share in the individual market (74 percent), with health maintenance organization plans accounting for only 3 percent (Exhibit 4). Yet nearly three-fourths of enrollment in gold plans was in health maintenance organizations.

Discussion

Using simulated claim payments, we found that the average actuarial value of group plans in 2010 was 83 percent, and the average for individual plans was 60 percent. For an average family, annual out-of-pocket expenses were $1,765 with group coverage, compared to $4,127 with

EXHIBIT 4

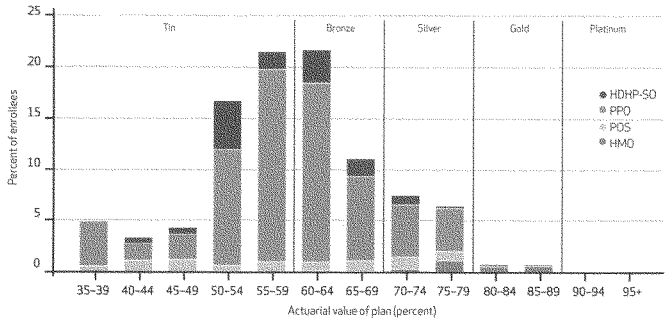
Percentage Of Enrollment, By Tier And Type Of Plan, Group And Individual Insurance, 2010

	Tier					
Plan type	**Tin**	**Bronze**	**Silver**	**Gold**	**Platinum**	**All tiers**
GROUP INSURANCE						
HMO	0	3	7	16	45	20
POS	0	5	12	6	9	8
PPO	38	31	55	75	46	59
HDHP-SO without employer account contribution	3	16	3	1	0	2
HDHP-SO with employer account contribution[a]	59	45	23	3	0	11
INDIVIDUAL INSURANCE						
HMO	0	1	11	73	0	3
POS	9	6	15	0	0	9
PPO	76	78	66	27	0	74
HDHP-SO	15	15	8	0	0	14

SOURCE Authors' calculations based on Note 2 in text. NOTES Actuarial values for tin, bronze, silver, gold, and platinum tiers are given in the text. HMO is health maintenance organization. POS is point-of-service plan. PPO is preferred provider option. HDHP-SO is high-deductible health plan with a savings account option. [a]The employer's account contribution is counted as out-of-pocket expense.

EXHIBIT 5

Percentage Of Individual Policies, By Actuarial Value And Plan Type, 2010



SOURCE Authors' calculations based on data from the Kaiser/HRET annual employer benefit survey and Thomson Reuters' MarketScan (Notes 2 and 6 in text). **NOTES** Actuarial values for tin, bronze, silver, gold, and platinum tiers are given in the text. Account contributions by employers under high-deductible plans with savings options are treated as out-of-pocket expenses. HDHP-SO is high-deductible health plan with a savings option. PPO is preferred provider option. POS is point-of-service plan. HMO is health maintenance organization.

individual coverage. For people in poor health who incurred high medical expenses, the differences between the group and individual markets were even more dramatic.

Our findings have notable policy implications. First, the majority of Americans with individual insurance coverage today are enrolled in a plan whose actuarial value is too low to qualify for a state-based exchange. Insurance reforms that went into effect September 23, 2010, raised the financial protection offered by exchange plans. For example, lifetime maximum benefits were eliminated, effective preventive services must now be offered without cost sharing, and annual limits on insurance coverage were removed. But to qualify for exchanges, insurers will need to lower the average deductible level for individual tin plans, which today average nearly $3,900 for a single person.

Second, about two-thirds of today's employees are enrolled in a gold or platinum plan. Families with coverage through the exchanges are likely to have less financial protection than employees with employer-based coverage enjoy today. Employers choosing to buy insurance coverage for their employees through the small-employer exchange, which could eventually include employers with more than a hundred workers, will probably obtain less extensive coverage if they opt to buy a plan in the silver tier than if they now offer a plan typical of those provided in the employer-based market today.

Third, very sick patients—those in the top 1 percent of medical spending—incur sizable out-of-pocket expenses regardless of coverage. For example, these top spenders face out-of-pocket expenses of nearly $3,800 in a group platinum plan. But there are substantial differences in out-of-pocket spending between plans with high actuarial value and plans with low value. A family in the top 1 percent of medical spenders with tin coverage in the individual market incurs annual out-of-pocket expenses of more than $27,000.

Despite the limitations of the study, we are confident that our major conclusions hold. Individual insurance coverage does not meet exchange standards for the majority of covered lives. Group insurance coverage is likely to have higher actuarial value on average than plans offered by exchanges. Individual insurers will need to alter benefit designs to qualify for exchanges. Together with a ban on medical underwriting, the individual market of the future will sharply contrast with the market of the past decades. ■

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NOTES

1 The term *standardized population* refers to a common electronic medical claims database used for simulated bill paying. A common database is necessary so that differences in actuarial value will reflect differences in the benefit package rather than the health of the covered populations. The word *standardized*, rather than *standard*, is commonly used to avoid the implication that there is a specific database all analysts must use.

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ABOUT THE AUTHORS: JON R. GABEL, RYAN LORE, ROLAND D. MCDEVITT, JEREMY D. PICKREIGN, HEIDI WHITMORE, MICHAEL SLOVER & ETHAN LEVY-FORSYTHE

Jon R. Gabel is a senior fellow at NORC at the University of Chicago.

In this month's *Health Affairs*, Jon Gabel and coauthors report on their study of the actuarial value of individual health insurance plans in today's market—and how those compare to what will be required of products sold through exchanges under the Affordable Care Act. In essence, most Americans who have individual health insurance today have less generous coverage than the "bronze" plans, with 60 percent actuarial value, that will have to be sold on exchanges. In contrast, most group health insurance plans now in effect would qualify as highly rated "gold" plans in the exchanges, with an actuarial value of 80–89 percent.

Gabel is a senior fellow at the Health Care Research Department, NORC at the University of Chicago. He is an expert on private health insurance and manages projects on health reform, mental health, and the military benefits program TRICARE. From 1986 to 2008 Gabel was principal investigator of the annual Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Annual Survey and its predecessor surveys. Gabel received a master's degree in economics from Arizona State University.

Ryan Lore is a health care research associate at Towers Watson.

Ryan Lore is a health care research associate at Towers Watson. Lore's main research interests include modeling of health plan expense, analysis of medical claims and benefit surveys, and insurance reform initiatives. He has collaborated with NORC on several projects regarding actuarial value and health plan members' out-of-pocket expenses. Lore has a master's degree in public policy from Georgetown University.

Roland D. McDevitt is director of health care research at Towers Watson.

Roland McDevitt is director of health care research at Towers Watson. He has developed medical claims databases and microsimulation models to estimate actuarial value and member out-of-pocket expenses for health plans. McDevitt holds a doctorate in political science and public policy analysis from the University of California, Santa Barbara.

Jeremy Pickreign is a senior research scientist at NORC at the University of Chicago.

Jeremy Pickreign is a senior research scientist at the Health Care Research Department, NORC at the University of Chicago. His areas of research include employer, retiree, and military health benefits and small-group and individual insurance markets. Pickreign has been the lead statistician on several data collection efforts, including the Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Annual Survey. He has a master's degree in biometry and statistics from the University at Albany, State University of New York.

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Heidi Whitmore is a senior research scientist at the Health Care Research Department, NORC at the University of Chicago. Whitmore has experience in private health insurance and establishment surveys, with work on questionnaire design and administration and research focused on employer health benefits, retiree health benefits, and small-group and individual insurance markets. Whitmore is

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Michael Slover is a research associate at Towers Watson.

Michael Slover is a research associate at Towers Watson. He has provided programming and analytical support in multiple areas of health care research, including employer health benefits as well as group and individual-market health plans. He has experience working with multiple data sources, including Thompson Reuters' MarketScan and the Annual Social and Economic Supplement of the Current Population Survey from the Bureau of Labor Statistics. Slover has a master's degree in economics from North Carolina State University.

Ethan Levy-Forsythe is a research analyst at the Health Care Research Department, NORC at the University of Chicago. He specializes in quantitative and qualitative data collection and analysis, and he is working on projects funded by the Office of the National Coordinator for Health Information Technology, Health Resources and Services Administration, and Centers for Medicare and Medicaid Services, among others. Levy-Forsythe received a bachelor's degree in sociology from the University of Maryland, College Park.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

December 23, 2014

The Honorable Chris Collins
Chairman
Subcommittee on Health and Technology
Committee on Small Business
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman,

I am writing to follow up on the testimony of Ms. Mayra E. Alvarez during your Subcommittee hearing on the Small Business Health Options Program (SHOP) on September 18, 2014. A mistake was made in reporting the number of individuals with effectuated enrollment. When Ms. Alvarez testified before your Subcommittee, she reported that 7.3 million Americans were enrolled in Marketplace coverage and had paid their premiums as of August 15, 2014. This number represented effectuated enrollments in both medical and dental plans, including a small number of Small Business Health Options Program (SHOP) enrollments.

Moving forward, only enrollees with medical coverage in the individual market will be included in our effectuated enrollment numbers unless otherwise specified. Additionally, now that the Federally-facilitated SHOP is operational with online functionality, CMS will receive information about federal SHOP enrollment. We are focused on providing reliable, complete and accurate information on SHOP enrollment, and look forward to sharing that information with the Committee when it becomes available.

Thank you for your interest in this issue.

Sincerely,

Lauren Aronson
Director, Office of Legislation
Centers for Medicare & Medicaid Services

CC: The Honorable Janice Hahn, Ranking Member