California Health Benefit Exchange

Small Employer Health Options Program

Discussion Draft – Options and Recommendations

May 18, 2012

This document is a compilation of major issues the California Health Benefit Exchange needs to consider regarding the establishment of the Small Employer Health Options Program (SHOP) exchange. The options and preliminary recommendations reflect work of Exchange staff, supported by PricewaterhouseCoopers.

The options, recommendations and background material reflect input that has been received over the past six months by the Exchange and a deep review of national experience running small employer purchasing pools. In addition, they were developed with consideration both of the Exchange's overall mission and values, as well as a set of policy guidelines that were shared in draft form with the Board in April. Those guidelines are included in this document as the first Recommendation Brief. The five areas that follow that include recommendations have a summary of the issue, background, options, recommendations and background reference material. Staff is also providing a Background Brief, with no current recommendations, on the Employer Tax Credit. The Exchange is still in the process of developing options and recommendations in the umbrella area of its qualified health plan selection processes, many of which will have significant impacts on the SHOP. In addition, the Exchange will also develop an additional SHOP-specific Board Options Brief on the issue of managing the SHOP internally or contracting out the operations of the SHOP.

The options discussed and recommendations made in these materials are preliminary and will be revised based on input from the board and from stakeholders in general. The Exchange invites comments on these or other SHOP-related issues, ideally with written comments being provided to the Exchange by the close of business May 31, 2012. Please submit comments to info@hbex.ca.gov (note: that the "Stakeholder" section of the Exchange website provides an input form that we would appreciate commenters using).

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Executive Summary

The California Health Benefit Exchange is establishing Individual and Small Business Health Options (SHOP) exchanges. The Individual and SHOP exchanges offer a competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. The staff of the California Health Benefit Exchange, with support from PricewaterhouseCoopers, has prepared a series of briefs to help inform the Exchange Board of the issues pertaining to the establishment of the Small Business Health Options Program exchange and to present options and preliminary recommendations for the Board's consideration. In subsequent work, additional Briefs will be developed to address issues related to the definition of Qualified Health Plans under both the Individual and SHOP exchanges.

The issues addressed and preliminary recommendations outlined in this document reflect substantial input from a wide range of stakeholders. In addition, they were developed with consideration both of the Exchange's overall mission and values, as well as a set of policy guidelines that were shared in draft form with the Board in April. Those guidelines are included in this document as the first Recommendation Brief

The seven Board briefs contained in this package are as follows:

- Board Recommendation Briefs
  - Exchange QHP and SHOP Guidelines
  - SHOP and Individual Exchange QHP Alignment
  - Extent of Employer Versus Employee Choice
  - SHOP Agent Strategy
  - Small Employer Benefits Administration and Ancillary Benefit Options
  - Employer Contribution and Participation Options
- Board Background Brief
  - Promoting Employer Tax Credit for Health Coverage

In most areas, staff has presented the Board with initial recommendations. These recommendations are preliminary and we believe will be informed by both discussions with the board, but also input from small employers, consumers, health plan providers, agents and others.

Board Recommendation Briefs

SHOP and Individual Exchange QHP Alignment

Under California law, the California Health Benefit Exchange will establish a Small Business Health Options Program separate from the Exchange's activities related to the individual

market. Among the alignment issues to be considered, the Exchange will need to consider how closely aligned the QHPs should be between the two Exchanges to ensure adequate choice for the participants of each. The QHP alignment issues presented in the brief separately address alignment of health plan issuers and alignment of benefit plan offerings.

The following options are available for alignment of health plan issuers between exchanges:

- **Option A1: Full alignment:** Health plan issuers submit qualified health plan applications for participation in both individual and SHOP exchanges in the same geographic coverage regions, and contracts are only awarded to issuers that can serve both markets.
- **Option A2: Partial alignment:** Health plan issuers submit applications for participation in both the individual and SHOP exchanges. However, the Exchange would permit health plans that only want to participate in one exchange on an exception basis.
- **Option A3: No required alignment:** Health plans may participate in either Exchange.

The following options are available for the alignment of benefit plan offerings between exchanges:

- **Option B1: Full alignment:** Benefit plan offerings would be identical in both exchanges.
- **Option B2: Partial alignment:** Benefit plan offerings would generally be consistent in both exchanges, with the possibility of some differences to meet the needs of Individual and Small Group enrollees.
- **Option B3: No required alignment:** Benefit plan offerings are unique to each Exchange.

Staff has made a preliminary recommendation to pursue (partial alignment for both) plans and benefit design (A2 and B2).

Extent of Employer Versus Employee Choice

The Exchange is considering the extent to which employers and employees will have a choice of health plans and benefit designs under the Small Business Health Options Program exchange. Among considerations is the range of health plan choices made available, as well as the treatment of supplemental benefits such as adult dental and vision services. The following options are available:

- **Option 1. Employer chooses issuer and tier:** Employer selects the health plan and coverage level within the available SHOP options.
- **Option 2. Employer chooses issuers, employee chooses tier:** Employer chooses among available health plans and allows the employee to select the level of coverage among metal tiers.

- **Option 3. Employer chooses tier, employee chooses issuer:** Employer establishes the metal tier for all employees, and allows employee to select among available health plans.
- **Option 4. Paired or defined choice:** Employee chooses a specific combination of health plans for employees to select from. Further choice may or may not be available among coverage tiers.
- **Option 5. Full employee choice:** Employer determines the maximum contribution that will be made on behalf of employee, and allows employee to select health plan and coverage level.

Staff has made a preliminary recommendation to pursue the paired or defined choice option (Option 5).

SHOP Agent Strategy

Agent engagement and structure of the agent payments have important implications for sales and distribution of the SHOP Exchange products. Based on prior market experience the role of agents, as well as how the SHOP commission payments are administered, are considered particularly critical for the SHOP. The following options are available for the Exchange:

- **Option 1. Match commissions (Plan pays):** Exchange matches health plan commissions and health plans administer payments to brokers and agents.
- **Option 2. Match commissions (Exchange pays):** Exchange matches health plan commissions and administer payments to brokers and agents.
- **Option 3. Exchange sets and pays commissions:** Exchange sets rates for brokers and agents, and issues payments to them.

Staff has made a preliminary recommendation to pursue the option of the Exchange either "matching market compensation or setting its payments, but under either option paying agents directly (Option 2 or Option 3).

Small Employer Benefits Administration and Ancillary Benefit Options

To encourage the broadest participation in the SHOP Exchange, the Exchange may provide health and administrative support that best serve the needs of small businesses as well as brokers and agents. By aggregating services to administer COBRA and Cal-COBRA, Flexible Spending Accounts, and Health Spending Accounts, the Exchange has the potential of providing value-added benefits that facilitate one-stop shopping at a modest cost. The following options are for consideration:

- **Option A1. Cal-COBRA/COBRA only administration:** Exchange undertakes a minimal role in employer benefits administration.
- **Option A2. Mixed vendor limited employer benefits administration:** Exchange engages vendor(s) to provide select employer benefit administration services and may offer some services directly.

- **Option A3. Full-service vendor-supported benefits administration:** Exchange engages a single vendor to provide an array of employer benefits administration services.

Staff has made a preliminary recommendation for the Exchange to offer limited benefits administration (COBRA, HRA, HSA, FSA and Section 125) (Option A2) through mixed vendors to maximize its flexibility in program design and opportunity to engage small employers and agents for key input. This recommendation is subject to further review of costs and employer interest.

There are two approaches for implementation of ancillary benefits:

- Option B1. The Exchange provides employer benefits administration services and offers ancillary benefits using specialty carriers.
- Option B2. The Exchange provides employer benefits administration services and offers ancillary benefits through multiple participating health plans.

Under Option B1, the Exchange may consider an endorsed relationship whereby the Exchange shares in the fees that are collected from users. If Option B2 is considered, the Exchange would explore opportunities to leverage plan negotiations with access to selling supplemental products in the Exchange.

Employer Contribution Options

In part due to its tax-preferred status, employer contributions in lieu of wages are directly linked to the extent to which health care coverage is affordable for employees. However, as the cost of healthcare has soared, premium contributions are becoming more unaffordable for employers. Employers who have historically offered coverage are increasingly looking toward benefit plans that shift a higher share of costs to employees in the form of high deductibles, high copays, and other benefit limiting features in exchange for lower premiums, are turning toward defined contributions to limit expense increases, or are choosing to continue not to offer or to stop offering coverage altogether. The Exchange must consider the options related to the extent to which it requires small businesses to make premium contributions on behalf of their employees. The following options are available:

- **Option 1. Require contributions consistent with current market underwriting rules:** Establishes minimum employer contributions at levels consistent with the current small employer market.
- **Option 2. Require contributions at least meet minimum federal tax credit:** Establishes minimum employer contributions at levels that ensure the tax credit can be taken, if other requirements are satisfied.
- **Option 3. Require contributions at a level higher than current market or federal tax credit:** Establishes minimum employer contributions at levels higher than the current market or federal tax credit requirements to qualify for a tax credit to support more affordable coverage for employees.

Board Background Brief

Promoting Employer Tax Credit for Health Coverage

The tax credit is considered an important incentive for small businesses to participate in the SHOP. The Affordable Care Act also included a small business tax credit beginning in the 2010 tax year that has thus far had little take-up. The reason cited for the relatively low adoption of the tax credit has been that it is generally not well understood by small businesses and that it may be of marginal benefit to many small employers. The employer tax credit issue is fundamentally one of ensuring employer awareness of its value and availability, and should be considered a core marketing feature to support development of the SHOP marketing strategy.

Guidelines for Selection and Oversight of Qualified Health Plans and the Development of the Small Employer Health Options Program

The policies, procedures and criteria for the California Health Benefit Exchange's selection and oversight of Qualified Health Plans (QHP) and the Small Employer Health Options Program (SHOP) should be specifically guided by the Exchange's vision, mission and values. The Guidelines that follow reflect core issues that should be considered for each policy/decision made by the Exchange in the development and implementation of coverage offerings. Where possible, the positive or negative impact on each of the following considerations should be quantified or framed by clearly articulated rationales for the basis of the assumptions used.

There will be "trade-offs" among competing goals and interests, but Exchange policies should consider those trade-offs and the implications of alternative policies.

Policy guidelines (with detailed examples on following pages):

I. **Promote affordability** for the consumer and small employer – both in terms of premium and at point of care.

II. **Assure access to quality care** for consumers presenting with a range of health statuses and conditions

III. **Facilitate informed choice of health plans and providers** by consumers and small employers.

IV. **Promote wellness** and prevention.

V. **Reduce health disparities** and foster health equity

VI. **Be a catalyst for delivery system reform** while being mindful of the Exchange's impact on and role in the broader health care delivery system.

VII. **Operate with speed and agility** and use resources efficiently in the most focused possible way

I. Promote affordability for the consumer and small employer – both in terms of premium and at point of care

a. Offer health plans, plan designs and networks that foster competitive and stable premiums.
b. Offer health plans, plan designs and networks that will attract maximum enrollment as part of the Exchange's effort to lower costs by spreading risk as broadly as possible.
c. Assure Qualified Health Plans are not disadvantaged compared to the price or products offered outside of the Exchange.
d. Offer benefit plan designs and contribution strategies that encourage small employers to make available robust coverage and support effective employer contribution levels.
e. Link plan selection and designs to the Exchange's outreach and enrollment practices geared at maximizing enrollment of subsidy-eligible individuals and tax-credit eligible small businesses, as well as unsubsidized individuals and businesses.
f. Rely on existing standards, measures or processes for selecting and monitoring health plans and provider performance, building toward more robust standards and outcome measures over time to minimize burden and costs.
g. Evaluate all Exchange policies, marketing and oversight in context of the potential impact on premiums

II. Assure access to quality care for individuals with varying health statuses and conditions

a. Require robust performance measures in order to ensure that consumers receive high quality care. Exchange measurement strategies should include:

1. Align with standard measures, such as those adopted by the National Quality Forum and as reflected in the National Quality Strategy, the National Prevention and Health Promotion Strategy and the Medicare Strategic Framework for Multiple Chronic Conditions.
2. Build on established quality, performance and patient experience measures currently in use.
3. Support the expansion of measures that focus on health outcomes, patient-reported health status and cost of care.

b. Ensure that plan design, provider network and access standards promote access to care based on patients' needs, health status and personal characteristics, including the desire to promote continuity of care for individuals that may move between coverage types (e.g., Medi-Cal, Healthy Families, Individual and Employer) or have family members with different coverage. Evaluate options in consideration of the following:

1. Meaningful access and timeliness standards;
2. Language and culturally appropriate care to Exchange enrollees;
3. Access to primary care and reduction of health risks;
4. Effective management of chronic conditions;
5. Specialty care, including addressing rare and complex conditions; mental health and substance abuse care needs.
6. Effective inclusion of safety net community health centers; academic, children's, rural and public hospitals; a mix of trained health professionals.

c. Consider how access to needed care is promoted and how Exchange policies can expand primary care access over the medium to long term, including through innovations in care delivery such as use of telemedicine and person-centered care that meets the needs of each individual.

III. Facilitate informed choice of health plans and providers by consumers and small employers.

a. Because "health care is local", health plan choice should be anchored in local options for consumers and employers, while assuring the Exchange offers statewide coverage.
b. Foster a high level of plan participation that will permit meaningful choice for individuals and small employers.
c. Contracted plans should provide Exchange enrollees with tools to understand the implications of their coverage selection on provider and treatment choices and tools to choose their providers.

IV. Participate in and support efforts to efficiently collect and appropriately report information that can inform consumers' choice of coverage, providers and treatment options including information on QHP and provider quality, cost and consumer experience. Promote wellness and prevention

a. Offer health plans, plan designs and networks that will promote enrollees' maintaining good health and preventing disease.
b. Identify opportunities to align with community health and wellness initiatives.

V. Reduce health disparities and foster health equity.

a. Consider and evaluate on an ongoing basis the extent to which Exchange policies promote health equity and the reduction of health disparities.
b. Exchange policies shall assure that QHPs offer a sufficient number of providers with linguistic and cultural competence to serve diverse enrollment.

VI. Be a catalyst for delivery system reform while being mindful of the Exchange's impact on and role in the broader health care delivery system.

a. Align Exchange strategies to foster improvements in care delivery with other National and state payment and delivery system redesign efforts to maximize impact on the delivery system, including Centers for Medicare and Medicaid Services, Medi-Cal, CalPERS and private sector purchaser initiatives.
b. Adopt policies that encourage and measure provider payment, provider contracting and measurement processes that foster the Exchange's values.
c. Promote consistent evidence-based care while allowing for innovation and person-centered care that meets the individual's needs.
d. Support effective use of health information technology to expand access and foster electronic information exchange.
e. Support making care affordable for individuals inside and outside of the Exchange and be mindful of impacts of Exchange policies on care systems that provide care to the uninsured.

VII. Operate with speed and agility, using resources efficiently and in the most focused possible way.

a. Consider the administrative capacity of the Exchange and the need to phase in some programs over time.
b. In adopting standards, consider the practical capabilities of impacted parties to meet the standards, which may include the need to phase in some standards over time and to modify some standards as data capacity, the delivery system and markets evolve.

SHOP and Individual Exchange QHP Alignment

Summary

While under the federal Affordable Care Act, exchanges can consider merging their individual and small group efforts, under California's law the California Health Benefit Exchange is directed to establish a Small Business Health Options Program (or "SHOP" exchange) separate from the Exchange's activities related to the individual market. As a result, the Exchange will need to consider how closely aligned the qualified health plans (QHPs) and other policies should be between the two exchanges to ensure adequate choice and the best value for the participants of each. This "SHOP and Individual Exchange QHP Alignment" Board Recommendation Brief provides background on these issues, a summary of the options available to the Exchange, and preliminary recommendations for the Board's consideration.

Background

The Affordable Care Act allows states to choose to operate separate exchanges for the individual and small group markets, or merge the two markets into a single exchange. Under a merged exchange both markets would be offered the same certified QHPs. However, operating separate Exchanges will require the state to evaluate how closely aligned the QHPs should be between them. California has elected to operate separate SHOP and Individual exchanges.

A QHP is defined as a health plan certified by the Exchange as providing essential health benefits, following established limits on cost-sharing, and meeting other requirements as specified under the Affordable Care Act federal regulations and as established by the state and/or the Exchange. Generally speaking there are three QHP alignment options: full alignment between the Individual and SHOP exchanges, partial alignment, or no required alignment. However, at a more refined level, alignment of the issuers of health care coverage should be considered separately from alignment of the offered benefit designs (which here is intended to include the type of health plan including provider network structure and size in addition to the cost sharing provisions). Decisions on alignment of QHP should be considered in conjunction with decisions on the number of QHPs to be offered respectively in the individual and SHOP exchanges, the range of benefit plans to be offered in the exchanges, and the level of standardization in benefit designs that will be required.

Alignment of Health Plan Issuers

There are a number of reasons that alignment of the health plan issuers between the Individual and SHOP exchanges might be desirable, including:

- It would promote continuity of care for individuals that move between the Individual and SHOP Exchanges.

- It would reduce total administrative costs by reducing the total number of issuers that the Exchanges would have to certify and negotiate contracts.

- It may provide the Exchange with negotiating leverage, particularly with regard to encouraging participation in the SHOP Exchange, given its smaller size relative to the Individual Exchange.

There are also a number of reasons a health plan issuer may want to participate in one Exchange but not the other including:

- Historical or desired market focus: Health plans may not want to expand into the Individual or Small Group markets if they have not historically participated in it or if it does not fit their business strategy. (Note: Historically one reason that some health plans have been in the small group market and not the individual market has been a lack of interest in performing individual underwriting. Due to the changes under the Affordable Care Act, this will likely be less of an issue effective 2014.) Conversely, some plans have focused entirely on serving individuals, such as Local Initiative plans, which serve Medi-Cal or Healthy Families beneficiaries and have not developed the capacity or expertise to serve employer groups.

- Market Size: In total the individual market will be approximately five to six times larger than the small group market. The size of the likely enrollment in the California individual Exchange is large, with estimates ranging from 1.0 to 1.5 million by 2018, representing 50% to 70% of the entire individual market in California. In contrast, while the total market for small business remains large -- estimated at 3.4 million currently -- a small percentage of that market is likely to enroll through the Exchange.

- Adverse Selection Risk: Even with the protections provided by the risk adjustment, reinsurance, and risk corridor provisions under Affordable Care Act, the Individual market may be perceived as "too risky" for some insurers, as its composition is likely to be significantly different than its historical make up due to the change to a guaranteed issue market. Although the Affordable Care Act includes a provision that requires all individuals to have health insurance coverage, the penalties attached to that requirement may not be sufficient to encourage all healthy individuals to purchase coverage, providing the potential for adverse selection. The general expectation is that small employers enrolling in the SHOP Exchange will have a risk profile comparable to the average small employer market. There is a risk, however, that small group employers that have, on average, favorable claims experience may decide to pursue a self-insured arrangement, whereas employers with higher than expected claims costs may elect to purchase coverage through the outside small employer market or the SHOP Exchange. While it is unusual today for employers with 50 or fewer employees to self-insure, there is interest in that option among some groups.

- Individual/Medicaid link: Some health plans currently operating as Medicaid managed care plans may see the Individual market as a natural expansion market due to the linkages and expected movement between those coverages as incomes fluctuate, but may not have the administrative capacity to serve the small employer market.

Alignment of Benefit Designs

In the context of health insurance, benefit design may refer to the following:

- Product type (e.g., PPO, HMO)
- Coverage or exclusion of specific benefits or services
- Form and level of point of service patient cost sharing (e.g., deductibles, copays, coinsurance, out-of-pocket payment limits)
- Benefit limits (e.g., total annual or lifetime maximum benefit payment, dollar or visit/day limits for specific benefits/services
- Provider network characteristics (e.g., broad network, narrow network)

The Affordable Care Act included several provisions that impact benefit coverage. First, it eliminated most annual and lifetime benefit limits, though limits on specific benefits are allowed. The elimination of annual and lifetime limits applies to plans offered to employees of large businesses in addition to individual and small employer plans. It also created groupings of plan designs into metal tiers (platinum, gold, silver, bronze) based on the percentage of covered benefits for which the plan pays, ranging from 90% for platinum plans to 60% for bronze plans. To assist in defining the "Essential Health Benefits" to be covered under each benefit plan, the US Department of Health and Human Services proposed defining Essential Health Benefits based on 10 broad benefit categories that all benefit plans offered in the individual and small group markets have to cover beginning in 2014. The specific covered services and benefit-specific limits will be defined based on the "benchmark plan" selected by the state from 10 potential benchmarks. Legislation introduced in California defines the benchmark plan as the Kaiser Small Group HMO plan.

There are a number of reasons that alignment of the benefit plan offerings between the Individual and SHOP exchanges might be desirable, including:

- It would reduce total administrative costs by reducing the total number of health plan offerings for which the Exchange would have to analyze, certify, and prepare marketing/sales materials.
- Though there is a tendency for Individual purchasers to lean toward plans with higher cost sharing requirements, benefit offerings in the Individual and Small Group markets effective 2014 will likely be very similar, particularly since essential health benefit

requirements standardize coverage to a large degree, including mandating coverage of maternity and mental health benefits in both markets as well as the market outside the exchanges. Further, the definition of actuarial value is standardized for the purpose of measuring benefit richness, and the federal government will develop and provide standardized tools for calculating the actuarial value of benefit plans.

The potential reasons that would counsel against alignment of benefit design offerings include:

- The possibility of stifling innovation if changes must be implemented in both markets simultaneously
- A preference for specific types of benefit designs in one market or the other
- Variation in the willingness of either Individuals or Small employer groups to work within constrained provider networks to the extent narrow networks are used as a mechanism to contain costs.

Stakeholder Perspectives

Many respondents expressed the belief that SHOP standards should be the same as standards for individual coverage. At the same time, small business advocates have noted the importance of the SHOP Exchange being specifically sensitive to the needs and perspectives of small business. Some stakeholders thought it was important to encourage local health plans to participate in the Exchange due to their geographically-sensitive provider networks. If full alignment of QHPs was required, local health plans might be precluded from participating in the Exchanges because they are not licensed to sell group insurance and would need to develop the administrative capacity to operate in that market.

Options

There are a range of topics associated with alignment of QHPs between the individual and SHOP exchanges. This Board Recommendation Brief presents options and recommendations related to the following two alignment issues:

Issue A: Alignment of health plan issuers
Issue B: Alignment of benefit plan offerings

Under each of these categories, the options are:

Option 1: Full alignment
Option 2: Partial alignment
Option 3: No required alignment

The options are detailed in Tables 1 and 2 that follow the Recommendations.

Recommended Approach

One of the state's goals in developing its individual and small group Exchanges is to ensure that the participants have an adequate choice of health plans. Staff recommends that the Exchange partially align its health plans and benefit design structures between the exchanges (Options A2 and B2). The partial alignment model provides the Exchange with the flexibility to select QHPs that provide an optimal level of choice for participants, while limiting additional administrative expenses and maintaining negotiating leverage with health plan issuers.

To protect against adverse selection and assure a good mix of plans in both exchanges, staff recommends that health plans with a license to sell both individual and small group coverage be required to participate in both exchanges, while issuers licensed to participate in only one of those markets be permitted to participate in the relevant Exchange. Requiring full alignment of the QHPs (health plan issuers and benefit offerings) between exchanges may be too restrictive, resulting in inadequate levels of choice between health plan issuers as well as benefit plan designs, given that many issuers currently are licensed to sell in only one market. At the same time, requiring alignment where it is an option will enhance offerings to Exchange participants.

Staff recommends alignment of benefit plan offerings except where a clear argument can be made for differences will reduce confusion among consumers. Because the definition of Essential Health Benefits must be identical across both markets, and the definition of actuarial value is the same, there is a limited range of variation that may be offered. The exception is in the area of provider network coverage, where issuers may wish to test innovative options on a smaller scale, and where that innovation may be stifled if it has to be implemented in both markets simultaneously. Consequently, we believe that some flexibility in alignment of benefit design offerings should be available.

In addition to determining a general direction regarding health plan issuer and benefit design alignment, the Exchange will need to consider additional issues, including:

- Whether the level of alignment should vary geographically based on health plan licensing status;
- Whether there are specific differences in preferred alignment in benefit design options due to pricing differences; and
- Whether issuers should be encouraged to broaden their licensed coverage areas over time.

Staff would explore these issues and others raised by health plans and other stakeholders before finalizing these recommendations.

Table 1: Alignment of Health Plan Issuers between Exchanges		
Option A1: Full Alignment	**Option A2: Partial Alignment**	**Option A3: No Required Alignment**
SUMMARY The Exchange would require that health plans submit QHP applications for participation in both the individual and SHOP Exchanges in the same geographic coverage regions.	**SUMMARY** The Exchange would require that health plan issuers submit applications for participation in both the individual and SHOP exchanges. However, under this design, exceptions would be allowed for health plans that are only licensed to sell insurance in one of the market segments. Additionally, niche health plans (e.g., Medicaid only plans) could submit applications to participate in one Exchange, and selection would depend on the extent to which it supported the goals of the Exchange.	**SUMMARY** Health plans would have the option of submitting applications to become a QHP for either of the Exchanges but would not be required to submit for both. Each Exchange would select the health plan issuers that it believes would best help it meet its objectives.
PURPOSE Requiring health plan issuers to submit a joint application to both exchanges would ideally result in the availability of adequate choice of health plans across both Exchanges.	**PURPOSE** For various reasons, some health plans may not have the ability or interest in providing coverage and/or adequate access if required to participate in both Exchanges.	**PURPOSE** This option would provide the greatest level of flexibility for health plans to strategically position themselves within the two Exchanges.
PROS ▪ Full alignment would foster continuity of care for individuals that move between the two Exchanges ▪ Would result in a reduced level of administrative costs across the Exchanges as compared with the other options ▪ May provide negotiating leverage to the Exchange ▪ May be important as a strategy to ensure adequate QHP options in rural areas	**PROS** ▪ Provides additional flexibility for health plans that may be better positioned to participate in only one of the Exchanges ▪ Would likely result in an increased level of choice for individuals ▪ Supports Exchange mitigation strategies for addressing geographies with inadequate choice of QHPs, in particular in the SHOP Exchange	**PROS** ▪ Would provide increased flexibility to develop choice options across the state ▪ Could result in an increased level of choice for individuals ▪ Increased flexibility may support Exchange mitigation strategies for addressing geographies with inadequate choice of QHPs relative to Option 1

Table 1: Alignment of Health Plan Issuers between Exchanges		
Option A1: Full Alignment	**Option A2: Partial Alignment**	**Option A3: No Required Alignment**
CONS ▪ Some health plan issuers may not want to participate in both markets and may choose not to contract with the exchanges if alignment is required ▪ There may be limited numbers of issuers with the capacity to serve both markets, resulting in an inadequate level of choice for individuals	**CONS** ▪ As compared with option 1 it could lead to an insufficient number of health plans submitting applications to participate in the SHOP Exchange, given the lower enrollment projections ▪ Depending on the amount and type of alignment, could be confusing and lead to disruptive care for individuals that transition between exchanges when consistent health plans are not participating in both	**CONS** ▪ May result in an insufficient number or mix of health plans participating in the SHOP exchange ▪ Could be confusing and lead to disruptive care for individuals that transition between exchanges when a health plan does not participate in both ▪ Administrative costs and complexities would be the greatest under this option

Table 2: Alignment of Benefit Plan Offerings between Exchanges		
Option B1: Full Alignment	**Option B2: Partial Alignment**	**Option B3: No Required Alignment**
SUMMARY The Exchange would require that the benefit offerings be identical in both exchanges.	**SUMMARY** The Exchange would require that the benefit plan offerings be generally consistent in both exchanges, with the possibility of some differences to best meet the needs of Individual and Small Group enrollees.	**SUMMARY** The Exchange would evaluate benefit plan offerings in each Exchange separately, without any specific intent to make the offerings similar in the type or number of benefit plans.
PURPOSE This option would provide consistency in the types and range of benefit plan options available in each Exchange.	**PURPOSE** This option provides for general consistency in the offerings of both exchanges, with the flexibility to offer different plans depending on population needs.	**PURPOSE** This option would provide the greatest level of flexibility for the exchanges to offer benefit plan designs that meet the needs of Exchange participants.
PROS ▪ Promotes understanding of available benefit options by participants ▪ Reduces Exchange administrative costs	**PROS** ▪ Promotes understanding of available benefit options by participants ▪ Allows each Exchange the flexibility to address the needs of its participants	**PROS** ▪ Provides each Exchange with the greatest flexibility to address the needs of its participants ▪ Allows health plans in each Exchange to better tailor products that are targeted to the market
CONS • Does not address differing needs of each market	**CONS** ▪ Insofar as benefits are different, may be more confusing to participants, particularly those moving between the Individual and SHOP exchanges ▪ May increase Exchange administrative costs	**CONS** ▪ Likely to increase Exchange administrative costs relative to other options

Reference Material

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Extent of Employer Versus Employee Choice

Summary

The California Health Benefit Exchange is considering the extent to which employers and employees will have a choice of health plans and benefit designs under the Small Employer Health Options Program (SHOP) Exchange. This "Employer Versus Employee Choice" Board Recommendations Brief provides a summary of the options available to the Exchange to optimize employer and health plan participation, and to ensure employees have meaningful choice. In considering how much choice will be made available to employers and employers, the key issues that must be addressed are adverse selection both within the Exchange and between the Exchange and the broader insurance market, the amount of information and decision support that will be needed to enable employers or employees regarding how to make appropriate choices, the interest level of health plans in participating in the Exchange, and the interest level of employers in purchasing insurance through the Exchange. The brief includes preliminary recommendations.

Background

Federal guidance provides that the SHOP has the option of allowing employers either to make a full range of health plans available to their employees, or may allow the employer to limit choice to one or more Qualified Health Plans (QHPs). Within that guidance is also the opportunity for employers to limit the "metal tier" of coverage available to employees, or to set a contribution level and allow the employee to choose among metal tiers (but not to choose a lower tier than the minimum established by the employer.) Note that this limitation would be linked to the employer contribution requirement and the decision regarding the number of plans to be made available through the SHOP, which are discussed in separate Board Recommendations Briefs. The level of choice afforded to employees represents a tradeoff between providing employees with more choice, such as that available to individuals purchasing on their own, and concerns about adverse selection on the part of health plans that may impact the availability or pricing of plans in the SHOP Exchange. The ultimate level of choice also depends on decisions regarding the number and range of QHPs that will receive contracts in each geographic area. For example, if the decision is made to limit the number of plans receiving contracts, choice will be naturally limited to those plans, whereas if there are a large of health plans choice will inherently be greater in the absence of any limitations that are imposed.

The final federal regulation requires that the SHOP allow employers to **select a level** at which all QHPs are made available to employees. The final rule further provides that Exchanges may

permit participating employers to make **one or more** QHPs available to their employees through a different method.

Stakeholder Comments

Stakeholders provided the Department of Health and Human Services with many comments on the proposed employee/employer choice provisions, ranging from those supporting additional employee choice options such as offering plans across cost-sharing levels, to comments concerned about risk selection and in favor of more limited employee choice options in the SHOP. The final regulations note that nothing in the Affordable Care Act limits an Exchange's ability to offer additional options, including choice across cost-sharing levels, or allowing employers to offer only one plan.[*]

Most health plans tend to prefer options that are anchored in "employer choice" and result in less choice for employees to protect against adverse selection. As one example, a large health plan offered in their comments to the Exchange the following:

> *"…We recommend that the California Health Benefit Exchange employ reasonable limits to guard against adverse selection and preserve a functional small group market. In particular, we are concerned that permitting employees to select from among any plan available in the SHOP exchange will lead to sicker employees selecting richer products while healthier employees select slimmer benefit packages.*
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> *To address these concerns, we recommend that the exchange follow the default option set forth in the final exchange rule and direct employers to select a metal level, and that employee choice be within that level. And to further avoid adverse selection, we strongly encourage the exchange to include a provision ensuring employees are not allowed to enroll in a QHP below the level selected by their employer. Alternatively, to permit employers to offer multiple plan designs to their employees, such as the choice of an HMO or a PPO, we propose that employers could select several QHPs offered by a single QHP issuer and permit employees to choose among them. Lastly, the exchange should permit issuers to price accordingly for any version of employee choice given the selection dynamics that will result from this option."*

There is some experience with employee choice in exchanges that suggests that full unlimited choice may indeed have negative impacts. In an article written for Health Affairs, Micah Weinberg of the Bay Area Council and William Kramer of the Pacific Business Group on Health write:

[*] 1. Employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

2. SHOP options with respect to employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

> *"The experience of PacAdvantage shows that choice can come in many forms. The most commercially successful product offered through this purchasing pool was a hybrid that combined employer and employee choice. The Paired Choice product allowed an employer to select among a number of different PPOs, one of which would be paired with an HMO from the large integrated delivery system, Kaiser Permanente. Employees then chose between the PPO and the HMO paying higher premiums if they wanted lower point-of-service costs."*

However, advocates for consumers and some small businesses tend to favor more choice for employees. In the case of Massachusetts Connector's pilot employee-choice program, 90% of responding employees reported liking a model that offers choice of plans. While adverse selection in the small group market is perhaps the biggest risk of an employee-choice model, the model offers new opportunities for many small businesses and it has been successful in New York, Connecticut and Massachusetts. According to the Center for State Health Policy report,

> *"Connecticut's Health Connections launched in 1995, serves 6,000 small employers and covers over 80,000 lives. By ensuring a level playing field and robust participation of diverse small businesses and their employees, this cooperative has avoided adverse selection and remained a viable market since inception. New York HealthPass, a not-for-profit exchange operating since 1999, offers another example of widespread use of employee-choice model and defined contributions. HealthPass has not struggled with adverse selection undermining its operation, perhaps owing in part to the pure community rating environment in New York State. Like Health Connections, HealthPass offers participating employers and their employees extensive administrative support, such as enrollment and premium aggregation services. Together with employee choice of coverage option, the rich administrative services help attract many small businesses, particularly those without in-house human resources staff.*
>
> *Both Health Connections and HealthPass also maintain good relationships with the broker community, which has been instrumental in reaching and enrolling new small businesses. A large and growing pool of covered individuals is more likely to have a risk profile that resembles the larger population and to attract insurers to the market, further reducing the potential for adverse selection."*

In a report documenting the results of a forum held on the California SHOP Exchange, the Small Business Majority reports:

> *"Creating an employee choice model, however, will differentiate the SHOP from the outside market and provide an incentive for businesses to purchase coverage through the exchange. Small business owners will be relieved from the administrative burden of finding a one-size-fits-all plan and workers will have the freedom to select the plan that is right for them. Today, employee choice is something only usually offered by large companies and government agencies, putting small businesses at a competitive disadvantage when trying to attract and retain the best employees."*

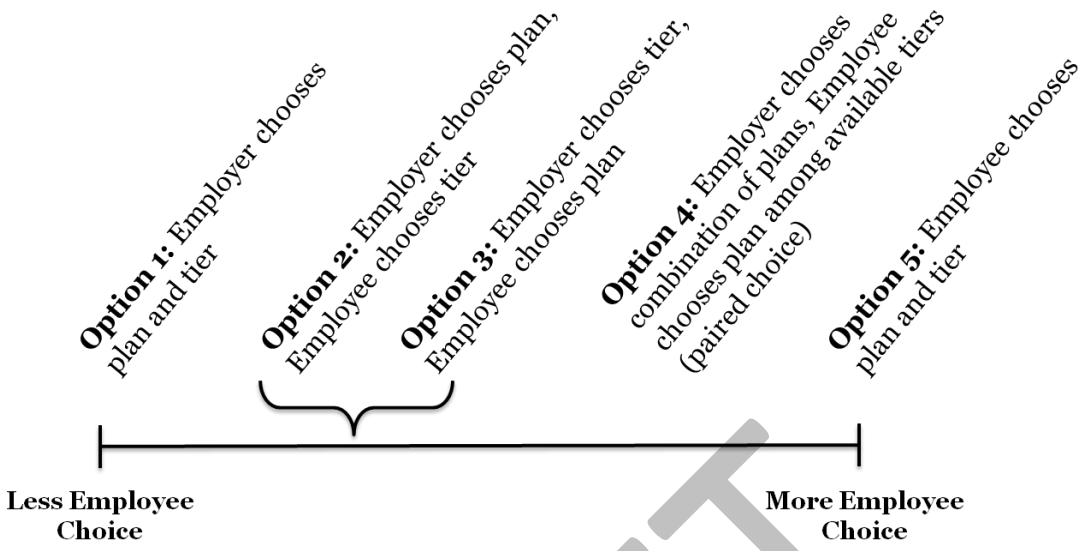
Response to Stakeholder Comments

Among the features considered to be important to the success of the employee choice model in New York, Connecticut and Massachusetts was common pricing in and out of the exchange, which is a requirement of the Affordable Care Act. Other market reforms that are expected to reduce the potential for adverse selection between the Exchange and the broader insurance market are the requirements for common benefit designs and common pricing in both markets. Further, market wide Risk Assessment and Risk Adjustment is intended to adjust for any adverse selection that exists

The Affordable Care Act specifically requires that health plans price the same benefit plan identically in and outside of the Exchange, and California law requires that all health plans offering coverage in the Exchange offer identical benefit designs in the external market (they may also offer other benefit designs). Health plans must pool their Individual market pricing and their Small Group pricing, such that the difference in premium rates relates to variation in actuarial value rather than difference in risk mix. The Affordable Care Act also establishes market-wide Risk Assessment and Risk Adjustment that will mitigate the effects of adverse selection among health plans and between plans offered through the Exchange and the outside market. In California's earlier experience with a small employer purchasing pool these common pricing and benefit design rules did not exist, and there was a challenge in maintaining competitive pricing compared to the external market. The lack of common rules in both markets ultimately required the development of different marketing arrangements to try to offset the effects of adverse selection both in and out of the Exchange, including the decision to use a Paired/Defined Choice offering, defined more fully below.

Options

There are several options for defining the range of choice made available to employers and employees in the Exchange, which are identified below and are detailed in the table following the Recommendations. Included in the options is the notion of "Paired/Defined Choice" whereby specific combinations of plans are made available to employees. The following illustration describes the continuation of choice that may be considered.



Employer - Employee Choice Options

The options are:

- Option 1: Employer chooses Issuer and Tier, requiring that the Employer make all of the choices for his/her employees;
- Option 2: Employer chooses Issuer, employee chooses Tier, providing that the Employer chooses which health plan will be made available, and allowing the employee to choose the coverage level they prefer;
- Option 3: Employer chooses Tier, employee chooses Issuer, providing that the Employer chooses the coverage level for all employees, but allowing the employee to choose their health plan from the available options;
- Option 4: Paired/Defined Choice, requiring that the Exchange negotiate paired options from which the employer would choose to make Issuers available to his/her employees; and
- Option 5: Full Employee Choice, whereby the employee would choose among all options available within their geography, limited by the contribution level made by the employer.

Attached as Table 3 is a summary comparison of the options.

Recommended Approach

The decision regarding the range of choice that will be offered to employees in the SHOP Exchange depends in part on other decisions the Board must make. For example, if the Exchange decides to limit contracting to a smaller number of QHPs in each geographic region and decides to limit the range of benefit designs offered within each rating tier, broader employee choice among the available options may be preferred. Alternatively, if a large number of health plans and benefit design options are offered, less employee choice may be

preferred or complex decision support tools will need to be provided to assist employees in selecting appropriate plans among the range of options. We note that participants in the Individual Exchange will have the full range of options available to them, and will need to have a similar level of decision support. The decision is also dependent on health plan interest in and willingness to contract with the Exchange under the various options, as well as the price at which the options will be made available.

Among the significant advantages to small employers and their employees of purchasing coverage through the SHOP is expanded choice compared to current options and options in the external market, as well as administrative simplification. Consequently, an approach that capitalizes on those elements should be considered, while also monitoring the approach for its impact on adverse selection, both within the Exchange and relative to the broader insurance market. Full choice among health plans and rating tiers will give employees the broadest range of options and will give employers the least responsibility for decision making. The hybrid option of Paired/Defined Choice may be a viable alternative, putting some boundaries around the choices employees must sift through, but puts greater burden on the employer to choose the correct pairings for their employees within the options offered. Exchange staff would need to negotiate those defined offerings with each of the interested health plans to arrive at acceptable offerings, which may be difficult to achieve in the start-up period of the Exchange. This approach was used in PacAdvantage in its later years, when the universe of interested health plans was known.[3]

We believe it is premature to develop Paired/Defined Choice options for the SHOP at this time, as many issues would need to be explored and known, including the effect of such an approach on the price of products offered to the Exchange, to the extent there is latitude in premium pricing. It may also be necessary to ask health plans to submit Paired Choice proposals without knowing which other plans may be interested in contracting with the SHOP.

Staff recommends Option 5, Full Choice of QHPs and coverage tiers for employees, with a defined contribution paid by the employer. The Exchange should recognize that preference may change as more information becomes available through the operation of the SHOP. This option provides maximum choice for employees which may encourage long term participation of employers in the Exchange, requires minimal decision-making by the employer, and enhances competition among health plans. This recommendation should be revisited after QHP policy decisions are made to determine the impact, if any on adverse selection, issuer and employer interest in the Exchange, and pricing.

We also believe significant additional work is needed to finalize the decision on Employer/ Employee choice, including investigation of the following:

- Level of health plan interest in contracting with the SHOP under the different choice options;

[3] At the time the Paired Choice option was implemented there was one large HMO participating in the pool, and a limited number of PPO products.

- Premium pricing differences that may be charged under the options, recognizing that premium rates will be constrained by provisions of the Affordable Care Act;
- Operational challenges that may arise as a result of selecting a particular option, including decision support needs and interactions with the Risk Assessment and Risk Adjustment methods;
- The overall level of choice that will be available in the SHOP, including the number of Issuers that will receive contracts and the mix of plan type and benefit design;
- Employer interest in broader choice options compared to the external market.

Table 3: Summary Comparison of Employer Choice Options		
Option 1: Employer Chooses Issuer and Tier	**Option 2: Employer Chooses Issuer, Employee Chooses Tier**	**Option 3: Employer Chooses Tier, Employee Chooses Issuer**
SUMMARY: The employer makes a choice of health plan and coverage level within the available SHOP options for their geography	**SUMMARY:** The employer chooses among the available health plans for the geography, and allows the employee to determine the level of coverage among the metal tiers	**SUMMARY:** The employer establishes the metal tier for coverage for all employees; the employees choose among available health plans
PURPOSE: This option is similar to the situation commonly available to small employers in the existing market, whereby the employer chooses either a single health plan's product or suite of products and offers that plan to his/her employees	**PURPOSE:** Option allows employees additional choice among coverage levels to better meet individual employee needs, but continues to work with a single health plan	**PURPOSE:** Option ensures all employees of a given employer have the same level of coverage, but can choose among offered plans to allow employees to express their preference
PROS ▪ Most similar to current options for small employers ▪ Simplest to understand ▪ Minimizes adverse selection risk across health plans	**PROS** ▪ Increases options for employees, while minimizing selection challenges ▪ Information on offered health plan is uniform for employees, so decision making can be focused on coverage level	**PROS** ▪ Ensures a common level of coverage for all employees of a given employer ▪ Allows employees to select health plan that best meets their provider and network coverage needs ▪ Enhances competition among plans ▪ Enhances continuity of coverage for employees that switch jobs
CONS ▪ Provides limited reason for employers to select the SHOP, as the same range of options are likely to be available in the external market, except those eligible for tax subsidies ▪ Potentially added cost without added benefit to employers and employees	**CONS** ▪ Limits employee options, particularly if available network of selected plan is relatively narrow ▪ Modest increase in options compared to purchasing in external market, may be insufficient to encourage broad participation	**CONS** ▪ Less choice than Individual Exchange ▪ Level of coverage may be insufficient to meet employee needs, without option to "buy up"

Table 3: Summary Comparison of Employer Choice Options	
Option 4: Paired or Defined Choice	**Option 5: Full Employee Choice**
SUMMARY: The employer chooses a specific combination of health plans that will be made available to employees that is less than full choice, but more than a single plan. Further choice may or may not be available among coverage tiers	**SUMMARY:** The employer chooses neither the health plan options or coverage levels, but determines the maximum contribution that will be made on behalf of employees within the constraints of the minimum contributions established by the Exchange
PURPOSE: Provides a hybrid of choice options to the employer and employee, ensuring the employee has choice within a relatively narrow range of options	**PURPOSE:** Provides maximum choice to employees, similar to options available in the Individual Exchange; takes the employer out of the decision making process once the contribution level is established
PROS ▪ Provides options without overwhelming employee ▪ Choice may encourage long term participation of employers in the Exchange ▪ While some level of decision making by the employer is required, the extent is minimal and most decision remain in the hands of the employees ▪ Less susceptible to adverse selection than unlimited choice ▪ Enhances competition among plans compared to Options 1 & 2	**PROS** ▪ Maximum choice for employee, similar to Individual Exchange ▪ Choice may encourage long term participation of employers in the Exchange ▪ Minimal decision making required by employer; opportunity to provide employees with health insurance coverage with no further time commitment by employer ▪ Enhances competition among plans
CONS ▪ Compared to unlimited choice, some desired options may not be available ▪ Requires negotiations with health plans regarding which other plans they may be paired with	**CONS** ▪ Broad choice may be confusing for employees, decision support tools will be needed ▪ Increased potential for adverse selection across health plans that may exceed corrections made by risk adjustment

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Small Employer Health Options Program (SHOP) Agent Strategy

Summary

The California Health Benefit Exchange is exploring approaches to assure the most effective outreach and enrollment in both its individual and SHOP exchanges, including how best to engage agents. Agent engagement and the structure of agent payments have important implications for sales and distribution of both the individual and SHOP exchange products. Based on prior market experience and the significant proportion of small group sales that are administered through agents, the role of agents is considered particularly critical for the SHOP exchange. Because of the wide agreement regarding the need for agent policies to be largely consistent with the small group marketplace, this "SHOP Agent Strategy" Board Recommendation Brief focuses on various options surrounding ***how*** to administer SHOP commission and compensation payments, rather than if they should be used. It should be noted that there are parallel issues and potentially different recommendations to consider for the Individual Exchange.

Background

The structure of agent compensation in the California Health Benefits Exchange will have a major impact on the enrollment of small businesses in the SHOP. If the rate is above market norms the SHOP may attract some existing groups, but may raise concerns among participating carriers. Paying higher rates would also increase SHOP costs. If the rate is below market norms, agents will likely not promote the SHOP Exchange. These commissions and potential General Agency (GA) load affect the overall affordability of Exchange plans. Like the Exchange, General Agencies aggregate information and products and considerably expand access to the agent community.

Small group plans in California generally compensate agents and general agents at the same level (currently 7% and approximately 2 to 3%, respectively), with some plans paying slightly less. Some issuers are also moving toward models that decrease commissions in later years, and that pay a flat fee that increases with general inflation rather than medical inflation. Agents are generally compensated at a higher percentage level for individual sales than small group, ranging from 9 to 15%, with increased rates linked to volume, and on a descending scale for renewals. Historically, these higher rates of compensation have been attributed to the wide variation in products, the individual health underwriting and more intense ongoing customer service provided. However, these rates have been trending lower in conjunction with the Medical Loss Ratio requirements and the anticipated standardization of products due to clarification of Essential Health Benefits and the actuarial valuation of the metal level designs under the Affordable Care Act.

General Agents assert that the turnover rate among agent-aided sales is lower than direct sales, often because consumers also rely on these agents for their property and casualty coverage.

Agents also function as benefits administration support for small businesses which often do not have dedicated human resources support. Beyond providing rate quotes, they may advise on benefit design options, contribution strategy, interpretation of benefit coverage rules, and resolution of administrative and claims payment issues. They may provide ongoing support for enrollment changes and process coverage status changes through health plan eligibility and enrollment Web portals.

While the agent load has a material effect on premium and overall affordability, prior attempts to eliminate or reduce commissions have had a severe impact on sales. In its initial implementation the Health Insurance Plan of California (HIPC) paid lower commissions and in a different structure than was common in the market and alienated many agents by attempting to limit fees, and then subsequently introduced flat rate fees that were much lower than the prevailing commissions paid directly by health plan. This ultimately reduced potential sales volume and may have adversely impacted the risk mix of the Exchange.

Among California plans, Anthem and Kaiser manage a considerable volume of direct sales through an embedded sales organization. Kaiser builds their commission costs into premium on a community-wide basis. Although PacAdvantage had direct sale accounts, it eventually established a policy to assign groups to agents as small groups required significant resource support during open enrollment and major provider/carrier terminations. CalChoice[2] also refers all potential direct sales to an agent. Attempts by carriers such as PacifiCare (subsequently acquired by UnitedHealthcare) to drive small employer business to online sales in the mid-1990s also met with great resistance. The Exchange will need to determine whether all small groups will be required to use agents, or whether direct sales will be an option for those who prefer not to work with an agent.

Payment to agents is generally issued on a monthly basis through electronic funds transfer with a summary remittance to the agent. When a General Agency is involved, payment is routed through the General Agency, which aggregates information across carriers and issues a consolidated payment and report to the individual agents. All plans use General Agents, but the contracting relationships with Anthem Blue Cross and Blue Shield of California are held uniquely, such that a General Agent would contract with one or the other, but not both Blues. The General Agency load is typically an additional 2 to 3% on top of the agent commission. General Agencies typically pass through the published agent fee for small group sales but split the commission on individual sales to account for support or other purchased services. Related

[2] CalChoice is a small group purchasing pool operated by Choice Administrators, a subsidiary of the general agency Word and Brown.

to the discussion on small employer benefit administration services, General Agencies may serve as an aggregator (e.g., LISI) or owner (e.g., Word and Brown) of such services and offer packaged products to agents and their small business clients. Depending on individual agent sales volume, the General Agency may absorb the fees for such services.

Stakeholder Viewpoints

Health plans and agents are generally universal in the belief that the Exchange should assure continued use of agents in the small employer market "consistent" with market practices. Health plans and agents were very opposed to the Exchange having each plan pay agent commissions for members enrolled through Exchange. Due to the lag time in enrollment and eligibility confirmation, health plans would pay for Exchange enrollees at least one month behind payments to agents who sold their product directly. Agents and General Agents noted that such a payment process would be cumbersome and a disadvantage the Exchange. Both stakeholder groups cited reconciliation and bookkeeping challenges, with health plans noting that payment disputes may surface 6 months or more after the fact. Both stakeholder groups also felt that an Exchange role in paying producers was important for marketing purposes, and that the visibility of the Exchange as a payer would be lost in a remittance report.

Consumer advocates and others have noted that while agents play a critical role for the majority of small businesses, there is a significant portion of small businesses that do not use – and potentially do not trust – agents. In a survey conducted by Pacific Community Ventures among 804 small business owners, 27% of businesses say they will still continue to purchase insurance directly through their agent, and 43% anticipate a combination approach of using both the Exchange and their agent. Among the 25% that do not use agents, they trust small business organizations and non-profits as sources of information. The study notes also the need to provide alternative sources of information, particularly for businesses with a large portion of Hispanic employees.

The following issues have an important bearing on the design of agent payments:

- The Affordable Care Act and subsequent exchange regulations establish that health plan pricing outside the Exchange must match pricing inside the Exchange, which may have a bearing on how selling, general and administrative ("SG&A") expenses are spread across products.

- The Affordable Care Act also establishes that Navigators will be used to provide educational support to assist new enrollees in Individual plans and that Navigators cannot receive agent commissions.

While Navigators cannot receive payments from health plans for SHOP enrollment, they can be compensated by the Exchange. The Exchange could also facilitate referrals to agents to

complete the sales process and provide programmatic information and orientation materials to the small business.

Options

The table that follows the recommendations discussion details the options related to engaging agents and General Agencies in the SHOP for consideration by the Board.

- Option 1: Match commissions with the Health Plans issuing payment to agents and General Agencies;
- Option 2: Match commissions with the Exchange issuing payment to agents and General Agencies;
- Option 3: The Exchange sets its rates for agents and General Agencies, and issues payment to agents and General Agencies.

Recommended Approach

Staff recommends Option 2 (Exchange Matches Commission and Pays) or Option 3 (Exchange Sets and Pays Commission) with additional considerations noted below. Both options include General Agents as part of the distribution channel. Options such as the exclusion of agents and the use of new group bonuses to encourage sales through the Exchange were considered and rejected due to their potential negative impact on stakeholders and distribution channels for the Exchange.

Under Option 2 or 3, the Exchange would reinforce its role as aggregator and could use the payment process to market its services and reinforce the value of the Exchange to its distribution channels. A key consideration under Option 2, whereby the Exchange pays commission consistent plan rates, is that it entails administrative resources and complexity of matching health plan fee schedules on a real time basis, including downgrades and occasional PMPM compensation structures. Additionally, to the extent that health plans hold direct contracts with agents and General Agencies, it could be challenging for the Exchange to administer different practice standards across plans. Additionally, the Exchange would need to work with carriers to assure that agents are certified to meet each carrier's requirements or establish a mechanism to amend such agreements to allow agents to "accept assignment" from the Exchange.

Under Option 3 (Exchange Sets and Pays Commission) the Exchange could more directly promote itself as an aggregator and establish direct agent relationships. Similar to CalChoice, the Exchange could also require health plans to recognize Exchange volume as part of its incentive programs, thereby providing an additional channel for agents that does not have a negative financial impact around crediting total business volume inside and outside of the Exchange.

Staff recommends that the Exchange also contract with General Agencies to increase its access to the large volume of agents that work through the General Agencies. While General Agencies add an additional cost on top of the agent commission, they represent a significant distribution channel that would materially increase Exchange exposure among agents. Although the additional fee increases premium costs, the load on premium would hopefully be offset by the expanded access to agents and new enrollment volume. While the Exchange in some ways duplicates the aggregator role of General Agencies, it would be extremely difficult for the Exchange to fully assume this role at the outset.[3] The Exchange will need to establish performance and transparency criteria with General Agencies to assure fair and accurate representation of plan information and rate quotes. Over time, the Exchange could reduce the number of General Agencies based on sales volume, but do so in a way that minimizes disruption for individual agents.

Next Steps

Staff recommends that the Exchange develop, in consultation with potentially participating Qualified Health Plans and agents the following:

- Pros and cons of matching commissions versus having generally parallel distinct commissions;
- The best way to include General Agencies to leverage relationships and the agent network.

In developing these recommendations, staff will seek to both assure effective involvement of agents and to minimize the cost load on small businesses. Staff will further develop how to address:

- Whether to offer direct sales, or how to assist employers who prefer not to work with an agent;
- How to best assist unrepresented small businesses, including those in start-up mode;
- The role of navigators in assisting small businesses to either generally understand the SHOP exchange or to enroll in the SHOP.

In addition, staff will need to further develop a range of operational issues related to implementing an agent strategy. Table 4 “Operational Considerations” highlights some of these issues and their implication for the options considered.

[3] Historically, PacAdvantage sales through General Agencies also represented larger group sizes, which were beneficial to the overall risk mix. Furthermore, the General Agency communications and sales delivery system was effective in PacAdvantage despite the additional cost.

Table 4: Summary of SHOP Agent Payment Options		
Option 1: Match Commissions (Plan Pays)	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
SUMMARY The Exchange would match or require participating health plans to match commissions and have plans administer payments for members enrolled through Exchange plans	**SUMMARY** The Exchange would match health plan commissions and issue payments directly to agents	**SUMMARY** The Exchange sets a rate based on prevailing health plan commission structures and issues payments directly to agents.
PURPOSE The Exchange leverages the prevailing health plan commission structures and may reduce the level of infrastructure and ongoing resources to manage agent support	**PURPOSE** The Exchange uses the prevailing health plan commission structures and leverages its visibility among agents by being the issuer of payment	**PURPOSE** The Exchange sets a common rate across health plans and supplemental vendors that leverages its visibility among agents but simplifies the administration of payment
DESCRIPTION The Exchange supports a level playing field among health plans and the SHOP program by matching or requiring participating plans to match existing health plan commission schedules. Any special incentive programs are simultaneously available through small groups sold under the Exchange, but the agent receives multiple payments from carriers depending on the distribution of the small group's beneficiaries	**DESCRIPTION** The Exchange supports a level playing field among health plans and the SHOP program by matching existing health plan commission schedules. The Exchange would require health plans to count Exchange enrollment towards individual agent incentive programs. By being the payer of record, the Exchange enhances its visibility among agents but also simplifies commission reconciliation by agents	**DESCRIPTION** The Exchange promotes itself as a unique entity with a market rate-based commission schedule. By being the payer of record, the Exchange enhances its visibility among agents. The Exchange would require health plans to count Exchange enrollment towards individual agent incentive programs. Additionally, the Exchange would negotiate participation agreements with General Agents who receive a load and in turn aggregate payments to agents

Table 4: Summary of SHOP Agent Payment Options		
Option 1: Match Commissions (Plan Pays)	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
PROS ▪ The Exchange minimizes its administrative burden; agent agreements and licensure verification are delegated to the plans ▪ The Exchange keeps health plans in the role of setting agent and General Agent commission levels and avoids the Exchange being viewed as the driver for any potential future payment changes ▪ Does not materially impact direct sales operations of health plans (Kaiser, Anthem), but potentially limits Exchange product exposure among the direct sellers ▪ Any vesting arrangements favored by agents and permitted by health plans would remain	**PROS** ▪ The Exchange increases its visibility among agents as the payer of record ▪ Using in-force commission rates limits potential gaming by agents to move business to optimize payment under incentive programs ▪ The Exchange reinforces its role as aggregator and simplifies billing administration and reconciliation for agents and General Agents ▪ The Exchange could build and reinforce agent relationships through referral of sales leads ▪ Any vesting arrangements favored by agents and permitted by health plans would remain	**PROS** ▪ The Exchange promotes itself and offers a simple payment design to agents and General Agents ▪ This approach reinforces the Exchange's role as aggregator and simplifies billing administration and reconciliation for agents and General Agents ▪ The Exchange could build and reinforce agent relationships through referral of sales leads ▪ The Exchange payment structure would likely supersede any vesting arrangements between health plans and agents ▪ The Exchange can require health plans to recognize Exchange volume as part of their incentive programs

Table 4: Summary of SHOP Agent Payment Options		
Option 1: Match Commissions (Plan Pays)	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
CONS ▪ The stakeholder response to this approach was overwhelmingly negative from health plans and agents for SHOP but viewed as acceptable for the Individual Exchange ▪ Plan payment results in lag time due to eligibility reconciliation ▪ Agents receive multiple payments from carriers for the same group, potentially at different times and payment reconciliation is difficult ▪ This approach may be difficult to operate with General Agents due to additional data collection and transfer times	**CONS** ▪ While the Exchange may require health plans to count new sales towards the volume incentives of individual agents, it is uncertain whether this can feasibly be administered if the sales incentives are linked to other plan-based products ▪ Management of variable rates, downgrade schedules and PMPM fees adds administrative costs ▪ If the Exchange lags in implementing payment incentive programs, agents may focus new sales outside of the Exchange ▪ The Exchange must establish a process to execute agent agreements and verify their licensure and other requirements	**CONS** ▪ The Exchange functions as another distribution channel and would jeopardize sales if it were to seek to reduce or adjust agent payments to improve affordability ▪ The Exchange could disadvantage those health plans with effective direct sales units (assuming that common product pricing would require the carrier to raise its direct sales pricing) ▪ The Exchange may place one or two carriers at a disadvantage (Aetna and Anthem Blue Cross) ▪ The Exchange must establish a process to execute agent agreements and verify their licensure and other requirements

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
Vesting (grandfathering historical contract arrangements and rate schedules which are higher than present market conditions)	Vesting would remain for legacy contracts.	While the Exchange could contractually limit new sales to current, in-force commission levels, it is not clear whether the Exchange could override direct plan-agent contracts if those contracts include vesting language. One policy approach could be that a legacy group moving into the Exchange would be subject to prevailing commission schedules, but this would be a disincentive for an agent to bring renewing business to the Exchange. If legacy fees were permitted, the Exchange would need to link individual members of the same employer group to different fee schedules.	The Exchange could establish as part of its contracts that only its in-force rates apply for all sales through the Exchange, and that fee schedules for new and renewing small groups are subject to modification by the Exchange. Agents would only be incented to sell new groups in the Exchange. To the extent legacy fees are higher, agents would not be incented to move that business anyway.
Role of health plans' captive agents (Direct sales programs operated by health plans independent of GAs, external agents and the Exchange).	This option would be least disruptive to health plan-based agents. While the Exchange could establish contract terms to require equal representation of Exchange-based products, it might be challenging to reinforce this in practice. Additionally, the amount of administrative premium load for Exchange products' would create a differential premium disadvantage for the Exchange.	The Exchange would have limited ability to market itself through these captive agents as there would be no added incentive to refer cases to the Exchange. However for subsidy-eligible individuals, plans should be motivated to support enrollment in the Exchange if they felt there was a likelihood of retaining the prospective member. The Exchange needs to consider seeking "fair marketing" rules as part of its health plan contract.	The Exchange would create competition with the plan-based agents who would not benefit from an outside commission schedule, and arguably could offer a similar product without the added commission cost. As part of its health plan contracts, the Exchange could formulate rules for referral of subsidy-eligible individuals and set expectations for training of internal agents on tax credits and Exchange options.
Graded payment schedules	This Option optimizes the ability to capture health plan-based schedules so as to not disadvantage Exchange products.	The Exchange would need to undertake potentially complex management of graded payment schedules and change payment based on the anniversary of subsequent renewal periods.	The Exchange could elect to adopt a graded payment schedule if that became common practice, but apply the schedule as a standard across all plans.

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
[1]This table below describes a range of operational considerations and implications for policy and implementation under each option. The table includes topics discussed in stakeholder interviews and is not intended to be an exhaustive list of operational issues.			
Adjusted payments based on agent volume	This Option optimizes the ability to capture health plan-based schedules. However, to the extent that subscribers from a single employer group split among carriers, a agent will be paid at different rates within the same employer group if volume incentives are achieved with one carrier and not another. An unintended consequence may also be that agents will steer members towards plans to maximize their compensation. This Option also allows the Exchange to best match agent payment designs in the Individual segment where tiered approaches are most common.	The Exchange would need to coordinate information with health plans to calculate the total volume of membership associated with the agent that may qualify that individual (or organization) for higher payment tiers.	The Exchange could establish incentive programs linked to Exchange volume or total plan volume. If linked to Exchange volume, health plans may have a concern about transfer of existing membership. The Exchange could also limit Exchange business to a fixed rate but require health plans to count SHOP volume in its internal reward programs for agents.
Adjusted payments based on employer group volume	This Option optimizes the ability to capture health plan-based schedules. However, to the extent that subscribers from a single employer group split among carriers, the Exchange would need to establish rules around premium thresholds and volume insofar as whether they apply at the plan level or employer group level. An unintended consequence may also be that agents will steer members towards plans to maximize their compensation.	If the Exchange permits groups that grow beyond 50 employees to remain in the Exchange prior to 2016, fee adjustments would need to be calculated for groups that produce more than $500,000 annual premium, if a plan has a total premium threshold trigger that reduces commissions.	The Exchange can establish a common policy for groups that grow beyond 50 beneficiaries consistent with general market practice. It should be noted that current practices vary with either a lower percentage commission or a rate that is triggered by $500,000 premium.

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
Recognition of high-performing agents	The Exchange could channel new sales referrals to top Exchange sellers to reinforce its value with these agents.	The Exchange could channel new sales referrals to top sellers to reinforce its value with these agents independent of their volume of direct plan sales.	The Exchange could channel new sales referrals to top sellers to reinforce its value with these agents.
Match special promotions	This Option optimizes the ability to capture health plan-based special promotions in real time so as to not disadvantage Exchange products.	The Exchange would need to require prior notification from health plans. While it is desirable to automatically match special health plan promotions, these promotions often are linked to total volume and/or the sales of embedded supplemental dental, vision and life products. Because of the lag time in data transfer to reconcile step-based rewards based on volume and potential system programming resources to recognize commission changes, it would be difficult for the Exchange to administer a match program.	The Exchange would have flexibility in creating special promotional programs to market its programs or new products, but health plan concerns about transfer of existing membership needs to be recognized.

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
Establish agent participation rules	The Exchange would need to encourage plans to standardize their agent participation rules and possibly facilitate global plan participation by requiring a "me-too" arrangement for transfer of licensure, financial and tax information. The difficulty is that some plans have more stringent requirements on bonding and E&O insurance at levels which could be problematic for small firm or individual agents. Additionally, there would need to be consistent rules for agent of record rules and adjudicating changes issued from the Exchange to occur in a common timeframe.	The Exchange could require that its contracted health plans maintain contracts with participating agents and validate licensure, continuing education or other requirements. To minimize burden additional among agents to contract with new QHPs, the Exchange could administer a common participation agreement and/or be delegated to hold such contracts by new QHPs. However, this would add administrative burden for the Exchange. Additionally, the Exchange would need to establish a financial relationship with agents, agencies and/or General Agencies for income-reporting. Additionally, the Exchange would need to manage reconciliation and audit processes to verify accuracy of payment, as well as address disputes about changes in the agent-of-record and accuracy of payment.	The Exchange would likely establish participation requirements and hold contracts with participating agents. As part of its contracting requirements, the Exchange could establish "fair marketing" requirements to represent all available plan options without bias. The Exchange would also undertake certification responsibilities such as license validation, W-9 reporting, etc. Additionally, the Exchange would need to manage reconciliation and audit processes to verify accuracy of payment, as well as address disputes about changes in the agent-of-record and accuracy of payment. In the future the Exchange could establish minimum sales requirements for agents.
Transparency of agent payment	The Exchange could potentially publish in-force rates similar to General Agencies, but it would be confusing to small employers to see different loads at a subscriber level on premium billings.	To the extent that the Exchange produces an aggregated bill for the small employer, it would be challenging to reflect inconsistent agent fees at a member level.	A common fee schedule lends itself to disclosure requirements and transparency goals.

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
Role of General Agencies (GA)	The Exchange would recognize existing health plan and GA contract rates but there could be transparency and consistency issues for agents who use GA-based IT systems to produce rate quotes.	Health plans likely have variable contract rates with GAs based on performance and historical alignment. The terms of these contracts may be held confidentially and likely, the higher paid GA contracts reflect greater direct sales. By matching these rates, the Exchange would potentially have a level playing field, but in direct completion with carriers for their high producers.	The Exchange would set selection criteria and either set a fixed rate or negotiate a rate with GAs. The transparency expectations point towards using a fixed rate, but the benefit of fostering competition among the GAs would potentially be lost.
Impact on SHOP operations	This strategy minimizes plan operational support after initial set-up for enrollment and retrospective reporting. Service support would be required to resolve agent of record and/or payment disputes. It also requires a service liaison with each carrier and a mechanism to access to health plan reporting and coordination of review requests.	This approach requires significant resources to program differences from plan to plan, and recognition of commission downgrade schedules upon renewal or total volume. Resources would be required to document financial relationship with agents and GAs, and produce tax reporting. The Exchange should require electronic funds transfer for payment and issue online notification of remittance reports available for review and download. Service support would also be required to resolve agent of record and/or payment disputes.	Resources required to certify, contract with and report income for agents and GAs. Assumes initial application documentation required, annual attestation of license in good standing, with sample audits, and process for de-certifying agents. Assumes bulk of transactions conducted via electronic fund transfer and online notification of remittance reports available for review and download. Service support required to resolve agent of record and/or payment disputes.

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
Impact on supplemental/ ancillary product sales	Option 1 would support an approach to offer supplemental benefits through health plan-based products so agents may count sales towards their plan bonuses. If the Exchange established direct vendor relationships, agents could be incented to sell outside of Exchange to optimize their plan-based bonuses.	Plans should be required to provide the Exchange with pre-notification (30-60 days) of producer incentive changes. It may be difficult to track external commissions on ancillary products because of the various combinations that are available through carriers and types of commission incentives added for supplemental benefit sales (see special promotions above). This option would support an approach to offer supplemental benefits through health plan-based products so agents may count sales towards their plan bonuses. If the Exchange established direct vendor relationships, agents could be incented to sell outside of Exchange to optimize their plan-based bonuses.	There is more variability in commissions for supplemental products so the Exchange would likely be looking at an average percentage rate, which could affect sales up or down. However, the total commission dollars associated with supplemental benefits is much lower than for health plans, so may not have a material effect.
Implications for internal Exchange-based agents	The Exchange could consider different internal compensation structures that include base salary and a full or reduced commission payment or link a bonus independent of commissions to total sales. Plan contracts could be structured to pay the direct Exchange sales commissions to the Exchange in the aggregate. If a matched commission is fully paid to internal agents, there may be an unintended consequence of promoting the higher paying plans.	The Exchange could consider different internal compensation structures that include base salary and a reduced commission payment or link a bonus independent of commissions to total sales. If a matched commission is fully paid to internal agents, there may be an unintended consequence of promoting the higher paying plans.	The Exchange could consider different internal compensation structures that include base salary and a reduced commission payment or link a bonus independent of commissions to total sales.

Table 5: Agent Payment[1] Operational Considerations			
Issue	**Option 1: Match Commissions (Plan Pays)**	**Option 2: Match Commissions (Exchange Pays)**	**Option 3: Exchange Sets and Pays Commissions**
Implications for direct sales	The Exchange may manage directly through an internal sales unit with licensed agents with payments to the Exchange for customer service support.	The Exchange may manage directly or provide sales leads to General Agencies and agents as part of its engagement strategy	The Exchange may manage directly or provide sales leads to General Agencies and agents as part of its engagement strategy
Implications for design of Individual product commissions	This option could be feasibly implemented for the Individual Exchange product if the plan acts as initial entry point for premium collection. If the enrollment rules (e.g., effective date of hire, limits on retroactivity based on payment date) are the same for the Exchange as outside the Exchange, the timeliness or lag time in payment should be comparable.	If enrollment and premium collection is managed by the plan, then the Exchange may be in a situation of paying agents with a lag time, which would be negatively received. However, the value of the member subsidy in driving new sales may outweigh this concern.	Given the greater variability in the Individual market around volume and downgrades, an Exchange-specific rate would need to be competitive with major carriers' standalone products. However, this option also allows the Exchange to operate its own incentive design and special promotions.

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Small Employer Benefits Administration and Ancillary Benefit Offerings

Summary

To encourage the broadest level of participation in the Small Employer Health Options Program (SHOP), the California Health Benefit Exchange is exploring approaches to offering benefits administration support and ancillary benefits that best serve the needs of small businesses as well as agents,. By aggregating services to administer COBRA and Cal-COBRA, Flexible Spending Accounts (FSAs), Health Spending Accounts (HSAs), Health Reimbursement Accounts (HRAs) or Section 125 accounts, the Exchange has the potential of providing value-added benefits that facilitate one-stop shopping at a modest cost. For the purposes of this brief, ancillary benefits are defined as supplemental benefits other than dental and vision.

Background

In seeking to increase the number of insured Californians through an innovative, competitive marketplace, the Exchange may provide health and administrative services that reduce the operational burden for small businesses and offer consumer-friendly experiences that best meet the needs of both employers and employees. By aggregating such services, the Exchange may be able to offer them at a lower cost to small businesses as well as making them available to agents. To the extent that these services are available through the Exchange, small business owners may elect to provide additional value-add services to employees that they would otherwise seek to purchase from individual vendors, or not offer at all. Beyond offering management of FSAs, HSAs, HRAs and Section 125 accounts, other services could include life and accidental disability insurance, and other voluntary benefits available for purchase as the individual subscriber level.

Currently, some agents and general agencies offer small employer benefits administration as a way of distinguishing their services in the marketplace. They may absorb the administrative costs as part of their value-add services to their clients, or pass through direct costs based on an employer opt-in model. Some general agencies currently aggregate these services as part of their support to agents, either as a single vendor or a menu of vendor choices. Where such services are offered by general agencies, the Exchange could contract with those agencies as potential suppliers of such services, or could act as a competitor to such agencies. The inclusion of benefits administration services in the Exchange would also potentially compete with professional employment organizations (PEOs), which may offer other human resources administration support and payroll management services. (Table 6 attached provides a reference summary of Exchange options for offering SHOP Administrative Services.)

Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers

Some health plans may also package some of these programs as value-added services to foster one-stop shopping within the carrier's offerings. An added complexity is that the selection of health-plan based supplemental benefits (often dental, vision, life and disability) may be linked to an agent incentive program that increases commission fee schedules. While the Exchange may consider additional banking arrangements to facilitate portability of account-based benefit plans, it may be premature to make this assessment until the Exchange has established its benefit design options such as inclusion of an HSA-qualified high deductible health plan. Furthermore, some health plans own their own bank or may already have an endorsed banking relationship to support account-based plans.

Two examples from the California market should also be noted. Choice Administrators, which operates a private small business exchange, CalChoice, currently offers both human resources support, payroll administration, and a full array of benefit administration services. PacAdvantage, which took over and managed the former Health Insurance Plan of California until 2006, offered solely COBRA and Cal-COBRA administration services, although a number of agents and employers expressed interest in Section 125 services. Note that in developing the options, we have assumed that the Exchange would only contract or facilitate making these services available to employers, but would not consider building those capabilities itself except possibly for COBRA administration.

Stakeholder Viewpoints

Stakeholder input has been incorporated into the options and recommendations through interviews with representatives of health plans, agents and general agencies, and small businesses.

It should be noted that the Affordable Care Act provision to preclude pre-existing condition limitations may obviate the need for COBRA coverage, but there has been no indication of forthcoming legislation to alter current requirements.

Options

The major options for benefits administration services proposed for consideration by the Board are described below as Options A1-A3. Details are summarized in Table 1.

- Option A1: The Exchange undertakes a minimal role and offers Cal-COBRA and COBRA Administration only (with an additional option of operating these services internally or through a vendor);
- Option A2: The Exchange offers limited services (COBRA, HRA, HSA, FSA and Section 125) through a mix of specialty vendors;
- Option A3. The Exchange offers limited services (COBRA, HRA, HSA, FSA and Section 125) through a single, full-service vendor

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Subject to the cost of implementation and potential opportunity for revenue sharing with the Exchange, there are two approaches for implementation of ancillary benefits described as B1-B2. Details are summarized in the Table 2.

- Option B1. The Exchange provides employer benefits administration services and offers ancillary benefits using specialty carriers.
- Option B2. The Exchange provides employer benefits administration services and offers ancillary benefits through multiple participating health plans.

Recommendations for Further Analysis

Subject to further review of costs and employer interest, staff recommends exploration of Option A2, whereby the Exchange offers limited benefits administration (COBRA, HRA, HSA, FSA and Section 125) through mixed vendors to maximize its flexibility in program design and opportunity to engage small employers and agents for key input. Option A2 also allows the Exchange to prioritize specific services and add programs in subsequent years based on employer and agent interest. If, however, fees and implementation costs instead offering services through one vendor (Option A3) are less and there is no material difference in quality, Option A3 may be preferred.[1] In general, interviews with agents and health plan representatives placed a high value in one-stop shopping and offering a full array of services to the agent and small employer. Respondents placed a higher value on convenience than the threat of providing services that could be competitive with General Agencies. It was noted also that because some agents may provide such services at no cost to their clients by absorbing limited service charges, the availability of these services would reduce administrative costs and burden for agents. Additionally, for those agents not currently offering such services, employer benefits administration would make the Exchange an attractive distribution channel.

Initial recommended services include Cal-COBRA and COBRA Administration and Section 125/Cafeteria plans. Depending on the functionality of the Exchange eligibility and enrollment systems, administration of Cal-COBRA and COBRA may be handled internally. As noted above, internal management entails additional resources to manage grievances and appeals due to incomplete or late applications and payment. These services may also be administered by a vendor subject to data integration with the Exchange and health plans. Additional consideration should be given to the process for eligibility and payment collection for the Individual Exchange program.

Since the initial set of benefit design offerings has not been determined, banking relationships for account-based plans may not be an immediate priority. Furthermore, health plans that offer such plans typically include a sponsored banking relationship. Therefore, additional service offerings may include HRA and HSA banking services.

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[1] Staff is still developing a board options material on whether the Exchange should consider more broadly to contract out the administration of the SHOP exchange. If the Exchange were to contract out administration it is possible the contractor would already provide the services discussed in this Brief.

The Board should also consider potential financial implications of each option, both the cost of offering various services and what small employers and/or agents are willing to pay for the added convenience. Customers would likely expect the Exchange to cover select costs such as COBRA administration. Additional services could be offered as a value-add to promote the Exchange's overall program and ease of use. Instead of absorbing some or all of the administrative costs, the Exchange could also operate services (e.g., Section 125/Cafeteria plans) under a pass-through model whereby the Exchange negotiates a vendor discount and provides user access, and the agent or small employer bears the cost of selected services. Under either Option A2 or A3, as well as Option B1, the Exchange may consider an endorsed relationship whereby the Exchange shares in the fees that are collected from users.

If the Exchange offering services through multiple participating health plans (Option B2) is considered, the Exchange should explore opportunities to leverage plan negotiations with access to selling supplemental products in the Exchange.

Next Steps

Additional analysis is needed in the following areas:

1. Assess the potential costs of using select vendors
2. Assess revenue opportunities for the Exchange
3. Evaluate current uptake of employer benefits administration and ancillary benefit offerings through General Agencies
4. Get Stakeholder input, including potentially conducting market surveys, on likelihood of small employers using these services and elasticity of demand relative to fee structure.

The Exchange may wish to include a solicitation for ancillary benefits as part of its health plan Request for Proposal to collect information on relative costs, potential leveraging opportunities and implications for agent fees before making a decision on the preferred approach.

Table 6: Exchange Options for Offering Administrative or Ancillary Services to Small Employers		
Option A1: Cal-COBRA/COBRA Only Administration	**Option A2: Mixed Vendor Limited Employer Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)**	**Option A3: Full-Service Vendor-Supported Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)**
SUMMARY The Exchange would undertake a minimal role in employer benefits administration.	**SUMMARY** The Exchange would engage vendor(s) to provide select employer benefits administration services and may offer some services directly.	**SUMMARY** The Exchange would engage a single vendor to provide an array of employer benefits administration services.
PURPOSE The Exchange would provide Cal-COBRA and COBRA administration which reduces administrative burden for small employers and agents.	**PURPOSE** The Exchange provides a wide range of employer benefits administration.	**PURPOSE** The Exchange provides a wide range of employer benefits administration services while minimizing its resource requirements
DESCRIPTION Because the Exchange will be a hub for managing eligibility and enrollment, it is well positioned to coordinate COBRA communications and billing while also facilitating access to public programs. NOTE: The Exchange may elect to provide these services internally or outsource.	**DESCRIPTION** The Exchange would solicit stakeholder feedback on the preferred array of employer and agent support services. Based on stakeholder input, the Exchange would conduct an RFP process for recommended services and engage vendor(s) to provide a limited set of employer benefits administration functions.	**DESCRIPTION** The Exchange would solicit stakeholder feedback on the preferred array of employer and agent support services. Based on stakeholder input, the Exchange would conduct an RFP process for recommended services and engage a vendor to provide an array of employer benefits administration functions.

Table 6: Exchange Options for Offering Administrative or Ancillary Services to Small Employers		
Option A1: Cal-COBRA/COBRA Only Administration	**Option A2: Mixed Vendor Limited Employer Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)**	**Option A3: Full-Service Vendor-Supported Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)**
PROS ▪ The Exchange provides a valuable service to agents and small employers that reduces their administrative burden. ▪ The Exchange fosters continuity in health insurance coverage by also facilitating access to public programs if a member is eligible.	**PROS** ▪ Offering select employer benefits administration services fosters one-stop shopping for agents and small employers and reduces their administrative burden. ▪ The Exchange offers best-in-class vendors. ▪ A selective approach would enable the Exchange to build and expand this function over time rather than make a significant marketing and sales commitment with uncertain demand for benefits administration services.	**PROS** ▪ The Exchange provides a full range of service options to agents and small employers ▪ Following an RFP process, this approach may be less resource intensive to manage in the long run. ▪ Selection of a single vendor may enable a shared revenue model. ▪ A full service vendor may also provide additional supplemental benefits that could be offered on a voluntary basis.
CONS ▪ Adds administrative expense (processing, late payment and grievance management) and Exchange oversight responsibilities if using an outsourced vendor.	**CONS** ▪ Services could be competitive with General Agencies that also serve as a SHOP distribution channel. ▪ Adds administrative and oversight responsibilities for multiple vendors. ▪ May be more resource-intensive in the long run if multiple vendors are selected.	**CONS** ▪ Services could be competitive with General Agencies that also serve as a SHOP distribution channel. ▪ Services may be duplicative of those offered by Professional Employment Organizations. ▪ Adds administrative and oversight responsibilities for a single vendor.

Table 7: Exchange Option for Implementing SHOP Administrative Services	
Option B1: Benefits Administration (Option A2 or A3) and Ancillary Benefits through Select Specialty Carriers	**Option B2: Benefits Administration (Option A2 or A3) and Ancillary Benefits through Participating Health Plans**
SUMMARY The Exchange would provide employer benefits administration services and offer ancillary benefits using specialty carriers.	**SUMMARY** The Exchange would provide employer benefits administration services and offer ancillary benefits through multiple participating health plans.
PURPOSE The Exchange provides a wide range of employer benefits administration services and ancillary benefits through specialty carriers	**PURPOSE** The Exchange provides a wide range of employer benefits administration services and ancillary benefits through multiple channels that leverage participating health plan products.
DESCRIPTION The Exchange would conduct an RFP process for recommended services and engage specialty carrier(s) to provide an array of employer benefits administration functions and ancillary benefits.	**DESCRIPTION** The Exchange would conduct an RFP process for recommended services and engage health plan(s) to provide an array of employer benefits administration functions and ancillary benefits.
PROS ▪ The Exchange provides a full range of service options to agents and small employers ▪ Following an RFP process, this approach may be less resource intensive to manage in the long run ▪ Selection of primary vendor(s) may enable a shared revenue model ▪ Potential to offer best-in-class vendors	**PROS** ▪ The Exchange provides a full range of service options to agents and small employers ▪ Leveraging health plan products may aid medical rate negotiations ▪ Availability of plan products may support agent access to volume-based commission bonuses

Table 7: Exchange Option for Implementing SHOP Administrative Services	
Option B1: Benefits Administration (Option A2 or A3) and Ancillary Benefits through Select Specialty Carriers	**Option B2: Benefits Administration (Option A2 or A3) and Ancillary Benefits through Participating Health Plans**
CONS ▪ Services could be competitive with General Agencies that also serve as a SHOP distribution channel. ▪ Services may be duplicative of those offered by Professional Employment Organizations. ▪ Adds administrative and oversight responsibilities to manage multiple specialty carriers.	**CONS** ▪ Services could be competitive with General Agencies that also serve as a SHOP distribution channel ▪ Services may be duplicative of those offered by Professional Employment Organizations ▪ Vendor changes or potential plan disruption would add administrative burden impact employer/employee experience negatively ▪ Plans do not consistently offer a comprehensive array of products (e.g., many health plans do not offer short-term and long-term disability, or their ancillary benefits are only available to groups larger than 6 or 10 employees) ▪ Plans may not be viewed as best-in-class vendors

Table 8: Background of Administrative Offerings by General Agents What follows is the results of a survey comparing employer benefits administration services from several General Agencies (Dental, Vision, Life, and to a lesser degree, Disability and Long Term Care, are also commonly offered through carriers or as a supplemental benefit). The information provided below is pulled from each Agency's web site.			
Choice Administrators (Word & Brown)	**LISI (General Agency) (San Mateo)**	**Intercare Solutions (San Diego)**	**Sitzmann Morris Lavis* (Oakland)**

Table 8: Background of Administrative Offerings by General Agents

What follows is the results of a survey comparing employer benefits administration services from several General Agencies (Dental, Vision, Life, and to a lesser degree, Disability and Long Term Care, are also commonly offered through carriers or as a supplemental benefit). The information provided below is pulled from each Agency's web site.

Choice Administrators (Word & Brown)	LISI (General Agency) (San Mateo)	Intercare Solutions (San Diego)	Sitzmann Morris Lavis* (Oakland)

Choice Administrators uses CONEXIS Benefits Administrators, LP, a wholly owned subsidiary of Word & Brown. CONEXIS is also sold to large employers
▪ COBRA Administration
▪ Direct Bill Services for:
  ▪ Retirees
  ▪ Surviving spouses
  ▪ Employees on a leave of absence (LOA)
  ▪ Employees on a Family Medical Leave Act (FMLA) leave
▪ Flexible Spending Accounts (FSA)
  ▪ Health FSA
  ▪ Dependent Care FSA
  ▪ Limited-purpose FSA
▪ Health Reimbursement Arrangements (HRA)
▪ Retiree Health Reimbursement Arrangements
▪ Section 132 Commuter Benefits
  ▪ Pre-tax transit
  ▪ Pre-tax parking
 	
SUPPLEMENTAL BENEFITS
▪ Life Insurance
▪ Disability
	LISI offers various benefits administration services through multiple vendors (Agent or employer selects vendor)
	▪ Aetna (COBRA Admin, FSA, HRA, HSA, TRA, Premium Only Plan (POP) 2-125)
	▪ ASH Plans Chiropractic, Acupuncture 2+, Wellness 50+
	▪ BeneFLEX (COBRA Admin, DCAP, FSA, HSA, HRA, POP 2+)
	▪ Ceridian Benefits Administration (COBRA Admin, FSA, POP 2+)
	▪ ClearBenefits (COBRA Admin, HR Online 2+
	▪ COBRA OnQue COBRA Admin Sterling HSA (HSA, HRA, FSA, POP, COBRA)
	▪ TASC (COBRA Admin, FSA, HRA, HSA, POP)
	▪ Disability available through multiple carriers
	
	*LISI also owns CoPower, which provides dental, vision and life options.
		▪ Business Travel and Accident
		▪ Flexible Spending (§Section 125)
		▪ International Benefits
		▪ Student Health Benefits
		▪ Health & Performance (wellness and disability)
		▪ Executive Benefit Planning
		
		OPTIONAL EMPLOYEE PLANS
		▪ Long-Term Care
		▪ Group Auto
		▪ Group Legal
		▪ Critical Illness
		▪ Accident Insurance
		▪ Pet Insurance
		
		SUPPLEMENTAL BENEFITS
		▪ Life Insurance
		▪ Disability
			▪ Employee Assistance Programs
			▪ Section 125 Plans
			▪ Section 132 Plans
			▪ Voluntary Benefits
			▪ Proprietary SML Wellness Center
			▪ Proprietary Employee Benefit Resource Guide
			▪ Proprietary Client Management System
			▪ In-house Legislative & Compliance Manager
			▪ HIPAA conformity
			▪ Wrap SPD preparation
			▪ Employee Benefit Seminars
			▪ Mid-Year & Annual Renewal Analysis
			▪ Budgeting
			▪ Benchmarking
			▪ Bill Reconciliation
			
			SUPPLEMENTAL BENEFITS
			▪ Life Insurance
			▪ Disability
			
			*Some of the services listed above are geared to larger clients

References

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Employer Contribution and Participation Standards

Summary

The California Health Benefit Exchange is considering the options related to the extent to which it requires premium contributions by small businesses on behalf of their employees and dependents, and the proportion of eligible employees that will be required to participate in the Exchange for each employer. This "Employer Contribution and Participation Standards" Board Options Brief provides background on these issues and a summary of the options available to the Exchange and includes preliminary recommendations for the Board's consideration.

Background

The Board of the Exchange has identified as among its core operating values its commitment to promoting affordability of health coverage. While affordability is seen first and foremost from the perspective of individuals, it must also be considered from the vantage point of the small business owners who may contribute to premiums on behalf of employees and their dependents. In part due to its tax-preferred status, employer contributions in lieu of wages are directly linked to the extent to which health care coverage is affordable for employees. However, as the cost of healthcare has soared, premium contributions are becoming more unaffordable for employers. Employers who have historically offered coverage are increasingly looking toward benefit plans that shift a higher share of costs to employees in the form of high deductibles, high copays, and other benefit limiting features in exchange for lower premiums, are turning toward defined contributions to limit expense increases, or are choosing to continue not to offer or to stop offering coverage altogether.

As of 2011, approximately 53% of California's smallest businesses (from 3 to 9 employees) offered health insurance coverage. For small businesses, the majority of those that do offer coverage only subsidize premiums for the employee. In those instances, spousal and dependent coverage is a "buy-up" option for employees who bear the full cost of that coverage.

It is expected that many small employers, both inside and outside the Exchange, will offer an "employee-only" premium subsidy. Because of this, a key "market" for subsidy eligible individuals for the Exchange, Medi-Cal, or Healthy Families, will be spouses and dependents of these workers. The Exchange will need to develop marketing, outreach, and enrollment approaches that maximize the enrollment of these individuals without undercutting employers' support.

In addition to employer contribution levels, consideration must also be given the proportion of eligible employees in each employer group who are required to participate in the Exchange. Lower participation levels increase the probability of an adverse mix of enrollees in the Exchange, while higher participation requirements may reduce adverse selection but also preclude some employers from participating at all, if the employees must pay a high percentage

of the health plan premium. A number of considerations factor into the determination of the appropriate level of required employer contributions and the participation levels. The most significant are described below:

Small Employer Tax Credit

The Affordable Care Act contains a provision creating a tax credit for small employers who contribute to health insurance premiums for their employees. For tax years 2010 through 2013, the maximum credit is 35% for small business employers and 25% for small tax-exempt employers such as charities. An enhanced tax credit will be effective beginning January 1, 2014, which increases the tax credit to 50% and 35%, respectively, but it will only be available to small businesses purchasing health insurance coverage through a SHOP Exchange.

The standards for being eligible for the tax credit are that , in addition to having fewer than 25 full-time equivalent employees (FTEs) with average wages of less than $50,000 a year, businesses "must cover at least 50 percent of the cost of single (not family) health care coverage for each of your employees."

To qualify for the tax credit, employer contributions must also satisfy the uniformity requirements of Section 45R of the Internal Revenue Code. Though there are a number of detailed technical issues, the uniformity requirements can be generally summarized as follows:

- Employers offering one benefit plan: employer contribution must be at least 50% of the premium for the Single Employee tier
- Employers offering more than one benefit plan:
    - employer contribution must be at least 50% of the premium for the Single Employee tier for each benefit plan, or
    - the employer may designate a “reference plan” and make employer contributions in accordance with the following requirements:
        - The employer determines a level of employer contributions for each employee such that, if all eligible employees enrolled in the reference plan, the contributions would be at least 50% of the premium for the Single Employee tier
        - The employer allows each employee to apply the amount determined above toward the cost of coverage for any of the available plans
        - Anti-abuse rule: the Single Employee premium for the reference plan must be at least 66% of the Single Employee premium for each non-reference plan for which the employer claims the tax credit

The tax credit will provide important support to some employers seeking to provide health coverage to their employees and is expected to be an important driver of small businesses toward the SHOP Exchange. It is unclear, however, how many will qualify for it and how many

employees and dependents are associated with those employers. A recent report estimated that 375,000 California small businesses with 2.4 million employees are eligible for the tax credit in 2011. (This issue is described in more detail in the "Promoting the Employer Tax Credit for Health Coverage Board Background Brief) The Exchange is responsible for employee contribution calculations and will need to ensure contributions meet the IRS requirements for those that do qualify.

Health Plan Underwriting Rules and Adverse Selection

Insurers have traditionally included minimum employer contribution requirements in their underwriting rules to help minimize adverse risk selection. The general thinking is that the more an employer contributes for coverage, the less likely it is that healthier individuals will opt out of coverage. Minimum employee participation requirements are typically applied in conjunction with minimum contribution requirements to ensure an adequate cross-section of individuals with a range of health risks enrolls. Typical minimum participation requirements in the current market are 70% to 75% of eligible employees.[‡]

In the current small employer market, a typical minimum employer contribution is 50% of Employee Only coverage (sometimes benchmarked against the lowest cost plan). Under defined contribution arrangements minimum contributions are typically $80 to $100 per employee per month, which may be less than 50% of premium for Employee Only Coverage. See links to underwriting materials for three of California's largest health plans participating in the small group market in the Reference section of this brief for more details.

Stakeholder Viewpoints

Comments from health plans on this issue have reinforced the importance of the Exchange being consistent with market standards and not deviating from the market in areas that would lead to risk selection against the SHOP exchange. Consumer advocates and others have underscored the importance of the Exchange providing information on individual subsidies that may be available to spouses and family members of employees in small businesses, while underscoring the importance of not undercutting employer-sponsored insurance coverage.

Options

Five options related to employer contribution requirements are presented. For all options we recommend that participation rules mirror the current market (i.e., at least 70% of eligible employees be required to enroll in the SHOP, and if the employer provides 100% coverage of employee-only premium costs the participation level should increase to 100%). Federal guidance may further address this issue, and the Exchange will continue to monitor it to determine whether different standards should be considered.

[‡] May be higher under defined contribution or multiple plan choice scenarios, or where the employer contributes 100% or 0% of premiums (both circumstances generally require 100% participation).

The five options related to the required employer contribution level are as follows. A more complete description of the options is below:

- Option 1: Require contributions consistent with current market underwriting rules
- Option 2: Require contributions at least meet federal minimum for tax credit
- Option 3: Require contributions at a level higher than current market or federal tax credit minimums
- Option 4: Require contributions lower than current market or federal tax credit minimums
- Option 5: Require contributions at a set percentage of premiums for all employees

Recommended Approach

We recommend that the Exchange require contributions consistent with the minimum requirements to qualify for the tax credit (Option 2). Though the tax credit will not apply to all small employers in the Exchange, this level is generally consistent with current market underwriting rules for small businesses and would therefore minimize disruption to the market while ensuring that eligible employers can receive the tax credit without additional administrative burden.

The federal rules allow the employer to select any tier level for determining their contribution level, while imposing a restriction on the premium of the plan selected as the reference plan for determining contributions, such that the premium for the reference plan must be at least 66% of the premium for all other plans for which the tax credit will be claimed. For perspective, if premium rates bear a reasonable relationship to the actuarial value of covered benefits, an employer choosing the lowest value plan (Bronze) as the reference plan with an actuarial value of 0.60 could claim a tax credit on contributions made to coverage from the same issuer under any of the metal tiers since the ratio of the Bronze plan to the Platinum plan would satisfy the requirement (0.60/0.90 = 0.66). To the extent that premium rates deviate from actuarial value relativities the test may not be satisfied, and the employer may need to select an alternative reference plan or limit employee plan options to ensure all premium contributions qualify for the tax credit.

Table 9: Employer Contribution Options		
Option 1: Require contributions consistent with current market underwriting rules	**Option 2: Require contributions at least meet federal minimum for tax credit**	**Option 3: Require contributions at a level higher than current market or federal tax credit minimums**
SUMMARY Require minimum employer contributions consistent with current small group underwriting rules. The rules generally require small employers to contribute: – At least 50% of the Single Employee premium – Defined contribution of at least $80-$100 (amount need to be reconsidered and indexed over time) – No contributions are required for Dependent coverage Minimum employee participation at market standard levels	**SUMMARY** Require small employers to contribute in accordance with the minimum requirements defined under IRS Code to claim the tax credit: – At least 50% of the Single Employee premium – If employer offers multiple plans, employer must select reference plan for which the premium must be at least 66% of the Single Employee premium for each non-reference plan for which the employer claims the tax credit – No contributions are required for Dependent coverage Minimum employee participation at market standard levels	**SUMMARY** Require contributions to be at a level that is higher than current small group underwriting rules or the minimum to qualify for the tax credit; for example, 60% of Single Employee premiums or a required contribution for dependent coverage. Minimum employee participation at market standard levels
PURPOSE This option establishes minimum employer contributions at levels consistent with the current small employer market.	**PURPOSE** This option establishes minimum employer contributions at levels that ensure the tax credit can be taken, if other requirements are satisfied.	**PURPOSE** This option establishes minimum employer contributions at levels higher than the current market or ACA requirements to qualify for a tax credit to support more affordable coverage for employees.

Table 9: Employer Contribution Options		
Option 1: Require contributions consistent with current market underwriting rules	**Option 2: Require contributions at least meet federal minimum for tax credit**	**Option 3: Require contributions at a level higher than current market or federal tax credit minimums**
PROS ▪ Does not inhibit employers' ability to contribute more than the minimum or the Exchange's ability to encourage higher contributions ▪ Minimizes market disruption ▪ Provides protection against adverse selection against the SHOP Exchange compared to the broader market	**PROS** ▪ Consistent with the ACA and generally consistent with current small group underwriting rules though reference plan requirement for employers offering a range of plan choices to employees may require a higher contribution than current underwriting rules ▪ Can easily be applied in conjunction with defined contribution strategy though it may require a higher contribution than the current underwriting standard of $80-$100 ▪ Anti-abuse provision of the uniformity requirement provides protections to employees in multiple plan scenarios by requiring the reference plan Single Employee premium to be at least 66% of the Single Employee premium for all other options for which the tax credit is claimed ▪ Does not inhibit employers' ability to contribute more than the minimum or the Exchange's ability to encourage higher contributions	**PROS** ▪ Increases affordability of coverage for employees ▪ Increases potential tax credits for employers ▪ May reduce adverse selection risk through increased enrollment ▪

Table 9: Employer Contribution Options

Option 1: Require contributions consistent with current market underwriting rules	Option 2: Require contributions at least meet federal minimum for tax credit	Option 3: Require contributions at a level higher than current market or federal tax credit minimums
CONS ▪ Minimum contributions may not satisfy IRS requirements for tax credit – Reference plan is often designated as the lowest cost plan, which may not comply with IRS tax credit requirements that require the reference plan Single Employee premium to be at least 66% of the Single Employee premium for all other options for which the tax credit is claimed – Current defined contribution minimums of $80-$100 do not ensure compliance with IRS minimum of 50% of the Single Employee premium – Result of this inconsistency would be more complex communication and administration on the part of the Exchange, which would need to merge the two sets of contribution requirements ▪ Contributions at the minimum may result in premiums that are unaffordable to employees ▪ Does not require any contribution for family coverage, which may make coverage unaffordable for employees	**CONS** ▪ Tax credit does not apply to most small employers ▪ Contributions at the minimum may result in premiums that are unaffordable to employees, though minimum contributions should generally be consistent or slightly higher than under Option 1 ▪ Does not require any contribution for family coverage, which may make coverage unaffordable for employees ▪ Somewhat more complicated to determine minimum contributions requirement	**CONS** ▪ Employers currently contributing at the minimum under current underwriting rules may object to being forced to contribute higher amounts ▪ Higher potential for small group employers to drop current coverage offering or obtain coverage outside the SHOP Exchange

Table 9: Employer Contribution Options	
Option 4: Require contributions lower than current market or federal tax credit minimums	**Option 5: Require contributions at a set percentage of premiums for all employees**
SUMMARY Require contributions to be at a level that is lower than current small group underwriting rules or the minimum to qualify for the tax credit; for example, 25% of Single Employee premiums. Minimum employee participation at market standard levels	**SUMMARY** Require small employers to pay a percentage (e.g., 50%) of each employee's age-rated premium for their selected benefit plan. The minimum contribution may be set at levels at, above, or below current underwriting rules or federal tax credit requirements. Minimum employee participation at market standard levels
PURPOSE This option establishes minimum employer contributions at levels lower than the current market or federal tax credit requirements to qualify for a tax credit to provide more affordable options for employers.	**PURPOSE** This option establishes employer contributions in a way that is simple to calculate and complies with tax credit requirements.
PROS ▪ Increases affordability of coverage for employers	**PROS** ▪ Simple concept ▪ If the contribution is at least 50%, it would be compliant with requirements for the small-employer tax credit
CONS ▪ Decreases affordability of coverage for employees ▪ Prevents employer from claiming tax credit ▪ Increases adverse selection risk	**CONS** ▪ Employees may receive very different employer contributions to their premiums ▪ Could encourage employees to choose more expensive plans to increase the contribution

Reference Material

IRS Small Business Tax Center: Small Business Health Care Tax Credit for Small Employers
http://www.irs.gov/newsroom/article/0,,id=223666,00.html

IRS Notice 2010-82: Section 45R – Tax Credit for Employee Health Insurance Expenses of Small Employers

Institute for Health Policy Solutions, "Small-Employer ("SHOP") Exchange Issues", Paper prepared for California Healthcare Foundation, May 2011

Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust, "Employer Health Benefits, 2011 Annual Survey", September 2011

Families USA and Small Business Majority, "Good Business Sense: The New Small Business Health Care Tax Credit in California", May 2012

California Healthcare Foundation, "California Employer Health Benefits Survey", December 2011

Promoting the Employer Tax for Health Coverage

Summary

The California Health Benefit Exchange is investigating what options it has relative to the employer tax credit to encourage enrollment in the Small Business Health Options Program (SHOP). This "Promoting the Employer Tax Credit for Health Coverage" Board Background Brief provides a discussion of issues for the Exchange board's consideration. The employer tax credit issue is fundamentally one of ensuring employer awareness of its value and availability and providing information and support rather than the Exchange having design options that might influence the size of tax credits. Therefore, the small employer tax credit should be considered a core marketing feature, and this brief is provided as background information that will be part of development of the SHOP marketing strategy.

Background

The Affordable Care Act (ACA) contains a provision creating a tax credit for small employers who contribute to health insurance premiums for their employees. For tax years 2010 through 2013, the maximum credit is 35% for small business employers and 25% for small tax-exempt employers such as charities. An enhanced tax credit will be effective beginning January 1, 2014, which increases the tax credit to 50% and 35%, respectively, but it will only be available to small businesses purchasing health insurance coverage through a SHOP Exchange.

For two years starting in 2014, small businesses purchasing health insurance through the SHOP may be eligible for a tax credit. The tax credit is only available to those employers with 25 or fewer full-time equivalent employees whose average annual wage is less than $50,000. Employers must pay at least 50% of the Single Employee premium and offer coverage to all full-time employees. The tax credit is on a sliding scale up to 50% of the employer contribution.

The tax credit is considered an important incentive for small businesses to participate in the SHOP and to offer insurance coverage to their employees. The Affordable Care Act also included a small business tax credit beginning in the 2010 tax year that has thus far had little take-up. Only about 5% of estimated eligible businesses nationally filed for the tax credit for the 2010 tax year. Among the reasons cited for the relatively low adoption of the tax credit has been that it is generally not well understood by small businesses and that it may be of marginal benefit to many small employers.

A recent survey conducted by Small Business California indicated low awareness of the tax credit among small business owners (57% of respondents were unfamiliar with tax credits). The federal government is continuing to try to raise awareness through an outreach campaign, including targeted mailings and emails to small business owners and accountants, presentations at business forums, informational flyers, YouTube videos, and other means.

Even with successful outreach, the tax credit by itself may not draw large numbers of small employers to the SHOP for a number of reasons, including:

- The tax credit is only available to the subset of small employers who meet the qualifications
- The tax credit may not be sufficient to make coverage affordable for many employers as it is not refundable and therefore depends on the tax liability of the small employer (usually small) as well as the employer contribution
- The enhanced tax credit is only available to businesses for two years Low income workers may have access to subsidized coverage through the Individual Exchange which employers may prefer versus offering coverage

According to a recent report by the Small Business Majority and Families USA, more than 375,000 small businesses in California are eligible for tax credit, and more than 42% small businesses that are eligible for this tax credit are eligible for the maximum tax credit when they file their 2011 taxes. For thousands of small employers the potential of getting a federal tax credit can serve as added incentive. The small business tax credit is an important incentive for some small businesses to participate in the SHOP; it should be leveraged by the Exchange as part of its broader marketing to promote the SHOP and increase employer participation. As there is a clear lack of awareness of its availability, educating small businesses on the tax credits should be a component of the SHOP outreach and marketing efforts. Since small business owners rely heavily on agents for health coverage information, the agent community may serve as a key mechanism for raising the awareness of small employers to the availability of tax credits through the SHOP. Agent training on the tax credit should be developed and training on the tax credit should be considered as a requirement for agents placing business in the Exchange.

Ultimately, the Exchange must offer other high value features and services that make the SHOP the preferred venue from which to purchase insurance in order to attract and retain small employers regardless of their eligibility for the tax credit. The Exchange should focus on the core operations and features of the SHOP that are likely to appeal to small employers and employees since ultimately that will form the basis for its success or failure.

Next Steps

The Exchange will continue to investigate how the employer tax credit can best be leveraged to promote enrollment in the SHOP, particularly for businesses that currently do not offer insurance to their employees. Additional analysis is needed in the following areas:

1. Are there particular types of employers eligible for the tax credit that would benefit direct from those credits?
2. What efforts have proven most effective around the country at engaging employers in the tax credit?

Reference Material

IRS. "Small Business Health Care Tax Credit for Small Employers" Available from: http://www.irs.gov/newsroom/article/0,,id=223666,00.html

IRS. "Who gets the credit?" Available from: http://www.irs.gov/newsroom/article/0,,id=252897,00.html

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