California Health Benefit Exchange

Small Employer Health Options Program

Final Board Recommendations

August 20, 2012

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

The following recommendations and background material reflect input that has been received from stakeholders from the original preliminary recommendations submitted to the Board in May, with new elements proposed in July, 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 our final Recommendation Brief submitted for board action. There are seven Briefs, the first six of which include a summary of the issue, background, options, recommendations and background reference material. The seventh brief is a Background Brief, with no current recommendations, on the Employer Tax Credit. The Exchange has also developed options and recommendations in the umbrella area of its qualified health plan selection processes, many of which have significant impacts on the SHOP Exchange. In addition, the Exchange has developed an additional SHOP-specific Board Options Brief under separate cover on the issue of managing the SHOP internally or externally sourcing the operations of the SHOP.

The recommendations made in these materials are based on input from the board and from a broad range of stakeholders. The Exchange solicited and received comments on these and other SHOP-related issues, with many provided in written-form and through in-person meetings.

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Executive Summary

The California Health Benefit Exchange is establishing both 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 issuer and providers that give them the best value. The staff of the California Health Benefit Exchange, with support from PricewaterhouseCoopers, 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 presented options and preliminary recommendations for the Board's consideration. In subsequent work, additional Briefs were developed to address issues related to the definition of Qualified Health Plans (QHP) under both the Individual and SHOP exchanges.

The issues addressed and final board recommendations outlined in this document reflect substantial input from a wide range of stakeholders from consumer groups, health plan issuers, dental and ancillary plans, health insurance agents, small business, chambers of commerce, general agents, health care providers, industry, trade and professional associations across a broad geography. 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.

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 and General Agent Strategy
  - Small Employer Benefits Administration and Ancillary Benefit Options
  - Supplemental Benefits: Dental and Vision
  - Employer Contribution and Participation Options
- Board Background Brief
  - Promoting Employer Tax Credit for Health Coverage

In most areas, staff has presented the Board with recommendations. These recommendations have been vetted and discussed with the board, and with input from small employers, consumers, health plan issuers, agents and other stakeholders.

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. The Exchange considered 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.

Issue 1: Extent to which issuers participate in both the Individual and SHOP Exchange

The following options were considered for alignment of health plan issuers between exchanges:

- **Option A. Full alignment:** Health plan issuers submit QHP 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 B. 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 C. No required alignment:** Health plans may participate in either Exchange.

Issue 2: Extent to which products are aligned in both the Individual and SHOP Exchange

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

- **Option A. Full alignment:** Benefit plan offerings would be identical in both exchanges.
- **Option B. 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 C. No required alignment:** Benefit plan offerings are unique to each Exchange.

Staff recommends partial alignment for both plans and benefit designs (Options B for both Issues) to encourage plan issuer participation yet preserve reasonable exception for issuers only licensed for one but not both market segments (e.g. individual but not small business). While the goal is to maintain reasonable consistency between the two exchanges, the market needs are slightly different and plan issuers will be more likely to participate in the exchange if permitted to provide some differentiation between the two exchanges.

Staff also believes the metal structure and essential health benefit requirements will serve to maintain alignment and continuity between individual and shop exchanges, as well as issuers own product nomenclature and branding. Most plan issuers and a majority of stakeholder input supported our recommendation for partial alignment of benefit plans with some sharing

serious concern for adequate plan issuer participation in both exchanges if no alignment were required.

Extent of Employer and Employee Choice

The Exchange considered 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. The Affordable Care Act and federal regulations require that employers must have the option of choosing any coverage level and giving employees the choice of any QHP at that coverage level, offered by any issuer, which is available through the SHOP. The California Affordable Care Act requires issuers that offer products through the SHOP to offer products at all four coverage levels.

The regulations also give the SHOP the flexibility to provide additional choices to employers. The following options, including the one which the Affordable Care Act requires, were presented to the Board on July 19, 2012 and are recommended by the Exchange staff:

- **Option A. Employer chooses tier, employee chooses issuer and plan:** Employer establishes the metal tier for all employees and allows employee to select among available health plans. The employer may choose to offer plans at any one of the bronze, silver, gold or platinum levels. (Note: This option is required under the California Affordable Care Act.)
- **Option B. Paired/Defined Choice with Limited Tier** options, requiring that the employer choose two issuers among the available options, and choose two or more contiguous Tier options to be made available to their employees. This option would be made available to employers with 10-50 employees.

Staff is seeking further stakeholder input and clarification on regulator processes before making a final recommendation to include Option C.

- **Option C. 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.

While staff recommends offering the three options A and B with further consideration of Option C, it considered and is not recommending the following additional options:

- **Option D. Full Employer Choice:** The employer, on behalf of employees, selects the health plan and coverage level within the available SHOP options.
- **Option E. Paired Choice:** The employer chooses a specific combination of issuers and qualified health plans from which employees can choose. Choice of qualified health plans within a metal tier may or may not be limited.

- **Option F. Full Employee Choice:** The employer determines the maximum contribution that will be made on behalf of an employee, and the employee can choose a qualified health plan among all issuers and metal tiers.

There are a number of options for determining the level of employer and employee choice in the SHOP Exchange, ranging from asking the employer to choose the level of coverage available to their employees, to giving the employees full choice of both issuer and metal tier. The Exchange staff recommendations are to apply rules that will promote the availability of affordable products for small business and their employees, provide broad choice of product offerings with a greater level of standardization to health insurance options for small employers.

These recommendations are submitted after completing additional analysis and stakeholder feedback. It is the goal of the Exchange to make affordable coverage available to small employers and their employees while fostering informed choice. The Exchange staff believes that Employer Choice (Option A), Employee Tier Choice (Option B) and Paired Choice Plus (Option C) balance employer choice, employee choice and affordability. These recommendations reflect the Exchange staffs' understanding that plans offered in the SHOP Exchange are expected to be offered at the same price for all small groups of 2-50 employees, and for all combinations of offerings. In addition, they reflect independent actuarial counsel that this mix of offering would be more likely to reflect the most affordable mix of offerings.

SHOP Agent and General 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 were considered for the Exchange:

Issue 1: Payment of Commissions to Agents

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

Staff's recommendation is to offer agent compensation competitive with the market and pay agents directly (Option B). As there is no current standard for agent commissions for all health plan issuers, the SHOP cannot exactly "match" commissions across multiple issuers. Rather, the SHOP will provide market-competitive commissions offered in the commercial market.

Issue 2: Use of General Agents in the SHOP Exchange

In addition to considering how the SHOP Exchange relates to individual agents, the Exchange also considered the extent to which General Agents should participate in the SHOP Exchange. As aggregators of multiple plan issuers, the role of general agents is significant in the small business segment, accounting for more than 50% of new sales in the current market. In

addition to providing multi-plan proposals, they also provide sales support, product training, agent commission reconciliation, field enrollment assistance and group application support through the underwriting and implementation process. Currently, General Agents contract directly with the plan issuers who also compensate them for services. The following options were presented for stakeholder feedback at the July 19, 2012 board meeting and staff have continued to meet with various stakeholders, including health plan issuers, agents and general agents. The following options were considered:

- **Option A**. SHOP excludes General Agents from distribution
- **Option B**. SHOP contracts with some General Agents through a bid process (2-4 General Agents)
- **Option C**. SHOP contracts with all qualified General Agents

Staff recommends the Exchange select participating general agents through a bidding process (Option B), with the bid process to be further defined. Bidder criteria will be based on a series of factors like the reach of agents (statewide and regional); how they partner with the Exchange; General Agent override costs and technology, tools and value adds to either employers and agents.

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 were considered:

Issue 1: Extent to which the Exchange will offer supplemental or ancillary options in SHOP.

- **Option A: Cal-COBRA/COBRA only administration:** Exchange undertakes a minimal role in employer benefits administration.
- **Option B: Mixed vendor limited employer benefits administration:** Exchange engages vendor(s) to provide select employer benefit administration services and may offer some services directly.
- **Option C: Full-service vendor-supported benefits administration:** Exchange engages a single vendor to provide an array of employer benefits administration services.

Staff has made a final recommendation that the Exchange offer limited benefits administration (e.g. COBRA, CalCOBRA, HRA, HSA, FSA and Section 125) (Option B) 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.

Issue 2: Implementation of ancillary benefits

There were two approaches for implementation of ancillary benefits:

- **Option A.** The Exchange provides employer benefits administration services and offers ancillary benefits using stand-alone specialty carriers.
- **Option B**. The Exchange provides employer benefits administration services and offers ancillary benefits through multiple participating health plans.

Staff recommends providing administrative services and ancillary benefits using stand-alone specialty carriers. Under Option A, the Exchange may consider an endorsed relationship whereby the Exchange shares in the fees that are collected from users.

Supplemental Benefits: Dental and Vision

The Affordable Care Act defines ten broad categories of Essential Health Benefits. The health plans must offer benefit packages to individuals and small employers both in and out of the exchanges that include a range of services from all ten categories, but are not obligated to provide any services beyond those stipulated in the EHB package. While pediatric dental and vision services are part of the Essential Health Benefits, adult coverage for those services is not. However, small employers commonly purchase supplemental dental and vision benefits for their employees, and offering those benefits in the SHOP may enhance SHOP enrollment.

The following options are available for structuring Dental and Vision offerings:

- **Option A. Combined with medical:** Offer dental and vision coverage as part of medical QHP plans.
- **Option B. Stand-alone plans:** Offer stand-alone dental and medical plans.
- **Option C: Hybrid:** Offers a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits.

Staff recommends reviewing proposals from both stand-alone dental plans and medical plans (Option B). This does not preclude the Exchange from accepting bids from Qualified Health Plans that cover the full complement of benefits. However, allowing stand-alone dental and vision plans are most consistent with current market practices commonly offered through employer group plans. Option B does not change the current environment for small group employer decision-making, and may attract a greater number of health plan bidders. Even with separate vendors for these supplemental services the employer will receive a single invoice through the Exchange, so issues related to administrative complexity that may arise in the external market with multiple providers will not apply. The SHOP Exchange may consider offering additional supplemental benefits (e.g. Group term life and group disability).

Employer Contribution and Minimum Participation Requirements

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 considered the options related to the extent to which it requires small businesses to make premium contributions on behalf of their employees. The following options were considered:

Issue 1: Extent to which small business are required to make premium contributions on behalf of employees

- **Option A. Require contributions consistent with current market underwriting rules:** Establishes minimum employer contributions at levels consistent with the current small employer market.
- **Option B. 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 C. 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.

Staff recommends the SHOP require guidelines consistent with the commercial small business marketplace (Option A) (Note: This is a revision from the preliminary recommendation). The Exchange also recommends applying similar guidelines for minimum participation requirements to encourage employee enrollment and to mitigate adverse selection with the commercial market. SHOP will apply minimum participation requirements consistent with commercial market underwriting rules.

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 are affordable to consumers in terms of premiums and at the point of care, while fostering competition 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 individual characteristics, including but not limited to sexual orientation, 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.
d. Consider how Exchange policies can support improvement in health outcomes, patient safety and reduce avoidable readmissions.

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.
d. 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.

IV. 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 for all Exchange members, taking special circumstances into account in evaluating health disparities.

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.
f. Promote innovations and changes in the administrative processes that reduce the burden on plans, providers and consumers.

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.
c. Continue to learn and mature our approach based on input from our national partners, California stakeholders, on-going research, evaluation and measurement of quality of care and measurement of impacts of Exchange policies on achieving the goals of better care, improved health and lower costs.

Board Recommendation Briefs

SHOP and Individual Exchange Qualified Health Plan (QHP) Alignment

Summary

While under the federal Affordable Care Act, exchanges have the option to merge their individual and small group efforts, under California 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 considered how closely to align the qualified health plans (QHPs) and other policies 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 final recommendations from staff 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 issuer participation in the Individual and SHOP exchanges should be considered separately from alignment of the offered benefit plan designs (which include the type of health benefit plan, provider network structure and size, and cost sharing provisions). Decisions on alignment of QHP were 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.

Summary of Recommendations

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

Issue 1: Alignment of Health Plan Issuers between Exchanges
Issue 2: Alignment of Benefit Plan Offerings between Exchanges

Staff recommends the adoption of Option B for both issues.

Issue 1: Alignment of Health Plan Issuers between Exchanges

- **Option B. 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.

Issue 2: Alignment of Benefit Plan Offerings between Exchanges

- **Option B. 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.

Discussion

Alignment of Health Plan Issuers

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

- Promotes continuity of care for individuals that move between the Individual and SHOP Exchanges.
- Reduces total administrative costs by reducing the total number of issuers that the Exchanges would have to certify and negotiate contracts.
- Provides 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:

1. Historical or desired market focus: Issuers may not want to expand into the Individual or Small Group markets if they have not historically participated in them or if they do not fit their business strategy. (Note: Historically one reason that some issuers 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 issuers 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.

2. 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.
3. 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 growing interest in that option among some small employer groups.
4. 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 and 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 are desirable, including:

- Reduces 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 considered 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 (e.g., HRA-eligible plans are not popular with individuals whereas HSA-eligible plans are popular for both individual and group markets.)
- 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 plan issuers 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.

Issues and 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 final recommendations related to the following two alignment issues:

Issue 1: Alignment of Health Plan Issuers between Exchanges
Issue 2: Alignment of Benefit Plan Offerings between Exchanges

Issue 1: Alignment of Health Plan Issuers between Exchanges

The following options were considered for alignment of health plan issuers between exchanges:

- **Option A: 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 B: 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 C: No required alignment:** Health plans may participate in either Exchange.

Issue 2: Alignment of Benefit Plan Offerings between Exchanges

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

- **Option A. Full alignment:** Benefit plan offerings would be identical in both exchanges.
- **Option B. 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 C. No required alignment:** Benefit plan offerings are unique to each Exchange.

The options are detailed in Table 1 and Table 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 both its issuer participation and benefit design structures between the Exchanges (Issue 1, Option B and Issue 2, Option B). 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 issuers 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 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 that 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 considered 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 explored these issues and others raised by issuers and other stakeholders before finalizing these recommendations.

Table 1: Issue 1 Alignment of Health Plan Issuers between Exchanges		
Option A: Full Alignment	**Option B: Partial Alignment**	**Option C: No Required Alignment**
SUMMARY The Exchange would require that issuers submit QHP applications for participation in both the individual and SHOP Exchanges in the same geographic coverage regions.	**SUMMARY** The Exchange would require that issuers submit applications for participation in both the individual and SHOP exchanges. However, under this design, exceptions would be allowed for issuers 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** Issuers 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 issuers that it believes would best help it meet its objectives.
PURPOSE Requiring 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 A

Table 1: Issue 1 Alignment of Health Plan Issuers between Exchanges		
Option A: Full Alignment	**Option B: Partial Alignment**	**Option C: No Required Alignment**
CONS ▪ Some 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 A 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 issuers are not participating in both	**CONS** ▪ May result in an insufficient number or mix of issuers participating in the SHOP exchange ▪ Could be confusing and lead to disruptive care for individuals that transition between exchanges when an issuer does not participate in both ▪ Administrative costs and complexities would be the greatest under this option

Table 2: Issue 2: Alignment of Benefit Plan Offerings between Exchanges		
Option A: Full Alignment	**Option B: Partial Alignment**	**Option C: No Required Alignment**
SUMMARY The Exchange would require that the benefit plan 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 benefit plan offerings of both exchanges, with the flexibility to offer different benefit 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 plan options by participants ▪ Reduces Exchange administrative costs	**PROS** ▪ Promotes understanding of available benefit plan 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

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Health Access California, June 15, 2012 letter to CHBEX Additional Stakeholder Feedback

Extent of Employer Versus Employee Choice

Summary

The California Health Benefit Exchange considered 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 while minimizing the potential for adverse selection that could jeopardize the stability of the SHOP. In considering how much choice will be made available to employers and employers, the key issues that were 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 revised staff recommendations that are being carried forward for further comment. No board action is requested at this time.

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; for purposes of this Brief we have assumed that Qualified Health Plans will be required to offer all metal tiers in all geographic areas in which they contract with the SHOP.

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 qualified health plans 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 Exchange allow employers to select a level (metal tier) at which all qualified health plans 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.

The concern about offering full employee choice of both issuer and coverage level or metal tier is the potential that individual employees within an employer group who have a known need for health care services will choose a higher level of coverage that is not offset by the level of increase in premium rates, while those who predict they will not have high health care needs during the year will choose a lower level of coverage at lower premium rates. This risk is greatest for the smallest employers (those with fewer than 10 employees) since there are fewer employees over which to spread the cost of one or two high cost individuals. When considered within the SHOP, the aggregate experience across all employer groups will be important in determining the level of risk of the enrollees, while those risk differences would apply to individual employer groups for products purchased outside of the Exchange.

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 metal tiers, 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 metal tiers, or allowing employers to offer only one plan.[*]

Most health plans tend to prefer options that are rely on "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:

[*] 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.

> *"…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.*
>
> *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:

> *"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

The Affordable Care Act 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. Common pricing in and out of the exchange is considered important to the success of the employee choice model in New York, Connecticut, and Massachusetts. 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 intend to mitigate the effects of adverse selection among health plans and between plans offered through the Exchange and plans offered in the outside market. However, the Risk Assessment and Risk Adjustment program has not yet been tested, and there is uncertainty whether the program will fully measure and compensate for all risk differences. Consequently, the SHOP cannot rely on Risk Adjustment as a guaranteed solution to the full risk of adverse selection.

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.

Issues and Recommendations

There are a number of options for determining the level of employer and employee choice in the SHOP, ranging from asking the employer to choose the level of coverage available to their employees, to giving the employees full choice of both issuer and metal tier.

The Exchange staff recommendations are to apply rules that will promote the availability of affordable products for small business and their employees. The recommendations should also provide broad changes in product offerings with a greater level of standardization to health insurance options for small employers.

These recommendations are submitted after completing additional analysis and stakeholder feedback. Specifically, we considered the following:

- Level of health plan interest in contracting with the SHOP under the proposed choice options;
- Consideration of new stakeholder comments or suggestions which fully consider the new marketplace rules and dynamic not present today but in place for 2014 (e.g. community rating, new product offerings, impact of tax credits, standardized health plans, implementation of essential health benefits requirements and other market rule changes)
- Additional data analysis to validate the need for a premium adjustment if a paired choice approach is used, as well as legal analysis of whether a premium adjustment is permitted
- 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.

The Exchange staff recommends the following two options:

Option A. Employer Choice of Tier / Employee Choice of Plan: The employer establishes the metal tier for all employees and allows employees to select among available health plans within that tier. The employer may choose to offer multiple carriers and plans within any one of the bronze, silver, gold or platinum tiers. The figure below provides an example with the silver tier.

A: Employer Choice of Tier / Employee Choice of Plan				
	Bronze	Silver	Gold	Platinum
Issuer 1				
Issuer 2				
Issuer 3				
Issuer 4				
Issuer 5				
Issuer 6				

EMPLOYER: Selects Tier (e.g. Bronze or Silver Tier)
EMPLOYEE: Selects any plan within tier from all issuers

Option B. Paired/Defined Choice with Limited Tier The employer chooses (a) two issuers among the available options, and (b) two or more contiguous metal tier options to be made available to their employees. This "limited tier" option would be made available to employers with 10-50 employees.

B: Paired/Defined Choice with Limited Tier				
	Bronze	Silver	Gold	Platinum
Issuer 1				
Issuer 2				
Issuer 3				
Issuer 4				
Issuer 5				
Issuer 6				

EMPLOYER: Selects two Issuers & two contiguous tiers (e.g. bronze & silver)
EMPLOYEE: Selects from offered issuers and tiers

In brief, the Exchange staff recommends Options A and B because they:

- Comply with the ACA,
- Provide sufficient choice for employees, which may encourage long term Participation of employers in the Exchange,
- Requires minimal decision-making by the employer,
- Protect issuers and the SHOP against adverse selection,
- Support affordability of coverage for small businesses, and

- Encourage competition among health plans.

These recommendations reflect the Exchange staffs' understanding that plans offered in the SHOP Exchange are expected to be offered at the same price for all small groups of 2-50 employees, and for all combinations of offerings. In addition, they reflect independent actuarial counsel that this mix of offering would be more likely to reflect the most affordable mix of offerings.

The Exchange Staff would like to seek additional comment on the inclusion of Option C described below. Among considerations is modifying Option C to include only three of the four available tiers. Staff will continue to work with our regulator partners to clarify that the necessary rate review process is in place to support the fair inclusion of this and the other option in the marketplace.

Option C. Employer Choice of Plan / Employee Tier Choice: The employer chooses one issuer and allows the employee to select the level of coverage among metal tiers.

C: Employer Choice of Plan / Employee Tier Choice				
	Bronze	Silver	Gold	Platinum
Issuer 1				
Issuer 2				
Issuer 3				
Issuer 4				
Issuer 5				
Issuer 6				

EMPLOYER: Selects Issuer
EMPLOYEE: Selects plan from all tiers

The Exchange staff considered but does not recommend the following three options:

Option D. Full Employer Choice: The employer, on behalf of employees, selects the health plan and coverage level within the available SHOP options:

D: Full Employer Choice				
	Bronze	Silver	Gold	Platinum
Issuer 1				
Issuer 2				
Issuer 3				
Issuer 4				
Issuer 5				
Issuer 6				

EMPLOYER: Selects Issuer & Tier
EMPLOYEE: Makes no selection

Option E. Full Paired Choice: The employer chooses a specific combination of issuers and qualified health plans from which employees can choose. Choice of qualified health plans within a metal tier may or may not be limited.

E: Full Paired Choice				
	Bronze	Silver	Gold	Platinum
Issuer 1				
Issuer 2				
Issuer 3				
Issuer 4				
Issuer 5				
Issuer 6				

EMPLOYER: Selects two Issuers
EMPLOYEE: Selects tier from available issuers

Option F. Full Employee Choice: The employer determines the maximum contribution that will be made on behalf of an employee, and the employee can choose a qualified health plan among all issuers and metal tiers

F: Full Employee Choice				
	Bronze	Silver	Gold	Platinum
Issuer 1				
Issuer 2				
Issuer 3				
Issuer 4				
Issuer 5				
Issuer 6				

EMPLOYER: Sets maximum contribution that will be made on behalf of employee
EMPLOYEE: Selects plan among all SHOP issuers and tiers

Table 3 provides a summary comparison of the options with additional commentary (pro/cons).

Rationale

The Exchange staff recommends a "hybrid approach": Employer Choice of Tier / Employee Choice of Plan (Option A) and Paired/Defined Choice with Limited Tier (Option B). The Exchange staff recommends that all small business employers with 2-50 employees choose the coverage tier, and employees choose among the offered plans. Option A represents the Federal ACA requirement for Employer/Employee Choice. Larger employers (those with 10 - 50 employees) should also have the option to operate under a Paired/Defined Choice with Limited Tier approach.

The current small group rules generally allow small group employers to select a single health plan issuer from which all plans (products) may be offered to their employees, similar to the recommended Option C. The broad range of plan (product) types typically include HMO, PPO and High Deductible Health Plans eligible for health savings accounts (HSA), with a range of deductibles and benefits found in the full metal tier spectrum.

For somewhat larger groups, the option of offering another health plan issuer is also available. When two health plan issuers are offered, the plan issuers may apply specific "pairing" rules with a limited menu of health plans from which to choose. When multiple plans are offered, there are typically participation rules that require at least a minimum level of enrollment in each plan (i.e., typically a minimum of 5 employees must enroll in each plan), and there may be a premium increase to account for the offering of choice of two plan issuers. Employers choosing two issuers (Option B) allows employers to make the choices they believe will be most attractive to their employees while limiting insurer risk of adverse selection. Option C is similar to options available in today's small employer market for the employers with 10 or more employees.

In the current market, an employer with as few as 5 employees (in some cases, as few as two employees) may select a single plan issuer and could have as many as 40 plans from which to choose. In this hypothetical example of a group of 5 employees; each employee could enroll in a different plan across all plan tiers. While Option C is the current default option for most health plan issuers today, the market dynamic may change by 2014. Since this is the default option for many health plan issuers today, this option is still under consideration by Exchange staff.

The SHOP will serve as a gateway to coverage for many small businesses that have not provided coverage to date. Broad choice for very small groups may present a level of risk during the early implementation of the SHOP that cannot be sustained. In the current market, all small groups are subject to strict participation rules. These rules often result in small employers selecting a single issuer. When a single issuer is selected by the employer, the employees may still have a wide range of plans from which to choose (Option C).

Full Employer Choice (Option D) was not recommended as it provided insufficient value for consumers, employers or the SHOP Exchange. In this option, the employee has neither choice of issuer or tier. While it is a simple and administratively convenient option, the Exchange staff recommends Employee Tier Choice (Option B) when a single issuer is preferred.

Paired Choice (Option E) was also not recommended due to the impact of adverse selection. While the option for an employer to select two issuers is appealing and popular in the current market, also offering the broad range of all tiers could expose issuers and the exchange to adverse selection. The Exchange staff believes this paired choice option is better served by the recommended Paired Choice with Limited Tier (Option C) as it restricts selection to two contiguous tiers. The impact of adverse selection may be further mitigated by requiring ten or more enrolled employees for Paired Choice Plus.

Full Employee Choice (Option F) was not recommended for several reasons. While adverse selection was a significant factor, the administrative complexity and potential confusion (all issuers and all tiers) for employees and employers was also a consideration. The Exchange staff recommends two unique choice options with the consideration of a third which serve specific employer and employee needs. Employers seeking to provide the lowest cost bronze plan may find their needs are best met by Employer Choice (Option A). Larger employers seeking a paired choice option similar to what is offered by large employers with 100 or more employees may prefer to select Paired Choice with Limited Tier (Option B).

It is the goal of the Exchange to make affordable coverage available to small employers and their employees while fostering informed choice. The Exchange staff believes that Employer Choice (Option A and Paired Choice Plus (Option B) with the consideration of Employee Tier Choice (Option C) balance employer choice, employee choice and affordability.

Among the advantages to small employers and their employees of purchasing coverage through the SHOP are expanded choice compared to current options in the external market, and administrative simplification. 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.

Table 3: Summary Comparison of Employer Choice Options		
Option A: Employer Choice of Tier / Employee Choice of Plan	**Option B: Paired/Defined Choice with Limited Tier**	**Option C: Employer Choice of Plan / Employee Tier Choice**
SUMMARY: The employer establishes the metal tier for coverage for all employees; the employees choose among available health plans	**SUMMARY:** The employer chooses two issuers in a paired choice offering to their employees, and chooses two or more contiguous coverage tiers. Pairings are not negotiated by the Exchange	**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
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	**PURPOSE:** Provides a hybrid of choice options to the employer and employee, ensuring the employee has choice within a relatively narrow range of options, with the employer choosing the combination of offerings that best meet their employees' needs	**PURPOSE:** Option allows employees additional choice among coverage levels to better meet individual employee needs, but continues to work with a single health plan
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	**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 decisions remain in the hands of the employees ▪ Less susceptible to adverse selection than unlimited choice, so may be more attractive to issuers ▪ Employer choice of pairings ensures a match to each employer's circumstances while reducing adverse effects of broader choice ▪ Choice of two plan issuers often sufficient for larger employers	**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 ▪ Supports continuity of care if employee changes plans with same issuer at open enrollment. ▪ Mitigates adverse selection as risk is contained within a single issuer
CONS ▪ Less choice than Individual Exchange ▪ Level of coverage may be insufficient to meet employee needs, without option to "buy up"	**CONS** ▪ Compared to unlimited choice, some desired options may not be available ▪ Larger groups with ten or more enrolled employees will have more choice options than smaller groups ▪	**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

Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers

Table 3: Summary Comparison of Employer Choice Options		
Option D: Full Employer Choice	**Option E: Full Paired Choice**	**Option F: Full Employee Choice**
SUMMARY: The employer makes a choice of health plan and coverage level within the available SHOP options for their geography	**SUMMARY:** The exchange negotiates paired choice options from which the employer chooses; all coverage tiers are available.	**SUMMARY:** The employer chooses neither the health plan options nor 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: 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:** Provides a hybrid of choice options to the employer and employee, ensuring the employee has choice within a relatively narrow range of options, with the SHOP negotiating with issuers for the combination of offerings that will be made available	**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 ▪ Most similar to current options for small employers ▪ Simplest to understand ▪ Minimizes adverse selection risk across health plans	**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, so may be more attractive to issuers	**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

Table 3: Summary Comparison of Employer Choice Options		
Option D: Full Employer Choice	**Option E: Full Paired Choice**	**Option F: Full Employee Choice**
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 ▪ No employee choice as employer has selected both issuer and tier ▪ Employees seeking a different tier choice may be drawn to waive employer coverage and enroll in the individual market instead	**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 ▪ More susceptible to adverse selection than the recommended Paired Choice Plus	**CONS** ▪ Broad choice may be confusing for employees, decision support tools will be needed ▪ Most extreme potential for adverse selection across health plans that may exceed corrections made by risk adjustment ▪ Adverse selection may lead to pricing instability

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Small Employer Health Options Program (SHOP) Agent and General 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.

While not submitted for board action, the Exchange will also be considering the extent to which general agents participate in the SHOP Exchange. Currently, general agents contract directly with health plan issuers who also compensate them for services. This important relationship requires additional investigation before a board recommendation can be fairly prepared.

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 Agent (GA) load affect the overall affordability of Exchange plans. Like the Exchange, General Agents aggregate information and products and considerably expand access to the agent community.

Small group issuers in California generally compensate agents and general agents at the same level (currently 7% and approximately 2 to 3%, respectively), with some issuers 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 metal level designs required by 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 issuers. 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 individual sales through an embedded sales organization. Kaiser builds their commission costs into premium on a community-wide basis. Although PacAdvantage[3] 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, a small group purchasing pool operated by Choice Administrators, a subsidiary of the general agency Word and Brown, refers all potential direct sales or sales leads to an agent. Attempts by issuers such as PacifiCare (subsequently acquired by United Healthcare) 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 Agent is involved, agent payment is

[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

routed through the General Agent, which aggregates information across carriers and issues a consolidated payment and report to the individual agents. All issuers 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 Agent load is typically an additional 2% to 3% in addition to the agent commission. General Agents 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 to the discussion on small employer benefit administration services, General Agents 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 Agent may absorb the fees for such services.

Summary of Recommendations

There are a range of topics associated with SHOP Agent and General Agent Strategy. This Board Recommendation Brief presents options and final recommendations related to the following two alignment issues:

Issue 1: Payment of Commissions to Agents
Issue 2: Exchange use of General Agent for SHOP

Staff recommends the adoption of Option B for both issues.

Issue 1: Payment of Commissions to Agents

- **Option B. Match commissions (Exchange pays):** Exchange matches issuer commissions and administer payments to brokers and agents.

Issue 2: Exchange use of General Agent for SHOP

- **Option B**. General Agent Bid Process: SHOP Exchange contracts with some General Agents through a bid process (2-3 General Agents)

Stakeholder Viewpoints

Agent Strategy

Issuers 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, issuers 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 issuers 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 Navigators cannot receive agent commissions.

While Navigators cannot receive payments from health plans for SHOP enrollment, the Exchange can compensate them. The Exchange could also facilitate referrals to agents to complete the sales process and provide programmatic information and orientation materials to the small business.

General Agent Strategy

Health plan issuers and agents both recognize general agents currently play a significant role in the small group market segment. While many agents currently utilize general agents for aggregated multi-carrier proposals, enrollment assistance and general sales support, many agents shared uncertainty about the ongoing viability or need for general agents in the 2014 market.

Health plan issuers also expressed general concern about meeting the 80% medical loss ratio required by the ACA and may consider both agent and general agent compensation (commission override) among the many administrative costs warranting further review. Stakeholders generally want to maintain broad choice of general agents and believe General Agents will provide value for the SHOP Exchange.

The Exchange received feedback from agents expressing their preference to work with more general agents and concern if only two or three general agents are selected by the Exchange. All general agents contacted expressed interest in bidding for the SHOP general agent relationship. Each cited their own unique value proposition and capabilities to promote enrollment for the SHOP Exchange. Some said they understand the changing small business market dynamics may require additional services and responsibilities than currently provided and possibly different compensation terms to help health plan issuers meet their medical loss ratio requirements.

Stakeholders reminded Exchange staff to compare variable costs of the general agent compensation compared with the fixed costs for additional staff if the Exchange only contracted with a few or no general agents. As general agents are compensated by commission overrides only when a case is sold, they believe this sales distribution model is most efficient and should be considered. General agent stakeholders also felt they could be instrumental in helping the SHOP Exchange train and recruit agents to promote enrollment in the SHOP Exchange. Stakeholders also cited examples of the general agent role in helping successfully launch new carriers or products to the agent community.

Issues and Recommendations

Issue 1: Payment of Commissions to Agents

- **Option A. Match commissions (Plan pays):** Exchange matches issuer commissions and issuers administer payments to brokers and agents.
- **Option B. Match commissions (Exchange pays):** Exchange matches issuer commissions and administer payments to brokers and agents.
- **Option C. Exchange sets and pays commissions:** Exchange sets rates for brokers and agents, and issues payments to them.

Staff recommends Option B (Exchange grants market competitive commission and pays) 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 B, 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 B, 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. To the extent that issuers hold direct contracts with agents and General Agents, it could be challenging for the Exchange to administer different practice

standards across plans. Additionally, the Exchange would need to work with issuers to assure that agents are certified to meet each issuer's requirements or establish a mechanism to amend such agreements to allow agents to "accept assignment" from the Exchange.

Issue 2: Exchange use of General Agent for SHOP

- **Option A**. SHOP excludes General Agents from distribution
- **Option B**. SHOP contracts with some General Agents through a bid process (2-3 General Agents)
- **Option C**. SHOP contracts with all qualified General Agents

Staff recommends Option B whereby the SHOP Exchange contracts with 2-3 General Agents through a bid process. Bidder criteria will be developed based on a series of factors like broad reach of agents (statewide or regionally); how they partner with the Exchange; General Agent override costs and technology, tools and value-adds. While general agents currently play a significant role in the sales and enrollment of small business health insurance, the Exchange is also considering future needs and the challenges for plans issuers to meet new medical loss ratio requirements in 2014. 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. General agent compensation is expected to accrue toward health plan issuer's administrative expenses for MLR calculation, but how general agents are compensated by plan issuers may change between now and 2014.

Next Steps

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

- Bid criteria for selection of general agents to leverage relationships and the agent network.

In developing these recommendations, staff will seek to both assure effective involvement of general 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 6 "Operational Considerations" highlights some of these issues and their implication for the options considered.

Table 4. Summary of SHOP Agent Payment Options		
Option A: Match Commissions (Issuer Pays)	**Option B: Match Commissions (Exchange Pays)**	**Option C: Exchange Sets and Pays Commissions**
SUMMARY The Exchange would grant or require participating issuers to grant market completive commissions and have issuers administer payments for members enrolled through Exchange plans	**SUMMARY** The Exchange would grant market competitive issuer commissions and issue payments directly to agents	**SUMMARY** The Exchange sets a rate based on prevailing issuer commission structures and issues payments directly to agents.
PURPOSE The Exchange leverages the prevailing issuer commission structures and may reduce the level of infrastructure and ongoing resources to manage agent support	**PURPOSE** The Exchange uses the prevailing issuer commission structures and leverages its visibility among agents by being the issuer of payment	**PURPOSE** The Exchange sets a common rate across issuers and supplemental vendors that leverages its visibility among agents but simplifies the administration of payment
DESCRIPTION The Exchange supports a level playing field among issuers and the SHOP program by granting market competitive rates or requiring participating issuers to pay market competitive commissions. Any special incentive programs are simultaneously available through small groups sold under the Exchange, but the agent receives multiple payments from issuers depending on the distribution of the small group's beneficiaries	**DESCRIPTION** The Exchange supports a level playing field among issuers and the SHOP program by granting market competitive rates. The Exchange would require issuers 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 issuers 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 A: Match Commissions (Issuer Pays)	Option B: Match Commissions (Exchange Pays)	Option C: Exchange Sets and Pays Commissions
PROS ▪ The Exchange minimizes its administrative burden; agent agreements and licensure verification are delegated to the issuers ▪ The Exchange keeps issuers 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 issuers (Kaiser, Anthem), but potentially limits Exchange product exposure among the direct sellers ▪ Any vesting arrangements favored by agents and permitted by issuers 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 issuers 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 issuers to recognize Exchange volume as part of their incentive programs
CONS ▪ The stakeholder response to this approach was overwhelmingly negative from issuers 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 issuers 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 issuers 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 issuers with effective direct sales units (assuming that common product pricing would require the issuer to raise its direct sales pricing) ▪ The Exchange may place one or two issuers 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

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Table 5. Summary of SHOP General Agent Payment Options		
Option A: SHOP Excludes GA's	**Option B: SHOP Contracts with 2-3 GA's Through Bid Process**	**Option C: SHOP Contracts with All Qualified GA's**
SUMMARY The Exchange would exclude General Agents from its distribution channels	**SUMMARY** The Exchange would contract with 2-3 General Agents selected through a Bid Process	**SUMMARY** The Exchange would contract with all qualified General Agents.
PURPOSE The Exchange excludes General Agents from its distribution channels and provides more competitively priced SHOP products.	**PURPOSE** The Exchange leverages an existing distribution channel, which in turn expands sales and marketing options to a significant number of agents who are associated with the General Agents.	**PURPOSE** The Exchange maximizes its available distribution channels by using all qualified General Agents.
DESCRIPTION The Exchange excludes General Agents but relies on Agents and navigators to support SHOP marketing and sales.	**DESCRIPTION** The Exchange selectively leverages an existing distribution channel. Bidder criteria will be developed based on a series of factors including broad reach of agents (statewide or regionally); how they partner with the Exchange; General Agent override costs and technology, tools and value-adds	**DESCRIPTION** The Exchange recognizes all qualified General Agents and establishes a standard commission schedule for General Agents. This allows the Exchange products to be included in sales and bid proposals that are produced through General Agent systems.

Table 5. Summary of SHOP General Agent Payment Options		
Option A: SHOP Excludes GA's	**Option B: SHOP Contracts with 2-3 GA's Through Bid Process**	**Option C: SHOP Contracts with All Qualified GA's**
PROS ▪ The Exchange avoids additional commission load on its SHOP products. ▪ The Exchange minimizes its administrative burden.	**PROS** ▪ The Exchange manages its distribution channels more closely and sets performance expectations through its bid criteria. ▪ The Exchange ensures its load for General Agents is priced competitively. ▪ The Exchange expands access to a broader pool of agents. ▪ Selective contracting limits administrative burden on the Exchange (data management, premium and commission audits, etc.)	**PROS** ▪ The Exchange maximizes all available distribution channels. ▪ More General Agent sales representatives available to recruit, train and support agents in critical launch year. ▪ SHOP will receive more complete and electronic enrollment as general agents may be required to meet 'clean and complete' enrollment standards. ▪ Greater statewide coverage to reach agents and employer enrollments in both metropolitan and rural regions.
CONS ▪ Limits access to a significant distribution channel for small group sales. ▪ General Agents would be encouraged to sell against the SHOP Exchange as they have no interest to promote or enroll in SHOP. ▪ SHOP will receive more incomplete and paper applications otherwise prepared and completed by a general agent. ▪ SHOP may need to staff for additional recruitment, training and enrollment support otherwise provide by general agents.	**CONS** ▪ Limiting the number of General Agents may result in exclusion of regional organizations that support underserved populations. ▪ Negative impact on General Agents who are not selected for the Exchange. ▪ Mixed message to agents about value or competitiveness of SHOP based on general agent relationship with SHOP.	**CONS** ▪ Adds administrative and oversight burden on the Exchange. ▪ General Agents have significant variability in service capacity and systems support, which may add complexity to Exchange sales and marketing communications. ▪ May introduce quality control issues for the Exchange.

Table 6. Agent Payment Operational Considerations	
Issue	**Option B: Match Commissions (Exchange Pays)**
Vesting (agent agreement may require commissions be based on prevailing commission schedule at inception of group contract)	New sales enrolled in the SHOP Exchange may be subject to prevailing commission schedules. As market competitive commissions may change over time, the Exchange may need to manage payment of group accounts at various commission levels. The Exchange should manage commissions to avoid confusion and ensure accuracy of agent payment.
Graded payment schedules	Most commission schedules are currently based on a flat percentage of insurance premium. If the market moves to an alternate graded schedule , the Exchange would need to undertake potentially complex management of graded payment schedules and possibly change payment based on the anniversary of subsequent renewal periods.
Adjusted payments based on agent volume	The Exchange may consider commission schedules based on the total volume of membership associated with the agent that may qualify that individual (or agency organization) for higher payment tiers.
Recognition of high-performing agents	The Exchange could channel new sales referrals to top sellers to reinforce its value with these agents.
Match special promotions. Recognition of high-performing agents	The Exchange would need to require prior notification from issuers of special promotions or incentives. The Exchange may consider matching special promotions to maintain a level playing field.
Establish agent participation rules. Broker of Record Changes	The Exchange should consider best process 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.
Impact on SHOP operations **Electronic Funds Transfer**	The Exchange may consider requiring 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.

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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 explored 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 to provide value-added benefits that facilitate one-stop shopping for small employers at a modest cost.

The Exchange staff recommends engaging mixed vendors to provide benefits administration (COBRA, CalCOBRA, HRA, HSA, FSA and Section 125) (Option A1). The Exchange also recommends providing employer benefits administration services and ancillary benefits through specialty carriers (Option B1). The Exchange staff will initiate an RFP to determine which specialty benefits issuers or participating health plans will provide benefits in the SHOP Exchange.

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.

In the market today, some agents and general agents offer small employer benefits administration as a way to differentiate their services in the marketplace. Agents and General Agents may absorb the administrative costs of these value-add services to their clients, or pass through direct costs based on an employer opt-in model. Some General Agencies aggregate these services as part of their support to agents, either as a single vendor or as a menu of vendor choices. Some issuers also package benefits administration programs as value-added services to foster one-stop shopping within the carrier's offerings.

The SHOP Exchange could either contract with GAs as potential suppliers of benefits administration services or offer the services directly and compete with to these 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.

Prepared by California Health Benefit Exchange staff with support from PricewaterhouseCoopers

Offering ancillary benefits through the SHOP Exchange will require the Exchange to consider establishing additional banking arrangements to facilitate portability of account-based benefit plans. However, it is 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.

Recommendations

Issue 1: Exchange Options for Offering Administrative or Ancillary Services to Small Employers

The major options for benefits administration services proposed for consideration by the Board are described below. Details are summarized in Table 7.

- **Option A1. Mixed vendor limited employer benefits administration:** Exchange engages vendor(s) to provide select employer benefit administration services and may offer some services directly.
- **Option A2. Cal-COBRA/COBRA only administration:** Exchange undertakes a minimal role in employer benefits administration.
- **Option A3. Full-service vendor-supported benefits administration:** Exchange engages a single vendor to provide an array of employer benefits administration services.

The Exchange staff recommends **Option A1**: the Exchange engage mixed vendors to provide benefits administration (e.g. COBRA, CalCOBRA, HRA, HSA, FSA and Section 125).

Option A allows the Exchange to prioritize specific services and add programs in subsequent years based on employer and agent interest. 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. Often known as "POP Plans" or Premium Only Plans (under IRS Section 125), these plans allow employers to deduct employee premium contributions on a pre-tax basis. This has a direct savings impact for employees as they can deduct employee, dependent and other qualified payroll deductions before federal, state and other payroll taxes, thus slightly reducing their share of premium. These plans are popular for small business groups and should be considered as a core service or value-add for the SHOP exchange. 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 requires 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, issuers that offer such plans typically include a sponsored banking relationship. Therefore, additional service offerings may include HRA and HSA banking services.

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 or POP 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. The Exchange may also consider an endorsed relationship whereby the Exchange shares in the fees that are collected from users.

Issue 2: Implementation of ancillary benefits

Subject to the cost of implementation and potential opportunity for revenue sharing with the Exchange, there are two approaches for implementation of ancillary benefits below. Details are summarized in Table 8.

- **Option B1.** The Exchange provides employer benefits administration services and offers ancillary benefits using stand-alone specialty carriers.

- **Option B2**. The Exchange provides employer benefits administration services and offers ancillary benefits through multiple participating health plans.

The Exchange recommends Option B1. The SHOP exchange will provide additional value to small business employers seeking more robust and complete services and optional benefits. Rather than attempt to combine these services and optional products with a common health plan issuer, the Exchange staff recommends a stand-alone vendor strategy. This may also allow employers to select their preferred ancillary vendor without being coupled or linked to a designated health plan. Providing a stand-alone ancillary solution will also ease the administrative burden of having multiple vendors for both medical and specialty services.

Option B2 was not selected because some health plans do not offer the full array of ancillary services.

If the Exchange offers services through stand-alone specialty vendors (Option B1), 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:

- Assess the potential costs of using multiple vendors
- Assess revenue opportunities for the Exchange
- Evaluate current uptake of employer benefits administration and ancillary benefit offerings through General Agencies
- Obtain 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. The SHOP Exchange may consider offering additional supplemental benefits (e.g. Group term life and group disability).

Table 7. Exchange Options for Offering Administrative or Ancillary Services to Small Employers		
Option A1: Mixed Vendor Limited Employer Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)	**Option A2: Cal-COBRA/COBRA Only Administration**	**Option A3: Full-Service Vendor-Supported Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)**
SUMMARY The Exchange would engage vendor(s) to provide select employer benefits administration services and may offer some services directly.	**SUMMARY** The Exchange would undertake a minimal role in employer benefits administration.	**SUMMARY** The Exchange would engage a single vendor to provide an array of employer benefits administration services.
PURPOSE The Exchange provides a wide range of employer benefits administration.	**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 services while minimizing its resource requirements
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** 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 a vendor to provide an array of employer benefits administration functions.

Table 7. Exchange Options for Offering Administrative or Ancillary Services to Small Employers		
Option A1: Mixed Vendor Limited Employer Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)	**Option A2: Cal-COBRA/COBRA Only Administration**	**Option A3: Full-Service Vendor-Supported Benefits Administration (COBRA, HRA, HSA, FSA and Section 125)**
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 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** ▪ 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 ▪ 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** ▪ 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. ▪ Services may be duplicative of those offered by Professional Employment Organizations. ▪ Adds administrative and oversight responsibilities for a single vendor.

Table 8. Exchange Options for Implementing SHOP Administrative Services	
Option B1: Employer benefits administration services and offers ancillary benefits using stand-alone specialty issuers	**Option B2: Employer benefits administration services and offers ancillary benefits through multiple 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 8. Exchange Options for Implementing SHOP Administrative Services	
Option B1: Employer benefits administration services and offers ancillary benefits using stand-alone specialty issuers	**Option B2: Employer benefits administration services and offers ancillary benefits through multiple 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 9. Background of Administrative Offerings by Agents and General Agents

What follows is the results of a survey comparing employer benefits administration services from several General Agencies (COBRA, Section 125, HSA, FSA, HRA, 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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Supplemental Dental and Vision Benefits:

Summary

The California Health Benefit Exchange is considering the options related to supplemental benefits for dental and vision care to be offered through the SHOP Health Benefit Exchange. This "Supplemental Dental and Vision Benefits" Board Recommendations Brief provides background on some of the issues and a summary of the options available to the Exchange, and includes recommendations for the Board's consideration.

Background

Small Group Supplemental Insurance Markets

Nationwide in 2010, about 54% of the population was covered by dental insurance, a drop from 57% that is attributed to job loss in the recession. Virtually everyone with a dental policy obtains it through group insurance, be it a large or small employer, union or public program. In addition, dental policies are typically stand-alone products, distinct from medical coverage; only 2% of dental offerings are integrated with medical coverage. Most employers who offer both medical and dental coverage to their employees and dependents do so through different carriers (medical is different than dental). Less than a third, or 32%, of employers offer dental policies from the same carrier that underwrites both medical and dental coverage. Even dental policies sold by an affiliate or subsidiary of a medical plan may be offered in conjunction with medical plans sold by other carriers.

In 2007, the most recent state level data available for California, about 60% of the population had some source of dental coverage. The majority of Californians with dental insurance obtain their dental coverage through employment. Roughly 19% of small employers with 1-9 FTEs and 46% of small employers with 10-49 FTEs offer dental insurance.

Issues for Considerations

Offering Supplemental Benefits

The Exchange may offer supplemental benefits in the SHOP Exchange. Doing so would allow the SHOP to mirror the current Small Employer market.

Structuring Dental and Vision Benefits

In the current small and large employer markets, both supplemental dental and vision policies are typically sold and purchased separately from the medical policies. Furthermore, only about a third of the time is the medical and dental product offered by the same carrier. The dental and vision services included in the Essential Health Benefits package must be offered as part of a small group health plan, with the exception that inside Exchanges, the dental essential

benefits may be offered on a stand-alone dental plan basis. Non-essential and adult dental and vision services not included in the EHB package will have the option to be offered as separate products, or could be included in a comprehensive policy, but a separate premium rate will be required for that coverage.

Stakeholder Perspectives

Many stakeholders expressed their support of the Exchange offering supplemental dental and vision benefits beyond those EHBs required for children. Some agents also indicated that there is a correlation between consumers purchasing multiple products and keeping their medical insurance in the long-term. Others noted that the Exchange would be at a disadvantage in the SHOP market if it did not offer supplemental benefits. Small employers would need to engage the commercial market for these common supplemental/ancillary benefits. And outside of the Exchange, the carriers and the existing small group exchange, Cal Choice, offer employer sponsored or voluntary ancillary options. This could also put the SHOP at a disadvantage with private exchanges with bundled medical, ancillary and additional value-adds like payroll, compliance, cobra, FSA, and POP plans.

In contrast, other stakeholders raised concerns about allocating resources to offering supplemental benefits in the early years given the great number of challenges the Exchange is facing immediately. There was also skepticism from a small number of stakeholders about the value to the consumer of supplemental benefits given waiting periods and low coverage limits in common benefit designs.

Stakeholders presented varying points of view with regard to stand-alone dental and vision plans, and recognized that the language of the Affordable Care Act specifically provides for the Exchange to receive proposals from stand-alone dental plans for Essential Health Benefits, but does not contain such a provision for vision services. Some stakeholders strongly advocated for the offering of stand-alone plans for both dental and vision services, while others urged that those services be incorporated in health plan contracts.

A full compilation of the comments provided by stakeholders is available on the Exchange's web site at
http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf

Issues and Recommendations

The Issues and Recommendations that follow the Recommended Approach section, detail the major options proposed for consideration by the Board:

Issue 1: Offering Supplemental Benefits SHOP Exchange
Issue 2: Structuring Dental and Vision Benefit Offerings

The decision to offer supplemental benefits in the SHOP Exchange must consider current market practices, additional administrative costs, the desire by the Exchange to expand dental and vision coverage of Californians, consumer preferences, and the ability of the Exchange to fulfill the Affordable Care Act requirements while considering the impact of allocating additional resources to offer and manage supplemental benefits.

Issue 1: Offering Supplemental Benefits in the SHOP Exchanges

The following three options related to offering supplemental benefits (expanded pediatric dental and vision and adult and family dental and vision) are being considered:

- **Option A:** Offer supplemental benefits in SHOP Exchange
- **Option B:** Do not offer supplemental benefits in the SHOP Exchanges

Staff recommends that the Exchange offer supplemental dental and vision benefits in the SHOP Exchange as a first step (Option B). Evidence suggests small employers value offering dental and vision coverage to their employees today. The majority of people with dental coverage today purchase dental insurance through an employer group offering so offering supplemental benefits in the SHOP Exchange would support existing market practices.

Issue 2: Structuring Supplemental Dental and Vision Benefit Offerings

The following three main options are available to the Exchange to structure how the supplemental dental and vision benefits are offered within the Exchange (see Table 11 for detail):

- **Option A**: Offer dental and vision coverage only embedded as part of medical QHP plans
- **Option B**: Offer stand-alone dental and vision plans
- **Option C**: Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits

Staff recommends offering stand-alone dental and vision plans. The Exchange will allow stand-alone dental and vision plans to submit their bid for employer-sponsored supplemental coverage.

Table 10: Issue 1: Offering Supplemental Benefits in SHOP Exchange	
Option A - Offer Supplemental Dental and Vision Benefits in the SHOP:	**Option B - Do Not Offer:**
SUMMARY Offer supplemental benefits (expanded pediatric dental and vision and adult dental and vision) in the SHOP Exchange.	**SUMMARY** Do not offer supplemental benefits (expanded pediatric dental and vision and adult dental and vision).
PURPOSE This option allows employers to offer benefits beyond Essential Health Benefits requirements through SHOP Exchange and is consistent with current market practices.	**PURPOSE** Meets Affordable Care Act requirements and limits benefits offered only to the Essential Health Benefits.
PROS ▪ Enables employers who offer dental and vision coverage today to continue to do so through the Exchange ▪ Provides the opportunity for employers to offer enhanced coverage ▪ May enhance attractiveness of SHOP in the market and enhance retention of employer groups	**PROS** ▪ Focuses Exchange resources (financial and physical) on Affordable Care Act regulations and Essential Health Benefits requirements
CONS ▪ Requires Exchange resources to manage supplemental benefits beyond those required by the Affordable Care	**CONS** ▪ Requires employers interested in offering Supplemental benefits to obtain coverage from different sources (the Exchange and the outside market) ▪ Increases complexity for individuals by potentially forcing them to purchase pediatric dental and vision coverage in the exchanges and adult coverage outside of the exchanges ▪ May lead to retention challenges if employers prefer purchasing all coverages from a single source

Table 11: Issue 2: Structuring Dental and Vision Benefit Offerings		
Option A - Combined with Medical:	Option B - Stand-alone Plans:	Option C - Hybrid:
SUMMARY Offer dental and vision coverage only as embedded as part of medical QHP plans.	**SUMMARY** Offer only stand-alone dental and vision plans.	**SUMMARY** Offer a combination of (a) stand-alone dental, vision, and medical plans; and (b) medical plans with embedded dental and vision benefits.
PURPOSE This option allows consumers to view and understand their comprehensive coverage options more easily but limits choice and competition.	**PURPOSE** This option allows clear distinction between medical and dental /vision plans; allows financial benefit limits on non-essential health benefit dental services but does not offer comprehensive plans that include a variety of coverage.	**PURPOSE** This option provides the most choice to consumers that fits their individual situation but requires careful evaluation of how to present consumers with options in order to avoid too many options and too much information.
PROS ▪ Provides comprehensive (medical, dental, and vision), potentially easy to compare options ▪ Provides easier administration to the Exchange	**PROS** ▪ Consistent with current market practices ▪ Provides more choice and competition ▪ Allows individual with existing dental coverage outside of the exchange to keep their current coverage	**PROS** ▪ Provides most choice and competition ▪ Allows individual with existing dental and vision coverage outside of the exchange to keep their current coverage

Table 11: Issue 2: Structuring Dental and Vision Benefit Offerings		
Option A - Combined with Medical:	Option B - Stand-alone Plans:	Option C - Hybrid:
CONS ▪ Disruptive to the current market practices ▪ Significantly limits consumer choice ▪ Limits competition ▪ Potentially duplicates coverage for individuals with existing dental and vision coverage	**CONS** ▪ More difficult and costly to administer for the exchange ▪ Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical and dental plans	**CONS** ▪ Most difficult and costly to administer for the exchange ▪ Potentially requires the Exchange to offer aggregation functions to manage subsidies and tax credits across medical, dental, and vision plans ▪ May create confusion by offering too many choices, some comprehensive and some stand-alone ▪ Could create adverse selection if Affordable Care Act restrictions on annual and lifetime limits are imposed on dental and vision services.

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Employer Contribution and Participation Standards

Summary

The California Health Benefit Exchange considered 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 final staff 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.

[3]One large health plan issuer requires only 65% participation for a select product portfolio aimed at attracting employer groups interested in paired choice (offering their coverage alongside another issuer's HMO coverage). This slightly more flexible participation rule is especially popular with small groups uncertain if they will meet higher standard participation rules until they complete the enrollment applications.

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.

Issues and Recommendations

Five options related to employer contribution requirements were 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

[3] 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).

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.

Issue 1: Extent to which the Exchange requires small business to make premium contributions on behalf of their employees

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

- **Option A**. Require contributions consistent with current market underwriting rules
- **Option B**. Require contributions at least meet federal minimum for tax credit
- **Option C**. Require contributions at a level higher than current market or federal tax credit minimums
- **Option D**. Require contributions lower than current market or federal tax credit minimums
- **Option E**. Require contributions at a set percentage of premiums for all employees

Staff recommends that the Exchange require contributions consistent with the current market underwriting rules (Option A).

While requiring contribution at least meet the federal minimum for tax credit (Option B) was considered a logical and obvious choice by several stakeholders, most also observed the added complexity and disadvantage this rule might impose on the SHOP. Since the tax credit will not apply to all small employers in the Exchange, is the staff recommends a rule more consistent with current market underwriting rules for small businesses. This option would minimize disruption to the market while still ensuring that eligible employers will receive the tax credit through more effective communication during the proposal and enrollment process.

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 12. Employer Contribution Options		
Option A: Require contributions consistent with current market underwriting rules	**Option B: Require contributions at least meet federal minimum for tax credit**	**Option C: 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 12. Employer Contribution Options		
Option A: Require contributions consistent with current market underwriting rules	**Option B: Require contributions at least meet federal minimum for tax credit**	**Option C: 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 12. Employer Contribution Options		
Option A: Require contributions consistent with current market underwriting rules	**Option B: Require contributions at least meet federal minimum for tax credit**	**Option C: 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 13. Employer Contribution Options (cont.)	
Option D: Require contributions lower than current market or federal tax credit minimums	**Option E: 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

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Board Background Brief

Promoting the Employer Tax for Health Coverage

Summary

The California Health Benefit Exchange investigated 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.

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

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