Statement of

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The Small Business Health Options Program:

Its Promise and Challenges

Before The

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

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

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

The authors of the ACA designed SHOPs to bring the efficiencies of the large group market to small employers. Historically, the small group market (firms with 50 or fewer workers) was characterized by higher premiums and administrative expenses, and greater volatility in premium increases from year to year. For coverage with identical financial protection the smallest employers (1-9 workers) paid premiums 18 percent more than large employers.[1] Whereas administrative expenses constituted less than 10 percent of the premium dollar for the nation's largest firms, administrative expenses accounted for more than 20 percent of the premium dollar for small employers. One reason that administrative costs were higher in the small employer market was that insurers competed through medical underwriting – a technical term meaning making sure that an insurer does not sell to small firms with very sick people, or alternatively,

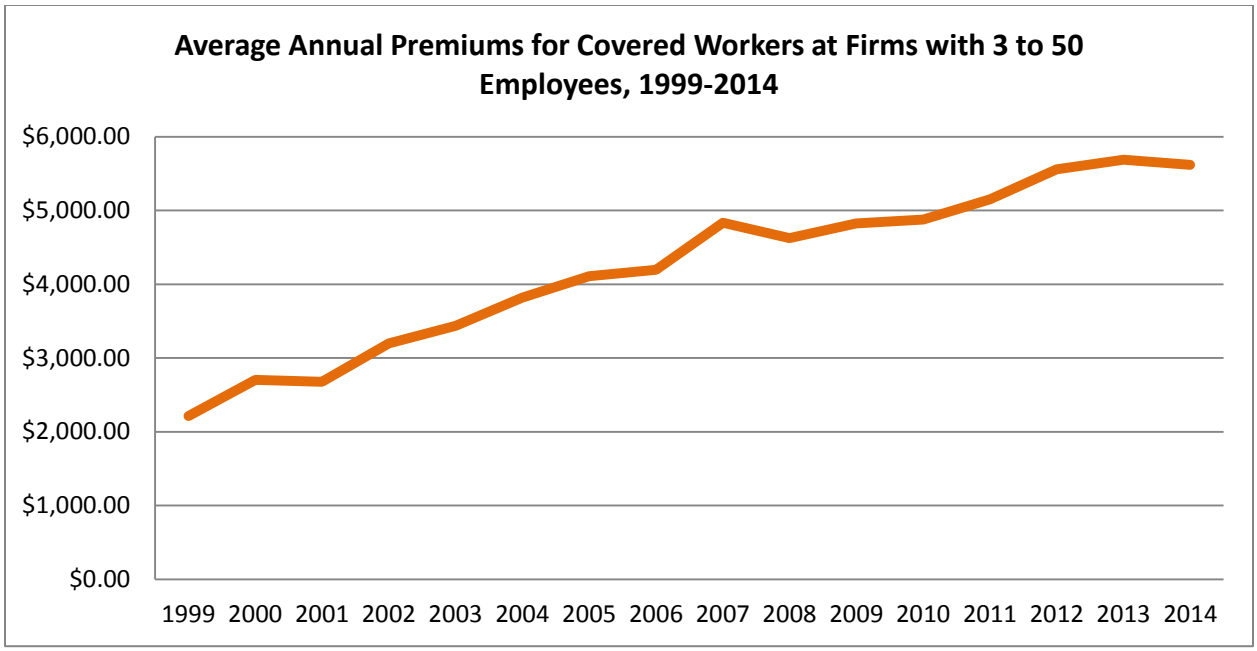
[1] J. Gabel, R. McDevitt, L. Gandolfo, J. Pickreign, S. Hawkins, and C. Fahlman, "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is up, Montana Is Down," *Health Affairs*, May/June 2006, 25(3): 832-843.

charging higher premiums to reflect expected expenses plus risk. Medical underwriting entailed examining the medical records and past insurance claims of the prospective new customers. Insurers did so not because they were "bad companies," but because the economics of health insurance dictated they do so. Medical expenses are concentrated among a few sick people. In employer-based insurance, the sickest 1 percent will account for 27 percent of claims expenses, the sickest five percent over 50 percent of expenses, and the healthiest 50 percent account for 5 percent of expenses. If an individual insurer unilaterally declined to medically underwrite, that insurer would attract the worst risks and be forced to price their products at non-competitive rates. The Affordable Care Act prohibits setting premiums based on the health status of the insured population. It does allow insurers to set premiums based on the age of the population within limits, by geography, and smoking status. Thus, the ACA transforms the small group market so insurers no longer compete on their ability to identify and exclude high-risk individuals and small groups, but now must compete on price and quality.

Recent Trends in the Small Employer Market

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

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



Brief History of SHOPs and Purchasing Pools

Exchanges for small employers are not a new idea. Over the past 25 years many states attempted to build what was termed "health insurance purchasing co-operatives" (HIPCs), but none enjoyed widespread success. Among the states attempting to build HIPCs were California, Connecticut, Washington, Florida, Kansas, Colorado and Kentucky. Connecticut was perhaps the most successful and attained an eight percent market share in the late 1990s.[3] Massachusetts invested more than a million dollars in research and marketing in 2012-13 to attract small employers to their "Connector." Enrollment today is less than 10,000 persons.

One clear lesson from earlier attempts to build HIPCs is that underwriting rules must be the same inside and outside the HIPCs.[4] Many states prohibited medical underwriting within the pools but allowed it outside the HIPCs. The inevitable result was that brokers sent their high risk groups to the HIPCs, medical claims expenses and premiums rose each year, risk selection worsened, and

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

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

the HIPCs went into a death spiral. Another challenge to HIPCs was that large insurers often did not want to participate.

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

Employee Choice and Employer Models

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

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

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

Value-Added Features of SHOPs

If SHOPs are to succeed in enrolling significant numbers of small employers, they must provide value-added features not available in the current off-SHOP Marketplace. SHOPs have the potential to do so. First, plans offered on the SHOP could have premium expenses lower than those plans only offered off the SHOP.[6] Second, employers seeking tax credits must purchase plans on the SHOP. These tax credits are linked to the size of the firm and the percentage of the workforce who are low-income workers. Third, SHOPs can enhance employee choice. When using the employee choice-model, employers can make a defined contribution, and employees can then select plans among multiple carriers, and in some states, multiple metal tiers – rather than having to choose one plan from one carrier. Fourth, the employee choice model is a defined contribution model, so employers reduce their financial risk against future increases in premiums. Note that two of these four features require the employee choice model.

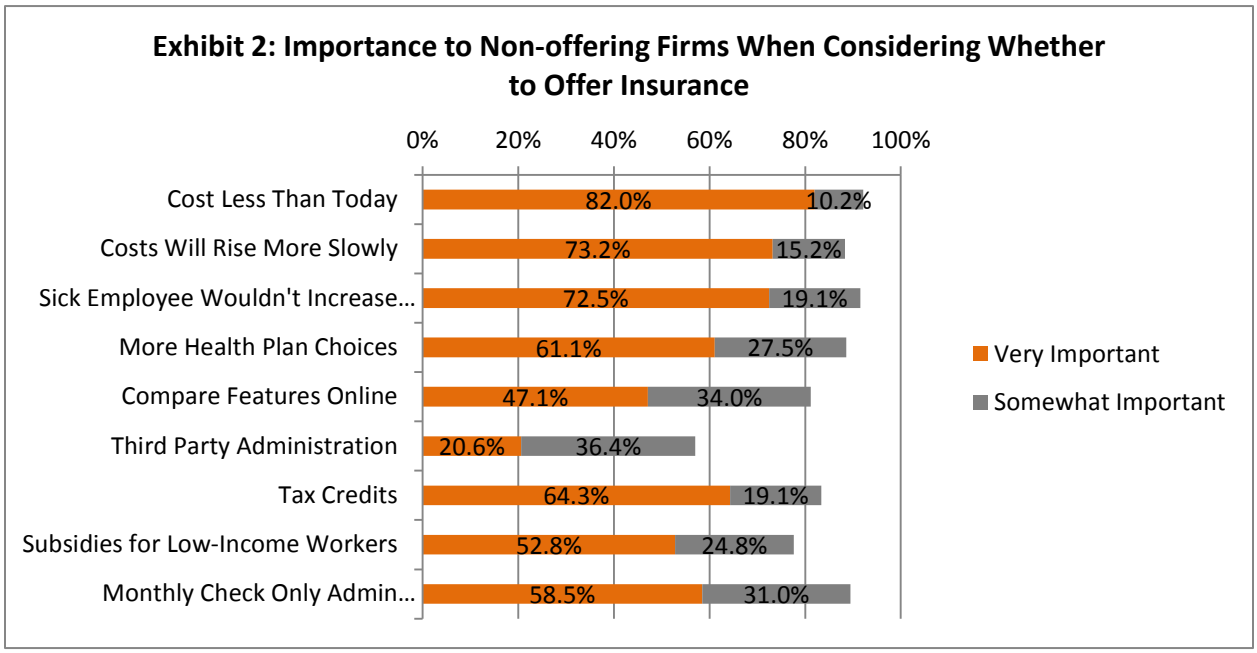
A survey of small employers that my colleagues and I conducted with funding from the Commonwealth Fund and published in *Health Affairs*, found many potential "value-added" features are highly attractive to small employers –both firms offering and not offering health benefits.[7][8] Exhibit 2 shows that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

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

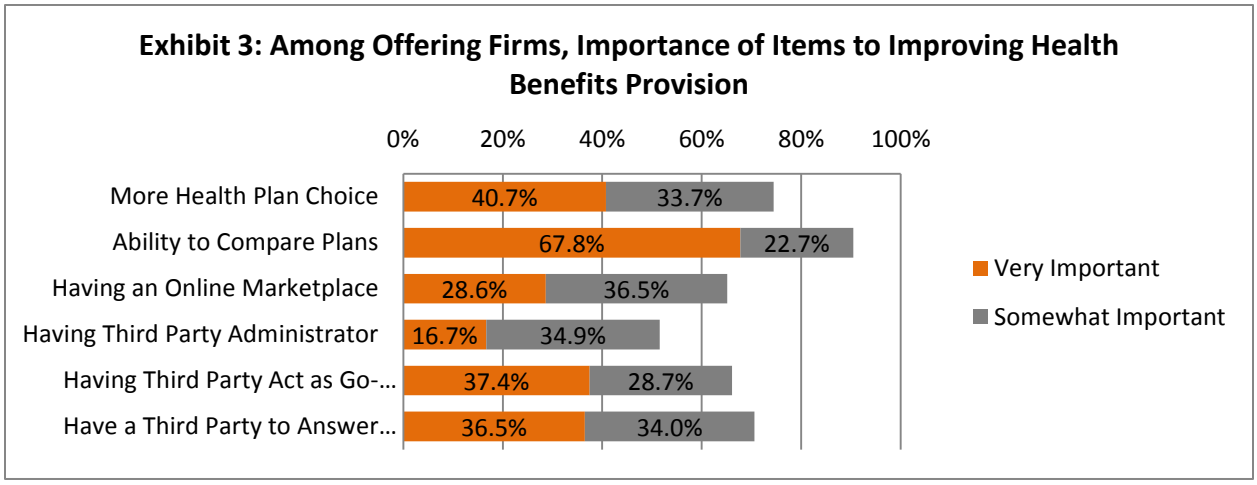
[7] J. Gabel, H. Whitmore, J. Pickreign, J. Satorius, and S. Stromberg," "Small Employers' Survey: Premiums, SHOP Exchanges, And Self-Insurance Are Main Concerns With The Affordable Care Act," *Health Affairs*, Web Special, October 16, 2013 and November, 2013, 32:11, 2032-2039.

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

37 percent to have a third party to handle claims questions and another 37 percent to have a third party to answer questions.



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



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

Availability of SHOP Plans

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

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

Cost of Plans on the SHOPs

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

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

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

Exhibit 4

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

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

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

In our multivariate analysis, we found, other factors held statistically constant, plans offered on the Marketplace on average have seven percent lower premiums than plans sold off the Marketplace only. Carriers not participating on the Marketplace have premiums two percentage points higher. One explanation for the lower premiums is that Marketplace plans are more likely to have narrower networks and thus obtain greater discounts from providers. Another possibility is the transparent and competitive market structure of Marketplaces leads to carriers offering lower premiums. A third explanation is the actuarial values used to assign plans to metal tiers are calculated for the essential benefit package. Non-Shop plans may offer more non-essential benefits.

Challenges to SHOP Success -- How Carriers View SHOPs

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

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

Challenges to SHOP Success –The Role of Brokers

Eighty percent of small employers use brokers or agents. Brokers often perform tasks that benefit managers do in larger firms. For example, among small firms using brokers, 84 percent responded that brokers select a health plan, 79 percent enroll employees, 59 percent provide customer service such as denied claims, and 31 percent decide employee contributions towards premiums.[11] Earlier HIPCs learned that broker buy-in was necessary for HIPC enrollment.

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

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

Insurers reported in our interviews that brokers do not feel "plugged in" to the SHOP Marketplace and view SHOPs as competitors. Carriers stated that brokers believe they provide a valued service to small employers and that their role and income will be diminished if small employers purchase through SHOP. The dilemma for SHOPs is they need broker co-operation, but that SHOPs aim to reduce administrative expenses, and a major component of administrative expenses are brokers' fees that may constitute five percent of premiums or more.

Challenges to SHOP Success – Self-Insurance

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

Summary

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

SHOP market to play by the same underwriting rules. All plans sold on the SHOP must now be sold off the SHOP and priced as the same product. Administratively, CCIIO has tied large carriers to participate in the SHOPs.

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

Of course, the immediate and perhaps major challenge for SHOPs is information technology difficulties that others have discussed. But beyond IT problems, many challenges remain if SHOPs are to succeed where HIPCs failed. Dominant insurers have an economic self-interest to see that SHOPs remain marginal. Along with established brokers and agents, they have a stake in maintaining the current delivery system where these groups have been so successful. The broker community poses a real dilemma. Health insurance is often too complicated and time consuming for small employers to master so small firms turn to brokers who are held in high regard. But SHOPs will perform many of the functions that brokers currently do. So to achieve broker buy-in, SHOPS may have to forfeit many potential savings.

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

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

I would be delighted to answer your questions.