

# Early 2014 Stakeholder Experiences With Small-Business Marketplaces in Eight States

August 2014

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Robert Wood Johnson  
Foundation

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in selected states to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states can be found at [www.rwjf.org](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org). The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit [www.rwjf.org/coverage](http://www.rwjf.org/coverage).

Though the enrollment of individuals into the nongroup health insurance Marketplaces exceeded expectations for the 2014 open enrollment period, participation of employers in the small group Marketplaces, or the Small Business Health Options Program (SHOP), has started very slowly. Enrollment figures, for the few states that have released them, measure in the low thousands—sometimes only in the hundreds. Though the SHOP Marketplaces have emerged sluggishly, the reasons for this are largely consistent across the states, and many of them lend themselves to reversal or improvement. Significant challenges remain, but it would be inappropriate to judge the long term prospects of SHOP merely on its first-year experiences.

This analysis of early implementation experiences with the SHOP is based on case study interviews in eight states: Colorado, Illinois, Maryland, Minnesota, New Mexico, New York, Oregon, and Rhode Island. Interviews were conducted with a broad array of stakeholders in each state, including producers (brokers and agents), small business representatives, insurance carriers, consumer advocates, and application assisters (navigators and in-person assistors). The general consistency of information provided across these states suggests a significant degree of generalizability with other state-based Marketplaces and partnership Marketplaces taking responsibility for both consumer assistance and plan management activities.

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## THE EARLY SHOP EXPERIENCE AND CHALLENGES FACED

There was a widespread perception across the study states that SHOP had yet to be made a priority either at the state or national level. Rhode Island and New Mexico were exceptions in that there was some explicit state marketing focused on the SHOP (sources described the Rhode Island effort as “robust” and the New Mexico effort as “comprehensive”); our sources were not aware of SHOP-targeted marketing by the state agencies in the other six states studied. The one-year delay in the introduction of the federal online SHOP Marketplace, which received significant press attention, fueled the sense that SHOP was of secondary importance.

Sources reported that there is a tremendous lack of

awareness of the SHOP at the most basic level within the small-employer community, and that many of those who are aware of it do not understand its function or role in the market. Consequently, a significant marketing and sales effort is required to engage employers, but such an effort has yet to significantly materialize. A clear, concise description of the SHOP and the added value it brings to the existing small group market seems not to have been elucidated or communicated. But developing an accurate, convincing description of the added value of SHOP has been challenging because of limitations of the reach of the small business tax credit, early renewals, extensions of non-ACA compliant plans, and other issues.

**Small-business tax credit.** The first obvious advantage of SHOP coverage, the ACA's small-employer tax credit provided exclusively through the SHOP, has shown itself to be largely irrelevant (with isolated exceptions). At its maximum, the small-employer credit covers 50 percent of the employer's contribution to the workers' coverage provided through the SHOP, but the maximum is only provided to employers of 10 or fewer full-time equivalents and with an average wage of \$25,000 per year or less. At larger sizes and higher average wage levels, the credit phases down, disappearing for employers of 25 or more full-time equivalents and with an average wage of \$50,000 or more per year. The phase-out is cumulative, so it can go to zero even before either the size or wage maximum is hit. Even for those eligible for sizable credits, the credit is only provided for two years.

Because of the narrow targeting of the credit and the phase-out schedule, few employers are eligible for sizable credits; this is particularly true in high cost-of-living areas where wages are higher. A source in Illinois, for example, noted that almost no small employers that offer or want to offer insurance qualify for the tax credits, adding that those employers that do qualify have employees who are better-off getting subsidized nongroup Marketplace coverage. Others noted that the complexity of computing the potential credit meant that employers felt that they had to use an accountant to explore their eligibility, the cost of which sometimes exceeded the value of the credit.

**Off-SHOP plan options.** The coverage options available to small employers outside of the SHOP for 2014 also decreased small employers' incentives to investigate and use the SHOP. The most important of these in many states was probably the widespread early renewals of existing policies. Even before the Obama administration relaxed the ACA's rules around the continuation of nongrandfathered non-ACA compliant small group and nongroup insurance plans, some insurers were already encouraging their 2013 customers to renew their existing plans early, before the end of 2013. By doing so, insurers could retain a larger share of their existing market in plans that did not comply with the ACA's rules introducing modified community rating, essential health

benefit standards, and consumer cost-sharing standards. This was also a strategy that likely helped these carriers to retain a larger segment of their small employers with low risk profiles.

In addition to renewals of already held plans, sources indicated that similar or identical plans to those offered on the SHOP were frequently available in the off-SHOP small group market at the same (or nearly the same) price as those provided inside. Sources in New Mexico reported that off-SHOP small group coverage options had more attractive benefit designs, and more-flexible PPO plans were available outside the SHOP, compared to mostly HMOs inside the SHOP. As explained further below, familiarity with, simplicity of, and encouragement by brokers to enroll in the off-SHOP alternatives also reduced demand for purchasing through the SHOP. Plus, as some broker sources indicated, no small employer wanted to be out front on changing their sources of coverage. Though they may participate more significantly in the future, continuity for their workers (i.e., keeping what they had) was a higher priority, where financially feasible.

#### **Other factors affecting SHOP enrollment in 2014.**

First-year software problems also discouraged SHOP use in 2014; in some cases, the IT problems were sufficiently serious that they all but prohibited enrollment. Multiple sources noted that small employers were much faster to abandon an online enrollment process when they ran into problems than individual purchasers seemed to be. In Maryland and Oregon, major IT problems created tremendous barriers for SHOP enrollment, no online enrollment was available, and SHOP plans could only be obtained via brokers and without employee choice.

In some substate areas, no plans provided coverage for providers outside of the plan's designated network. Multiple informants saw these types of circumstances as particularly unattractive to small-employer groups, particularly those who had provided broader coverage in the past. Some sources in Minnesota feared that the slow start for the SHOP there would discourage some of the carriers currently participating from doing so in the future.

# FUTURE COMPETITIVE CHALLENGES FACING SHOPS

In several states, sources reported potential competition for the SHOP coming from private insurance exchanges. Though these private exchanges focus on large-employer business in some locations, others are already selling small-group coverage. They provide some degree of employee choice of plan as well as administrative relief for small employers, similar to some of the public SHOPS' advantages. These private exchanges take on different forms, with some organized by a single carrier and offering a choice of plans offered only by that carrier; others are run by benefit-consulting firms or broker organizations, with these able to offer multiple plans from different carriers. Coverage via the private exchanges does not qualify for small employer tax credits, however, and private exchanges are not thought to have currently achieved substantial market share. In some states, such as Colorado and New Mexico, informants were unaware of any new private exchanges, but in other states, such as Minnesota, New York, and Rhode Island, the advent of private exchanges is seen as a threat to the viability of the SHOP.

The ACA allows for two central exemptions from its small-group market reforms for employers with 50 or fewer employees (this threshold will increase to 100 or fewer employees in 2016): coverage via self-insurance or through an arrangement such as a bona fide association of employers under the Employee Retirement Income Security Act (ERISA).<sup>1</sup> The issues associated with these employer coverage options have been discussed in depth elsewhere.<sup>2</sup> To the extent that states do not regulate whether small employers can purchase private reinsurance policies (the product that makes it financially feasible for small employers to self-insure) or the structure of those policies sold in the state (e.g., minimum attachment points), small employers with low expected health care costs may purchase these policies in an effort to avoid sharing in the costs associated with their less-healthy counterparts in the regulated small-business insurance pool.

Similarly, states that are not closely scrutinizing the status of associations claiming to be large groups under ERISA may find substantial shares of their healthier small

employers opting out of the small-group insurance pool regulated under the rules of the ACA. In the extreme case, these alternatives could undermine the stability of the ACA's small-group market reforms, with the ACA-compliant plans attracting predominantly employers with higher health care–cost workforces, or those employers with more-expensive cost profiles during particular periods of time.

In response to such potential risk-pooling problems, New York prohibited the sale of reinsurance to small employers even before the ACA, and Colorado and Rhode Island recently increased the minimum attachment point of reinsurance sold in the state. Oregon had similarly prohibited the sale of such policies to small employers, but rescinded that prohibition recently. The others have yet to take any steps in this direction. Most sources felt it was too early to tell whether reinsurance, a product traditionally unattractive to most small-employer purchasers, would become sufficiently widespread to compromise the ACA-compliant small group market. However, many noted that there is a growing interest among small employers in self-insurance options and a broader marketing of reinsurance products directed at small employers than in the past. In Oregon, many of the small-employer associations that offered association health plan coverage before the ACA are now claiming status as bona fide employer groups under ERISA.<sup>3</sup> Under federal law, an association health plan sponsored by an association that meets this status would be regulated under the standards applicable to the large-group market. In the other study states, associations claiming to be a large-employer group under ERISA were not reportedly widespread currently, though they remain a point of potential vulnerability without explicit regulatory action to set standards to limit the number of applicants meeting the criteria.

Finally, some sources voiced concern that SHOP price competition could actually decrease if the low rates of small-employer enrollment leads carriers to stop participating, but it was too soon to identify whether or not this would be an issue in 2015, and if so, in what specific geographic areas.

# EMPLOYEE CHOICE

Historically, small employers have seldom been able to provide a choice of health insurance plans to their workers. In 2012, for example, only 15.4 percent of employers in firms of fewer than 10 workers that offered health insurance to their workers provided a choice of two or more plans to their workers.<sup>4</sup> In contrast, 79.0 percent of employers in firms of 1000 or more workers that offered health insurance provided a choice of two or more plans. Early research cited employee choice models in the SHOPs as a major draw for employers considering whether or not to offer coverage through the new Marketplaces. Though the employee choice model may eventually encourage larger numbers of small employers to explore SHOP Marketplaces, the lack of a widespread small-employer marketing effort and time-consuming application processes have left many employers unaware of employee choice and have added to the first year's low enrollment numbers.

Some large, well-established carriers articulated early concerns that employee choice would allow high-cost workers to cluster in particular plans while healthier workers chose other options (i.e., adverse selection). At times, such concerns may have contributed to particular carriers deciding not to participate in SHOP Marketplaces in 2014, but generally, carrier participation was quite high (among our study states, the number of carriers participating in the first year were: six in Colorado, three in Illinois, 13 in Maryland,<sup>5</sup> three in Minnesota, three in New Mexico, nine in New York, eight in Oregon, and three in Rhode Island).

Business groups and associations in the study states have mixed opinions on the value of employee choice. In Colorado, a state that implemented employee choice in the first year, some employers expressed their preference for a limited choice model because they believe it will be more cost-efficient given the significant time it took to assist employees in selecting a plan (Colorado offers SHOP-participating employers three options, including employer choice of one plan (no employee choice), employee choice of any plan within a single actuarial-value tier (bronze, silver, gold, or platinum), or employee choice of a single plan in any actuarial-value tier. Other small business groups, in Colorado and elsewhere, were

adamant that the concept of employee choice will be a draw to the SHOP, but only if the IT systems are flawless and facilitate quick shopping, which is not yet the case in most states.

In New York, small-business representatives expressed concern that a lack of understanding of employee choice will lead to “accounting nightmares” during tax reconciliation. For businesses, as part of the employee-choice model, the employer has the option to instruct employees to select any plan at a designated actuarial-value tier or any plan offered by one carrier at different actuarial-value tiers. Employees will likely choose different plans; consequently, the amount of benefit falling under the auspices of the employer-based tax exclusion will need to be accounted for and adjusted for each employee. From the employees' side, if an employee purchases the cheapest plan available to them, thus using a smaller percentage of their wages toward healthcare, they may end up with more taxable income than expected when reviewing their taxes.

The federal government announced that it would delay the implementation of employee choice in the states in which the federal government is responsible for operating the SHOP.<sup>6</sup> Though this was believed to be a major setback for the SHOP, delaying employee choice likely helped the federal government focus on the nongroup marketplace, repair its IT problems, and maximize enrollment in the individually purchased market. Small employers who did purchase coverage through the SHOP in any of the 34 federally facilitated Marketplaces chose one plan from the locally available insurance plans that chose to participate and which met the qualified health plan standards. Each participating employer provided the selected plan as a single option to their employees—an approach known as traditional employer choice.

The federal government recently announced that they will allow some states to further delay implementation of employee choice until 2016.<sup>7</sup> Eighteen states have chosen to take up this option to delay, while 14 will implement employee choice through the federally facilitated Marketplace SHOP in 2015.<sup>8</sup>

## AGENT AND BROKER PARTICIPATION

In the small business community, brokers and agents have long been employers' trusted partners, educating and connecting small-employer groups to health coverage and other forms of insurance and services. Brokers and agents feel, however, that marketing campaigns for the new Marketplaces failed to recognize and advertise the support brokers can offer, focusing instead on navigators and in-person assistors under contract to the Marketplaces. In addition to feeling left out of the advertising campaigns, brokers frequently reported problems with the state-run broker training sessions, often finding the substance of the trainings inadequate. They also expressed frustration that the level of compensation was inadequate given the time demands of selling coverage through the SHOP; they consistently reported the time to sell coverage through the SHOP was much greater than the time to sell outside products. Consequently, even brokers certified to sell coverage in 2014 generally stated that they performed few to no sales through it, and many were unclear whether that would change in 2015. As one informant noted, "one of the main reasons that SHOP enrollment is low is because small businesses trust their brokers, and brokers have been steering people away from the SHOP."

In order to sell coverage through the SHOP in a state-based Marketplace, brokers must go through a state-specific training and certification process. Many brokers noted that the training program and materials provided were often ineffective and sometimes inaccurate. In New York, brokers noted that the training and certification materials were factually inaccurate—misstating the state's insurance market rules that differ from the federal minimums. Because this incorrect information was also reflected in questions on the certification test, instructors had to teach false information in order for the group to pass the test, hopefully correcting the group afterward. In Colorado, the broker training session was held before the website was functional, leaving many feeling like the training was impractical because they were unable to learn how to interact with the Marketplace system. In Minnesota, two of the "true or false" questions on the broker certification exam were, according to one source, "MNSure can be relied on as a reliable source of information," and "Using MNSure's on-line tools can be

fast, easy and convenient." Puff questions such as these fed the perception that the process was "embarrassingly uninformative." In Maryland, some sources complained that the navigators and assistors were inadequately trained on the SHOP and thus were unable to assist employers, the presumption being that the small employers would rely upon agents and brokers.

One chief complaint from brokers across all states was that the compensation structure for SHOP sales was the same as for selling directly through a carrier, despite the substantially greater time necessary to enroll a small business group through the SHOP's IT system. Whereas applying for off-Marketplace products is simply filling out one or two short forms, working with the Marketplace can take brokers up to a few days, especially if they have to educate employees about employee choice options. Brokers frequently felt that the training did not prepare them sufficiently for using the SHOP interface, sometimes adding to the time necessary to enroll a client because the broker had to work through the website with little to no understanding of the system. Consequently, brokers quickly lost interest in selling SHOP-based coverage. In states that allowed early renewal of policies, small-business groups reported that their brokers often urged them to renew their plan early rather than explore SHOP coverage.

In addition to complaints about the rate of compensation, brokers have expressed frustration with broker attribution systems, which have left some uncompensated for completed work. The attribution problem breaks down at one of two places: either the enrollment system does not properly inform the insurance company which broker helped sell the policy, or the enrollment system only allows for one name to be applied per consumer, leading to call centers dropping brokers from the system and vice versa. The call center in Colorado staffs brokers and health coverage guides; if a small business employer used the call center brokers even for a simple question, in order to receive compensation for the help, the call center broker could "drop" another broker's assignment to the same small group, regardless of whether or not the call center broker actually conducted the sale.

# EFFECT ON THE SMALL BUSINESS ENVIRONMENT

Because of the SHOP's slow start, it has had little impact on the small business environment so far. Although data on employer offers and worker coverage through their employers is unavailable for 2014, sources did note some changes that could grow in the coming years.

In some states, sources noted that, particularly for the very smallest employers with low-wage workers, the presence of a reformed and subsidized nongroup insurance market encouraged some small groups to drop coverage all together, sending their employees to the new Marketplaces for insurance. Employees seemed to

appreciate this, especially because of the availability of subsidized coverage for their dependents. One source expressed concern about employers that drop coverage and add a health coverage stipend to their employees' wages; this may adversely affect the employees because the employees may earn more taxable income despite part of that income being used for healthcare services. In addition, according to some sources, the reformed nongroup market may be facilitating hiring for small employers who have traditionally not offered coverage and have thus been at a competitive disadvantage in the labor market.

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## CONCLUSION

There is no doubt that the ACA SHOP Marketplaces have a long way to go to become successful. However, their current status is due in significant degree to the focus of resources and attention in the first year on the nongroup Marketplaces. This approach can be altered as the nongroup Marketplaces continue to increase in enrollment and stability. To move the SHOP business to stronger ground, however, considerable thought and effort must be put into the most effective framework for marketing and sales of the small-group products that they offer. A clear and concise understanding of the extra value brought to the market by the SHOP is particularly important, and is an effort that can be taken jointly by the state-based Marketplaces and the federally facilitated

ones. Administrative simplification and employee choice hold substantial promise in this regard, but developing avenues for adding additional product lines (e.g., COBRA management, disability insurance) may be especially vital to developing a strong competitive stance in the face of the growing presence of private insurance exchanges. In addition, smoothly operating websites, shorter application processing times, and increased business functionality for brokers are fundamentally needed improvements in order to make the SHOP product more attractive for small employers and, perhaps even more importantly, the individuals upon whom they have traditionally relied to sell them insurance coverage and other business services.

# ENDNOTES

1. An association health plan is deemed to be bona fide, and therefore treated as large group insurance under the Affordable Care Act (even if small employers are the ones purchasing the product for their employees), if it meets the federal standards set by ERISA for an employer. The Department of Labor has issued very little guidance on the requirements to meet those standards, and, as such, state departments of insurance are taking different approaches in deciding which applicants are and are not to be classified as bona fide association health plans under ERISA.
2. See Lucia K, Monahan C and Corlette S. *Cross-Cutting Issues: Factors Affecting Self-Funding by Small Employers: Views From the Market*. Washington: Urban Institute, 2013, <http://www.urban.org/UploadedPDF/412799-Factors-Affecting-Self-FundingbySmall-Employers.pdf>; Buettgens M and Blumberg LJ. *Small Firm Self-Insurance Under the Affordable Care Act*. New York: The Commonwealth Fund, 2012, [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2012/nov/1647\\_buettgens\\_small\\_firm\\_self\\_insurance\\_under\\_aca\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2012/nov/1647_buettgens_small_firm_self_insurance_under_aca_ib.pdf); and Lucia K, Corlette S and Ahn S. *Association Health Plans: A Changing Market in Oregon?* Washington: Urban Institute (Forthcoming 2014).
3. Lucia K, Corlette S and Ahn S, *Association Health Plans*.
4. Agency for Healthcare Research and Quality. "Percent of Private-Sector Establishments That Offer Health Insurance That Offer Two or More Health Insurance Plans by Firm Size and Selected Characteristics: United States, 2012." From *2012 Medical Expenditure Panel Survey—Insurance Component*, [http://meps.ahrq.gov/mepsweb/data\\_stats/summ\\_tables/insr/national/series\\_1/2012/tia2d.pdf](http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tia2d.pdf) (accessed July 30, 2014).
5. Although identified as 13 separate carriers, some of the 13 in Maryland have some relationship to one another. The full set includes: Aetna Health Insurance Inc., Aetna Life Insurance, CareFirst Blue Choice, CareFirst of Maryland, GHMSI (a CareFirst Company), Coventry Health and Life Insurance Co., Coventry Health Care of Delaware, Evergreen Health Cooperative, Kaiser Foundation Health Plan, MAMSI Life and Health Co., Optimum Choice, United Healthcare Insurance Co., United Healthcare of the Mid-Atlantic.
6. Pear R. "Small Firms' Offer of Plan Choices Under Health Law Delayed," *New York Times*, April 1, 2013, <http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html> (accessed July 30, 2014).
7. Centers for Medicare and Medicaid Services. "Small Business Health Options Program (SHOP)," <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html> (accessed July 30 2014).
8. Of the 34 states with federally facilitated Marketplaces, 14 will implement employee choice this year: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin, and Wyoming. Eighteen states will not implement employee choice until 2016: Alabama, Alaska, Arizona, Delaware, Illinois, Kansas, Louisiana, Maine, Michigan, Montana, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, and West Virginia.

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### **About the Authors and Acknowledgements**

Linda Blumberg is a senior fellow and Shanna Rifkin is a research associate in the Urban Institute’s Health Policy Center. This research was funded by the Robert Wood Johnson Foundation. The case study interviews in the study states were done by a team of researchers from the Urban Institute, Georgetown University, and Econometrica, Inc. In addition to the authors, they include: Ken Cannon, Lisa Clemans-Cope, Sabrina Corlette, Terri Coughlin, Stan Dorn, Sarah Gadsden, John Holahan, Eva Hrubá, Kevin Lucia, Mike Lyle, Megan McGrath, Katie Relihan, Anna Spencer, Laura Summer, Erik Wengle, and Steve Zuckerman. The authors are grateful to John Holahan and Kevin Lucia for their comments and suggestions on an earlier draft, as well as to the many anonymous stakeholder informants in the eight study states (Colorado, Illinois, Maryland, Minnesota, New Mexico, New York, Oregon, and Rhode Island) who supplied helpful information and their insights on their early experiences with the implementation of the Affordable Care Act.

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