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Small Business Health Options Program (SHOP) Exchange

(name redacted)
Analyst in Health Care Financing

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Summary

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes a number of provisions intended to improve access to health insurance coverage. Among these are provisions that apply to the small group market to address perceived problems in the market, including low offer rates among smaller employers and the sometimes prohibitive cost of health plans available in the small group market.

The small business health option program (SHOP) exchanges are among the ACA provisions directed at the small group market. SHOP exchanges are marketplaces where private health insurance issuers sell health insurance plans to small employers. All health plans available through SHOP exchanges must meet certain federally required criteria, such as offering a standardized package of benefits. Certain small employers may be eligible to receive tax credits toward the cost of coverage if they obtain coverage through a SHOP exchange.

A SHOP exchange is currently in operation in every state; some are administered by states, while others are administered in part or in entirety by the Department of Health and Human Services (HHS). ACA and its implementing regulations include some prescriptive requirements for the establishment and operation of SHOP exchanges. Although these requirements often apply uniformly to all SHOP exchanges, in some instances that may not be the case. For example, some requirements apply only to SHOP exchanges administered by HHS and not to SHOP exchanges administered by states. When ACA and regulations are not prescriptive, decisions about the establishment and operation of SHOP exchanges are left to a state or the entity administering the SHOP exchange (e.g., HHS). As a result, not all SHOP exchanges share the same features or similarly implement shared features.

This report describes certain features of SHOP exchanges, such as employer eligibility, methods for selecting health plans offered through SHOP exchanges, and how health insurance agents and brokers interact with SHOP exchanges. Each description includes information about how the feature is implemented in SHOP exchanges administered by states and those administered in part or in entirety by HHS. Each description also includes information about the timing of implementation. The report concludes with a discussion about the current and future place of SHOP exchanges in the broader context of the private health insurance market.

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Introduction

Most individuals in the United States obtain health insurance coverage in the group market (e.g., employer-sponsored insurance).[1] The predominance of group coverage can mask differences in its availability. Historically, access to coverage has been more limited in the small group market than in the large group market. For example, smaller employers have been less likely to offer health insurance coverage to employees compared with larger employers.[2] In 2013, 34.8% of private-sector employers with fewer than 50 employees offered coverage, compared with 95.7% of those with 50 or more employees.[3] Among smaller employers that do not offer coverage, the cost of offering coverage is often cited as a major reason for not doing so.[4]

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes a number of provisions intended to improve access to health insurance coverage. These provisions have been implemented over the course of several years; some went into effect shortly after ACA was enacted (2010), and many others were not effective until 2014. Some of these provisions apply to the small group market to address perceived problems in the market, including lower offer rates among smaller employers and the cost of coverage. The small business health options program (SHOP) exchanges are among these provisions.

As required by ACA, a health insurance exchange was established in each state as of January 1, 2014. Each exchange has two parts: a marketplace where individuals can shop for and enroll in health insurance coverage (*individual exchange*), and a SHOP exchange for small employers. SHOP exchanges are marketplaces where private health insurance issuers sell health insurance plans to small employers.

A Note on Terms Used in This Report

ACA requires that health insurance exchanges sell health insurance coverage to individuals and small employers. In this report, the term *individual exchange* refers to the portion of an exchange that sells coverage to individuals. The term *SHOP exchange* refers to the portion that sells coverage to small employers, and use of the term *exchange* without a modifier refers to both the individual and SHOP exchanges.

All SHOP exchanges are administered in one of three ways: solely by a state, solely by the Department of Health and Human Services (HHS), or by HHS with some degree of state involvement. For purposes of this report, SHOP exchanges solely administered by a state are referred to as *state-based* (SB-SHOP), and all SHOP exchanges with federal involvement are referred to as *federally-facilitated* (FF-SHOP). **Figure 1** shows SHOP exchange arrangements in each state in 2014.[5]

[1] Jessica C. Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2013*, U.S. Census Bureau, P60-250, September 2014.

[2] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 1996-2013 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).

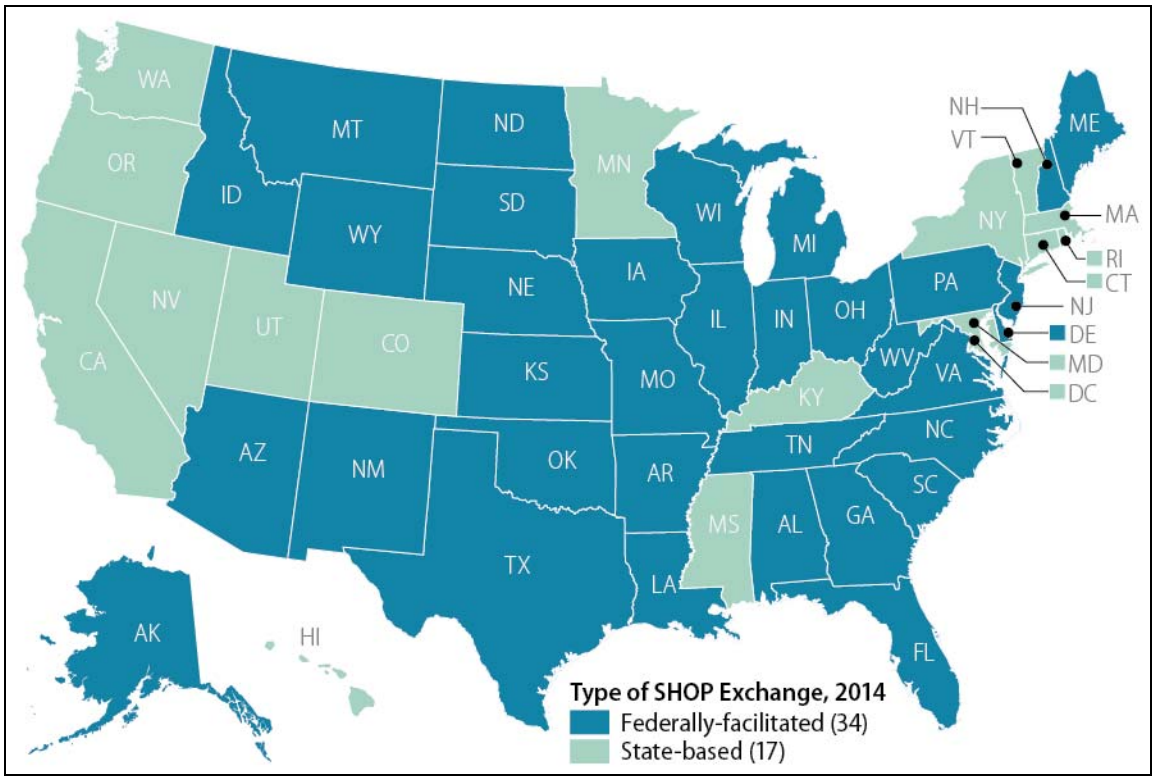
[3] Ibid.

[4] Kaiser Family Foundation and Health Research & Education Trust, "Employer Health Benefits: 2013 Annual Survey," August 2013.

[5] Based on CRS analysis of exchange arrangements. States may transition their exchange arrangements each year (e.g., switch from an SBE to an FFE), so some states may have different arrangements in 2015.

Figure 1. SHOP Exchange Arrangements in 2014

As of June 2, 2014



Notes: The assignment of federally-facilitated or state-based was determined by CRS analysis of exchange arrangements based on information obtained from the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS).

There are varying levels of state involvement in FF-SHOP exchanges. In 16 states (Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Louisiana, Missouri, North Carolina, North Dakota, Oklahoma, Pennsylvania, Tennessee, Texas, Wisconsin, and Wyoming) the FF-SHOP is wholly established and administered by HHS. Fourteen states (Arkansas, Delaware, Illinois, Iowa, Kansas, Maine, Michigan, Montana, Nebraska, New Hampshire, Ohio, South Dakota, Virginia, and West Virginia) have partnered with HHS in some capacity to carry out certain exchange activities in the state. HHS refers to two states (Idaho and New Mexico) as having "federally-supported state-based exchanges." Both states planned to have state-based exchanges in 2014 but are currently using the federally-facilitated exchange information technology (IT) platform. Two states (Mississippi and Utah) have state-based SHOP exchanges and federally-facilitated individual exchanges.

All health plans sold through a SHOP exchange must be certified as qualified health plans (QHPs). To obtain certification as a QHP, a health plan must meet certain ACA-required criteria, such as offering a comprehensive benefit package (the essential health benefits, EHBs). ACA does not require employers to purchase coverage through SHOP exchanges, nor does it prohibit employers from purchasing coverage in the market outside SHOP exchanges.

ACA and its implementing regulations include some prescriptive requirements for the establishment and operation of SHOP exchanges. These requirements often apply similarly to SB-SHOPs and FF-SHOPs. When ACA and regulations are not prescriptive, decisions about the establishment and operation of SHOP exchanges are left to a state or the entity administering the SHOP exchange (e.g., HHS). As a result, not all SB-SHOPs and FF-SHOPs share the same features or implement shared features in the same way.

This report describes certain features of SHOP exchanges. Each description includes information about how the feature is implemented in SB-SHOP and FF-SHOP exchanges. Each description also includes information about the timing of implementation. The report concludes with a discussion about the current and future place of SHOP exchanges in the broader context of the private health insurance market.

Eligibility

Small employers that offer health insurance coverage to all of their full-time employees are eligible to use SHOP exchanges. Prior to January 1, 2016, ACA allows states to define *small employer* as having either 100 or fewer or 50 or fewer employees.[6] Beginning in 2016, all states must define *small employer* as 100 or fewer employees. (Information about the definitions and methods employers must use to determine size is below.) Beginning in 2017, states have the option to allow large employers to use a SHOP exchange.

Small employers may be able to purchase coverage through one or more SHOP exchanges. A small employer may purchase coverage through a SHOP exchange that services its principal business address or through each SHOP exchange that services employees' primary worksites, if employees work at multiple worksites and those worksites are not all in the service area of one SHOP exchange.[8]

Sole Proprietors

HHS indicates that in order to be eligible to purchase a health plan through a SHOP exchange, an employer must have employees.[7] Neither sole proprietors nor their spouses are considered employees; therefore, sole proprietors and their spouses (absent additional common-law employees) are not eligible to obtain coverage through a SHOP exchange. If a sole proprietor were to hire a common-law employee, the sole proprietor would have an employee and may then be eligible to purchase coverage through a SHOP exchange.

In order for an employee to be eligible to obtain coverage through a SHOP exchange, a SHOP-eligible employer must offer the employee coverage.

Determining Employer Size and the Definition of Full-Time

An employer's SHOP exchange eligibility depends on size and whether the employer offers coverage to all full-time employees. ACA and its implementing regulations set forth methods and definitions with respect to determining employer size and whether an employee is full-time.

For plan years beginning in 2014, the FF-SHOPs rely on definitions and methods described in 4980H(c) of the Internal Revenue Code (IRC).[9] A full-time employee is defined as one who

[6] According to a March 2014 report published by the Commonwealth Fund, all states chose the 50-employee limit for 2014. See the Commonwealth Fund, *Implementing the Affordable Care Act: State Action to Establish SHOP Marketplaces*, March 2014.

[7] 77 *Federal Register* 18309, March 27, 2012.

[8] Statute provides that a SHOP exchange may serve an entire state or a geography larger or smaller than an entire state, depending on how the SHOP exchange is implemented.

[9] These are the same definitions and methods used for determining employer size and full-time status for purposes of ACA's employer shared responsibility provision (employer penalty) and include the Internal Revenue Service (IRS) aggregation rules governing controlled groups. The controlled group rules identify whether two or more corporations (continued...)

works 30 hours or more each week. The full-time equivalent (FTE) method, whereby both full-time and part-time employees are included in the calculation, is the method for determining the number of employees. Each full-time employee counts as one employee, and hours worked by part-time employees (i.e., those working less than 30 hours per week) are converted into FTEs by adding overall hours worked by all part-time employees during a month and dividing the total by 120. The result from the part-time employee calculation is added to the number of full-time employees to get the total number of FTEs.

For example, consider an employer with 10 full-time employees (30 or more hours). Assume the employer also has 20 part-time employees who all work 24 hours per week (96 hours per month). These part-time employees' hours would be treated as equivalent to 16 full-time employees for the month, based on the following calculation:

(20 employees x 96 hours) / 120 = 16

Thus, in this example, if the employer applied for coverage through an FF-SHOP, it would be considered a *small employer*, based on a total FTE count of 26—that is, 10 full-time employees plus 16 FTEs based on the number of part-time hours worked.

In the case of plan years beginning prior to January 1, 2016, SB-SHOPs may elect to use the definitions and methods set forth in 4980H(c) of the IRC, or they may use state-specific terms and methods to determine employer size. In the case of plan years beginning on or after January 1, 2016, all SHOP exchanges must rely on the definitions and methods described in 4980H(c) of the IRC currently used by the FF-SHOPs.

Consumer Assistance

Statute and regulations require that exchanges, both SHOP and individual, carry out certain consumer assistance functions. Some functions require that exchanges provide direct support to consumers. For example, exchanges must provide for the operation of a call center that addresses the needs of consumers who have questions about SHOP exchanges and individual exchanges.

Exchanges are also expected to provide indirect support to consumers by implementing consumer assistance personnel programs. Exchanges must establish Navigator programs and certified application counselor (CAC) programs, and exchanges have the option to implement a program for non-Navigator consumer assistance personnel.[10] Under these programs, individuals are trained to help consumers make informed decisions about their insurance options and help consumers access SHOP and individual exchange coverage. However, consumer assistance personnel may not enroll small employers or individuals in coverage.

(...continued)

and certain other groups of related trades or businesses are treated as if they were one employer. The controlled group rule applies under §414 (b), (c), (m), or (o) of the IRC and includes employees of partnerships, proprietorships, etc., which are under common control by one owner or group of owners.

[10] For information about Navigators, CACs, and non-Navigator assistance personnel, see CRS Report R43243, *Health Insurance Exchanges: Health Insurance "Navigators" and In-Person Assistance*, by (name redacted).

Pursuant to state law, exchanges may also allow insurance agents and brokers to help small employers and individuals obtain coverage through exchanges.[11] Unlike consumer assistance personnel, agents and brokers may enroll individuals and small employers in coverage through exchanges. See the "Role of Agents and Brokers in Enrollment Process" section of this report for specific information about how agents and brokers can enroll small employers in coverage obtain through SHOP exchanges.

Enrollment

To enroll in coverage offered through a SHOP exchange, both employers and employees must submit applications to the SHOP. The SHOP exchange must verify the information submitted and determine employers' and employees' eligibility.

Enrollment in a SHOP exchange is not limited to a specified open enrollment period, except in certain circumstances.[12] Specific circumstances aside, a SHOP must allow employers to enroll any time during a year, and the employer's plan year must consist of the 12-month period beginning with the employer's effective date of coverage.

Each SHOP exchange must establish uniform enrollment timelines for employers and employees. SHOP exchanges must provide a specific timeframe during which an employer can select qualified health plans (QHPs) to offer to its employees and a time period of no less than 30 days for an annual open enrollment period for employees. SHOP exchanges must provide special enrollment periods for employees and their dependents. Special enrollment periods allow individuals to enroll in coverage outside the open enrollment period. The eligibility criteria for special enrollment periods are outlined in regulations and include events such as the loss of eligibility for Medicaid or the State Children's Health Insurance Program (CHIP) and the experience of a life event such as marriage or divorce.[13]

Minimum Participation Rates and Contribution Rates

In general, a *minimum participation rate* is a requirement that at least a certain percentage of an employer's workers enroll in a health plan. Pursuant to state law, health insurance issuers may institute minimum participation rates.

SHOP exchanges are generally allowed to establish uniform minimum participation rates, as long as the rate is based on the rate of employee participation in the SHOP. Minimum participation rates cannot be based on enrollment in any given QHP or with a particular health insurance issuer. Employers that do not meet the minimum participation rate are not prohibited from purchasing coverage through a SHOP exchange; rather, if a SHOP exchange authorizes a minimum participation rate, an issuer may limit the availability of coverage for any employer that does not

[11] For detailed information about how agents and brokers can interact with exchanges, see *Resources for Agents and Brokers in the Health Insurance Marketplaces*, http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/a-b-resources.html.

[12] The circumstances are discussed in the "Minimum Participation Rates and Contribution Rates" section of this report.

[13] See 45 CFR §155.725(j) for a list of circumstances under which an employee could be eligible for a special enrollment period.

meet the minimum rate to an annual enrollment period that begins November 15 and extends through December 15 of each year.

For plan years beginning in 2014, the FF-SHOPs are generally using a 70% minimum participation rate. To calculate the rate, the number of employees accepting coverage is divided by the number of employees offered coverage, excluding from the calculation any employee who is enrolled in coverage through another employer's group health plan or through a government program (e.g., Medicare or Medicaid). Regulations allow FF-SHOPs to use different minimum participation rates in certain circumstances, such as if the state has a law indicating a different rate.[14]

The SB-SHOPs may establish their own minimum participation rates, provided they do so within the confines of the requirements described above: the rate must be based on employee participation in the SHOP exchange and employers that do not meet the specified rate must be given the opportunity to enroll in coverage during an annual enrollment period.[15]

A *minimum contribution rate* is a requirement that an employer contribute at least a certain amount to employees' premiums. Issuers may institute minimum contribution rates, provided they are allowed to do so under state law. With respect to SHOP exchanges, neither statute nor regulations explicitly prohibit minimum contribution rates for QHPs purchased through SHOP exchanges. However, HHS has indicated that in the 2014 plan year, FF-SHOP exchanges may not allow issuers to institute minimum contribution rates.[16] The restriction does not apply to SB-SHOP exchanges.

It should be noted that minimum participation rates and minimum contribution rates, whether implemented in the small group market inside or outside SHOP exchanges, are subject to the parameters of ACA's guaranteed issue provision. Under this provision, issuers offering coverage in the small group market must accept every applicant for coverage, as long as the applicant agrees to the terms and conditions of the coverage offer (such as the premium). As such, issuers cannot prohibit employers that do not meet an allowed minimum participation rate or a minimum contribution rate from purchasing small group coverage. Instead, issuers may limit the availability of coverage for any employer that does not meet an allowed minimum participation or contribution rate to an annual enrollment period—November 15 through December 15—of each year.[17]

[14] In 2014 and 2015, the FF-SHOPs in the following states are using a 75% minimum participation rate: Arkansas, Iowa, Nevada, New Hampshire, New Jersey, South Dakota, and Texas. The FF-SHOP in Tennessee is using a 50% minimum participation rate in 2014 and in 2015.

[15] For information about the minimum participation rates in SB-SHOPs, see Sarah J. Dash, Kevin W. Lucia, and Amy Thomas, *Implementing the Affordable Care Act: State Action to Establish SHOP Marketplaces*, the Commonwealth Fund, March 2014.

[16] REGTAP, Frequently Asked Questions Identification Number 103a, July 5, 2013.

[17] HHS indicates that this policy is meant to address concerns about adverse selection, which could occur if small employers took advantage of continuous open enrollment in the small group market and waited to purchase a small group plan until it was advantageous to the employer to do so (i.e., waiting until employees needed health care services). For more details, see the preamble to the final rule on health insurance market rules (78 *Federal Register* 13406, February 27, 2013).

Enrollment Pathways

There are multiple ways for small employers and their employees to enroll in QHPs offered through SHOP exchanges. The availability of various enrollment pathways differs among SHOP exchanges.

For the 2014 plan year, small employers and employees using FF-SHOPs can shop for and compare all available QHPs on the FF-SHOP website. However, small employers and employees can apply for coverage only by mailing an application to the FF-SHOP or by using the direct enrollment process.[18] Under direct enrollment, a small employer contacts an agent, broker, or insurance company that offers an FF-SHOP plan. The contacted entity helps the small employer fill out an exchange application and sends it to an FF-SHOP. The contacted entity may then allow the small employer and its employees to enroll in a QHP offered by the contacted entity without waiting to receive an eligibility determination from the FF-SHOP exchange.[19] For the 2015 plan year, it is expected that small employers and their employees will be able to enroll online, as well as mail in applications and use the direct enrollment process.[20]

In terms of timing, the availability of various enrollment pathways has differed across SB-SHOP exchanges. Some SB-SHOPs have supported on-line enrollment and enrollment through other pathways (e.g., mail-in application) since the SB-SHOPs opened, while others have not yet begun to offer on-line enrollment and rely on enrollment through other pathways. It remains to be seen what enrollment pathways will be available in SB-SHOPs for the 2015 plan year.

Role of Agents and Brokers in Enrollment Process

Regulations provide that a state may permit agents and brokers to help individuals and small employers enroll in exchange coverage using the agent's or broker's own website.[21] This feature is currently available in individual exchanges, but it is not available in SHOP exchanges for plan years beginning in 2014. SHOP exchanges may allow agents and brokers to enroll employers and employees through their own websites beginning in 2015, provided state law permits this activity. HHS has noted that it does not currently anticipate that FF-SHOPs will make this function available in 2015.[22]

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[18] Department of Health and Human Services, *FAQs on New Enrollment Process for the Federally Facilitated SHOP Marketplace*, November 27, 2013.

[19] However, if the FF-SHOP eventually determines that the employer is ineligible to use the FF-SHOP, the employees will not be able to keep the QHP coverage obtained through the FF-SHOP.

[20] CMS expects online enrollment to be available in all FF-SHOPs for the 2015 open enrollment period beginning November 15, 2014. In addition, CMS is allowing small employers and agents and brokers in five states (Delaware, Illinois, New Jersey, Missouri, and Ohio) to have "early access" to SHOP exchanges beginning October 27, 2014. During "early access" the small employers and agents and brokers will be able to establish an account and complete an application (among other things), but they will not be able to select and enroll in a plan until open enrollment begins November 15.

[21] The agent's or broker's website has to meet certain criteria, including either displaying all the QHP information that is available through an exchange or displaying a disclaimer provided by HHS stating that not all the required information is available on the agent's or broker's website but can be found on the exchange website.

[22] 79 *Federal Register* 13744, March 11, 2014.

Selecting a QHP

If an employer is eligible to use a SHOP exchange, the employer may select one or more QHPs to offer to its employees. Each SHOP exchange determines the number of QHPs an employer may offer (i.e., one or more than one) and the method by which employers can select which QHPs to offer. Provided a SHOP exchange allows employers to select more than one QHP, regulations identify two selection methods: employee choice or an alternative method. Under employee choice, employers may select a metal level of coverage (e.g., silver or gold)[23] in which all QHPs at that level are made available to its employees. An example of an alternative method is for the SHOP to allow employers to select more than one level of coverage in which all QHPs at the various levels are available to its employees.

For the 2014 plan year, FF-SHOPs allow employers to select only one QHP to offer to their employees. FF-SHOPS do not allow the employee choice method or any alternative selection method. For plan year 2014, most SB-SHOPs allow employers to select more than one plan to offer to their employees, either by the employee choice method or a different method.[24]

For plans years beginning in 2015, regulations provide that a SHOP exchange may choose whether to provide the employee choice method, based on a written recommendation submitted by the State Insurance Commissioner.[25] If an FF-SHOP elects not to implement the employee choice method, then it will allow an employer to select only a single QHP to offer to its employees. Among states with FF-SHOP exchanges, HHS has approved recommendations from State Insurance Commissioners not to implement employee choice in 18 states in 2015.[26] The 14 remaining FF-SHOPs will implement employee choice in 2015.[27] If an SB-SHOP chooses not to implement the employee choice method, it will allow an employer to make one or more QHPs available to employees by a different method.

HHS notes that the option to implement the employee choice function in 2015 (based on the recommendation from the State Insurance Commissioner) is a transitional policy.[28] HHS indicates that for plan years beginning in 2016, all SHOP exchanges must offer at least the employee choice method (and may offer an additional selection method). In other words, under current regulations, beginning in 2016, employers will have the option to offer more than one plan to

[23] Under ACA, all QHPs must meet a specific actuarial value (AV) designated by a precious metal: platinum, gold, silver, or bronze. In general, AV is the share of medical spending covered by a health plan (as opposed to the enrollee).

[24] For information about different methods allowed in SB-SHOPs, see Sarah J. Dash, Kevin W. Lucia, and Amy Thomas, *Implementing the Affordable Care Act: State Action to Establish SHOP Marketplaces*, the Commonwealth Fund, March 2014.

[25] The written recommendation must adequately explain "that it is the State Insurance Commissioner's expert judgment, based on a documented assessment of the full landscape of the small group market in his or her State, that not implementing employee choice would be in the best interests of small employers and their employers and dependents, given the likelihood that implementing employee choice would cause issuers to price products and plans higher in 2015 due to the issuers' beliefs about adverse selection." 45 CFR §155.705(b)(3)(vi).

[26] FF-SHOPs will not implement employee choice in the following 18 states: 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. For more information, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html.

[27] FF-SHOPs will implement employee choice in the following 14 states: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin, and Wyoming.

[28] See the discussion in the preamble to the final rule on Exchange and Insurance Market Standards for 2015 and Beyond (79 *Federal Register* 30240, May 27, 2014).

employees (by the employer choice method and possibly by another method) in all SHOP exchanges.

Purchasing a QHP Offered through a SHOP Exchange

ACA and its implementing regulations set forth some requirements about how issuers selling coverage in the small group market must develop premiums to offer to employers. In general, the requirements apply regardless of whether an issuer is offering coverage inside or outside a SHOP exchange. Once an issuer has set premiums for an employer, the employer must determine its contribution to employees' premiums.[29] SHOP exchanges may establish standard methods that employers may use to define their contributions toward employee and dependent coverage. In addition, SHOP exchanges are expected to implement certain administrative procedures related to collecting premiums from employers and paying premiums to QHP issuers.

Premiums Charged by Health Insurance Issuers

ACA imposes adjusted community rating rules on the determination of premiums. *Adjusted community rating* rules prohibit issuers from pricing health insurance plans based on health factors but allow premium variation for four factors: (1) self-only or family enrollment, (2) geographic rating area, (3) tobacco use, and (4) age.[30] These rules apply to health plans offered in the small group market both inside and outside SHOP exchanges, and they may be modified by state laws that impose stricter rating rules (i.e., states may impose pure community rating, or the prohibition of using any factor to vary premiums).

Issuers must use a per-member rating practice to determine the total premium for a health plan purchased by a small employer. Under a per-member rating practice, the total premium charged by an issuer to an employer is determined by summing the premiums of each employee and dependent enrolled in the plan, adjusted for any permitted rating variations (e.g., the age of each enrollee). When an issuer provides premium information to an employer, the issuer may offer the employer the per-member premiums, or the issuer may offer the employer composite premiums. Composite premiums are average enrollee premium amounts; to develop composite premiums, an issuer divides the total premium amount (based on the summation of per-member rating) by the total number of enrollees to develop an average premium amount per enrollee. **Table 1** illustrates how per-member and composite premiums may differ.

[29] See the "Minimum Participation Rates and Contribution Rates" section of this report for information about parameters that may affect the amount an employer contributes to employees' premiums.

[30] For more information, see CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

Table 1. Per-Member Premiums and Composite Premiums for a Small Group Health Plan Offered to Employees and Their Dependents

This example is intended for illustrative purposes only.

Enrollee Information			Annual Rates/Premiums		
Enrollee	Age	Age Rating Factor[a]	Rate[b]	Per-Member Premium	Composite Premium
Employee 1	44	1.397	$5,500	$7,684	$6,635
Dependent A	45	1.444	$5,500	$7,942	$6,635
Dependent B	13	0.635	$5,500	$3,493	$6,635
Dependent C	11	0.635	$5,500	$3,493	$6,635
Employee 2	35	1.222	$5,500	$6,721	$6,635
Employee 3	26	1.024	$5,500	$5,632	$6,635
Dependent D	27	1.048	$5,500	$5,764	$6,635
Employee 4	33	1.198	$5,500	$6,589	$6,635
Dependent E	31	1.159	$5,500	$6,375	$6,635
Dependent F	1	0.635	$5,500	$3,493	$6,635
Employee 5	62	2.873	$5,500	$15,802	$6,635

Notes: This table illustrates how per-member and composite premiums may differ. A per-member premium for any employee or dependent is determined by multiplying the health plan's base rate by any allowable rating factors (for purposes of **Table 1**, the only allowable rating factor is the individual's age). A composite premium is an average premium amount; to develop composite premiums, a health insurance issuer divides the total premium amount (based on the summation of per-member rating) by the total number of enrollees. For purposes of **Table 1**, this means that the composite premium is the sum of all the per-member premiums ($72,988) divided by the total number of plan enrollees (11).

a. Based on the federally established age curve created for the purpose of implementing ACA's rating restrictions. Some states opted to establish their own age curves and may have different rating factors for the ages shown in **Table 1**. For more information about state-specific age curves, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-08-09-2013.pdf.

b. For purposes of this example, the rate, which refers to the price of the unit of insurance, is already adjusted by the geographic rating factor as allowed under ACA rating restrictions.

If an issuer offers composite premiums to an employer, it must comply with the following: (1) the total premium must be based on per-member rating; (2) the composite premium cannot vary during a plan year, regardless of the addition or loss of enrollees in the plan; (3) tobacco use cannot be considered for the composite premium, it must be applied to the tobacco user's premium after the composite premium is developed; and (4) if an issuer makes composite premiums available for a health plan for one employer, it must make composite premiums available to all employers that want to purchase that health plan.

So far, the information presented in this section applies to small group plans offered inside and outside SHOP exchanges. However, QHPs offered through SHOP exchanges must abide by additional SHOP-specific rules. SHOP exchanges must require that all issuers make changes to their rates at uniform times that occur no more often than quarterly, and all SHOP exchanges must

prohibit QHP issuers from varying an employer's rates during the employer's plan year.[31] In addition, if the employee choice function becomes available in FF-SHOPs (for plan years beginning on or after January 1, 2015), employers that opt to use the employee choice function will not have the option to receive composite premiums from issuers.[32] Instead, employers may receive only per-member premiums from issuers. This is not a requirement in SB-SHOPs; unless otherwise prohibited by a state or a SHOP exchange, an issuer may provide composite premiums to employers that opt for the employee choice method in SB-SHOPs.

Methods for Determining Employer Contributions to Premiums

Once an issuer has developed premiums (whether per-member or composite) for a health plan offered to a small employer, the small employer can determine its contribution toward employees' premiums. A SHOP exchange may establish one or more standard methods that employers may use to define their contributions toward employee and dependent coverage. The methods that FF-SHOPs must establish are described in regulations,[33] but methods are not prescribed for SB-SHOPs.

For plan year 2014, the method for determining employer contributions in FF-SHOPs is relatively straightforward because employers may select only one QHP to offer to their employees. Once the employer has selected the QHP (the reference plan), the employer will define a percentage contribution toward premiums for employee-only coverage under the reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage. The resulting contribution amounts for each employee's and dependent's coverage may then be applied toward the QHP offered to employees.

Employee choice will be an option in some FF-SHOPs in 2015.[34] As such, a method for determining employer contributions if an employer selects more than one QHP to offer to its employee is outlined in regulations. In this case, the employer will select one QHP to serve as a reference plan on which contributions will be based (but the employees will be allowed to enroll in QHPs other than the reference plan per the employee choice arrangement). The employer will define percentage contributions. To the extent permitted by state law, an FF-SHOP may permit an employer to define different contribution percentages for full-time employees, non-full-time employees, dependents of full-time employees, and dependents of non-full-time employees. The resulting contribution amount (based on the reference plan) is then applied to the QHP selected by each enrollee.

Regulations specify that state law or the employer may require an FF-SHOP to base contributions on separately calculated composite premiums for employees, adult dependents, and dependents below age 21;[35] however, HHS issued guidelines in October 2013 indicating that FF-SHOPs are able to accommodate composite ratings only for employees.[36] Contributions for employees'

[31] 45 C.F.R. §155.705(b)(6).

[32] 45 C.F.R. §156.285(a)(4)(ii).

[33] 45 C.F.R. §155.705(b)(11).

[34] See the "Selecting a QHP" section of this report for more details.

[35] 45 C.F.R. §155.705(b)(11)(ii)(D).

[36] Centers for Medicare and Medicaid Services (CMS), *Federally-facilitated Marketplace for SHOP: Frequently Asked Questions*, October 2, 2013.

dependents will be based on per-member rating. HHS has not specified whether FF-SHOPs will be able to accommodate composite ratings for dependents in 2015.

See the **Appendix** for more details about how the different contribution methods in FF-SHOPs may work in practice.

Administrative Procedures for Collecting and Paying Premiums

SHOP exchanges are expected to establish one or more standard procedures to allow employers to pay premiums.[37] For plan years beginning in 2015, the established procedures must include *premium aggregation* functions: (1) a SHOP must provide each employer with a monthly bill that identifies the employer contribution, the employee contribution, and the total amount that is due to QHP issuer(s); (2) a SHOP must collect from each employer the total amount due and make payments to QHP issuers for all SHOP enrollees; and (3) a SHOP must maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

FF-SHOP exchanges are not performing premium aggregation functions for the 2014 plan year, and SB-SHOP exchanges have the option to perform the functions for the 2014 plan year. As noted above, regulations provide that all SHOP exchanges must offer the premium aggregation functions listed above beginning with the 2015 plan year.

Small Business Health Insurance Tax Credits

Under ACA, certain small employers are eligible for a small business tax credit. To be eligible, the small employers must contribute a uniform percentage of at least 50% toward their employees' health insurance.[38] The tax credits have been available to eligible small employers since 2010. Beginning in 2014, the tax credits are generally available only to eligible small employers that obtain coverage through a SHOP exchange; however, the Internal Revenue Service (IRS) provides transition relief for certain small employers that cannot obtain a QHP offered through a SHOP exchange because the small employer's principal business address is in a county in which a QHP through a SHOP is not available in 2014.[39] Also beginning in 2014, the credits are available only to eligible small employers for two consecutive tax years (beginning with the first year the small employer purchases coverage through a SHOP exchange).

Beginning in 2014, the maximum credit is 50% of an employer's contribution toward premiums for for-profit employers, and 35% of employer contributions for nonprofit organizations. The full credit is available to employers that have 10 or fewer full-time equivalents (FTEs) and that have average taxable wages of $25,400 or less. The tax credit is phased out as an employer's number

[37] 45 C.F.R. §155.705(b)(4).

[38] For more detailed information about the tax credits, see CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted).

[39] The IRS has identified counties in Washington and Wisconsin to which this transition relief applies. See IRS Notice 2014-6 for more details.

of FTEs increases from 10 to 25 and as average employee compensation increases from $25,400 to $50,800.[40]

Health Insurance Issuer Participation in SHOP Exchanges

In general, ACA does not require health insurance issuers to participate in individual or SHOP exchanges. However, HHS set forth requirements with respect to issuer participation in FF-SHOPs. An FF-exchange will certify a QHP for the individual market only if the issuer meets one of the following conditions:

- the QHP issuer offers at least one small group market QHP at the silver level and one at the gold level through the state's FF-SHOP;
- the QHP issuer does not offer small group market plans in the state, but another issuer in the same issuer group offers at least one small group market QHP at the silver level and one at the gold level through the state's FF-SHOP;[41] or
- neither the QHP issuer nor any other issuer in the same group has a share of the small group market greater than 20% (as determined by HHS).[42]

In other words, if an issuer wants to offer through the FF-individual exchange, it may have to also offer through the FF-SHOP exchange. This is dependent on the size of the issuer's presence in the small group market outside of an FF-SHOP exchange and whether an issuer in its same group offers QHPs through an FF-SHOP exchange. Issuers offering coverage through SB-SHOPs do not have to comply with these requirements, but states that have SB-SHOPs may have their own requirements related to offering coverage through a SHOP exchange. For example, at least three states (DC, Maryland, and Vermont) require issuer participation in SHOP exchanges for plan year 2014.[43]

SHOP Exchanges in Context

SHOP exchanges are just one part of the health insurance landscape in the United States. Being one part of a larger whole, the SHOP exchanges are both affected by and affect other parts of the landscape. This section provides some context to help clarify how SHOP exchanges currently operate within the broad health insurance landscape and how they are expected to do so in the future.

[40] ACA requires that these dollar amounts are adjusted for inflation using the Consumer Price Index–Urban (CPI-U) each year beginning in 2014.

[41] An issuer group is defined as "all entities treated under subsection (a) or (b) of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuer affiliated by the common use of a nationally licensed service mark." 45 C.F.R. §156.20.

[42] The share determination is based on data on earned premiums submitted by all issuers in the state's small group market.

[43] U.S. Government Accountability Office, *Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657, August 2014.

As noted earlier, while most individuals in the United States obtain health insurance coverage in the group market, access to coverage has historically been more limited in the small group market as compared with the large group market. Small employers often cite the cost of small group coverage as a reason for not offering coverage. ACA includes a number of provisions to address perceived problems in the small group health insurance market to improve access to coverage. The small business health care tax credit and the SHOP exchanges are among these provisions.

ACA also includes provisions intended to improve access to other parts of the health insurance market. For example, ACA includes a number of consumer protections that make it easier for individuals to access coverage in the nongroup (or individual) market, such as a prohibition on preexisting condition exclusions. ACA also requires that each state have an individual health insurance exchange, where certain lower-income individuals can obtain financial assistance to purchase nongroup health insurance coverage. ACA also expands access to Medicaid, includes a requirement for most individuals to obtain coverage or face a penalty (individual mandate), and assesses penalties on large employers that either do not offer coverage or offer coverage that does not meet required standards (often referred to as the employer penalty).

SHOP Exchanges in 2014

In 2014, internal and external factors affected the operation and functionality of SHOP exchanges and influenced small employers' interest in using SHOP exchanges. The factors also affected the role of SHOP exchanges in the larger health insurance landscape in 2014.

Internal Factors

The internal factors relate to the functionality of SHOP exchange features. SHOP exchanges had the potential to provide features to small employers that are not widely available in the small group market outside SHOP exchanges. Such features include the ability to view, compare, and enroll in plans offered by multiple issuers through one website; employee choice, or the ability for employers to allow their employees to select from multiple health plans; and assistance in administering the financial aspects of offering coverage (e.g., aggregating premiums owed to multiple issuers). To the extent that such features attracted small employers and issuers to the SHOP exchanges, the SHOP exchanges were potentially a vehicle for increasing small employer offer rates and reducing the cost of small group coverage by increasing competition in the market. However, as discussed in various parts of this report, implementation of many of the aforementioned features was delayed in 2014.

External Factors

The external factors relate to broader changes in the health insurance landscape (largely as a result of ACA) that may have discouraged, or at least not encouraged, small employers to obtain coverage through a SHOP exchange. ACA included many health insurance market reforms that apply to coverage sold in the small group market (including through SHOP exchanges). For example, beginning in 2014, small group health plans have to cover the essential health benefits (EHBs). The EHBs are a defined set of benefits,[44] and covering the EHBs may increase the cost

[44] For more information about the EHBs, see CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

of some health plans. To the extent a small employer finds obtaining ACA-compliant coverage unappealing (perhaps because compliance is seen as increasing the cost of the coverage), the small employer may choose not to purchase coverage to offer to its employees. Or the small employer may choose to self-insure, provided it is allowed to do so under state law, because self-insured employers can offer coverage that does not have to comply with all of ACA's market reforms. Either way, the small employer will not purchase coverage in the small group market, and will have no reason to use a SHOP exchange.

In 2013, media reports indicated that some small employers took advantage of the ability to *early renew*. Provided it was allowed under state law,[45] an issuer could allow a small employer that would typically renew its plan in 2014 (per the terms of the contract) to renew its plan prior to 2014. For example, instead of renewing a plan in January 2014, a small employer may have had the opportunity to renew the contract in November 2013. Going forward, the small employer's contract year would be November–October. If an existing plan was renewed in October 2013 with a 12-month contract, the plan would not have to comply with 2014 ACA market reforms until it renews in October 2014. A small employer that took this option would have no need to purchase a plan through a SHOP exchange for at least part of the 2014 plan year.

Similarly, under a transitional policy first announced by CMS in November 2013, issuers offering coverage in the small group market could choose to continue coverage that would otherwise be cancelled. Pursuant to the policy, state insurance commissioners could choose whether to enforce compliance with specified ACA market reforms. Presumably, if state insurance commissioners chose not to enforce compliance, then issuers could renew coverage for small employers that would otherwise receive cancellation notices. The transitional policy was extended in March 2014; pursuant to the extended policy, coverage renewed for a plan year between January 1, 2014, and October 1, 2016, does not have to comply with certain ACA market reforms, provided the coverage meets specified conditions. Just like small employers that opted to early renew, small employers that were (and still are) able to provide coverage that is not completely ACA-compliant have no reason to purchase coverage through a SHOP exchange.

Finally, some of the external factors affecting SHOP exchanges have less to do with small group market coverage and more to do with improved access to other types of coverage. ACA includes provisions that make it easier for individuals to access coverage in the nongroup market.[46] It creates individual exchanges and provides financial subsidies to lower-income individuals purchasing nongroup coverage through those exchanges,[47] and it expands the Medicaid program.[48] If a small employer found that its employees were able to easily obtain coverage outside of group coverage as a result of these provisions, the small employer may lack an

[45] The practice of early renewal is not regulated under federal law, but some states may have laws that regulate issuers' renewal practices. For example, some states have prohibited the practice of early renewals in the nongroup market, and others have indicated dates by which policies issued in 2013 must end in 2014. For more information, see the Commonwealth Fund blog, The Affordable Care Act's Early Renewal Loophole: What's at Stake and What States Are Doing to Close It, http://www.commonwealthfund.org/Blog/2013/Aug/The-Affordable-Care-Acts-Early-Renewal-Loophole.aspx.

[46] For example, ACA requires coverage in the nongroup market to be offered on a guaranteed issue and guaranteed renewal basis, and issuers that sell nongroup coverage cannot deny coverage based on an individual's preexisting conditions.

[47] For more information, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted).

[48] For more information, see CRS Report R43564, *The ACA Medicaid Expansion*, by (name redacted).

incentive to provide coverage to its employees, regardless of the potential attributes of a SHOP exchange. These factors may be particularly salient to small employers not subject to ACA's employer penalty—those employers with fewer than 50 full-time equivalent (FTE) employees.[49]

SHOP Exchanges in 2015 and Beyond

Some of the internal and external factors affecting SHOP exchange performance in 2014 will change while others will remain in place in 2015 and beyond. In addition, new factors will likely affect how issuers, employers, and consumers interact with SHOP exchanges going forward.

Internal Factors

It is expected that some currently delayed features of SHOP exchanges will be implemented in 2015 and in future years. For example, as discussed in this report, there are indications that SHOP exchange websites will generally be more functional going forward. HHS has indicated that on-line enrollment will be available in all FF-SHOPs in 2015. Also, the employee choice function is to be implemented in some FF-SHOPs in 2015 and is expected to be implemented in all SHOP exchanges in 2016 and beyond. The availability of these features may attract greater SHOP participation from employers and issuers.

In 2016, the definition of *small* changes for purposes of the small group market and SHOP exchange eligibility. Beginning in 2016, a *small* employer is defined as having 100 or fewer employees.[50] Larger firms (those with between 50 and 100 employees) are generally more likely to provide coverage than smaller firms; as such, the definition change may increase enrollment in SHOP exchanges (provided the larger employers decide to purchase coverage through SHOP exchanges). The change in the definition coincides with implementation of the employer penalty on employers with 50-99 employees; this could further incentivize these employers to provide coverage (although not necessarily through a SHOP exchange). In 2017, states have the option to open the SHOP exchange to large employers, which could also change employer and issuer participation patterns in SHOP exchanges.

External Factors

At the same time the SHOP exchanges change internally, the broader health insurance market will evolve as ACA-related changes continue to occur in the market. By the end of 2014, any coverage that was renewed early will have expired, and small employers will have to obtain ACA-compliant coverage for plan year 2015 if they want to continue to offer coverage. Also, the transitional policy may expire or be extended (depending on decisions made by state insurance commissioners), which will affect whether small employers have to offer ACA-compliant coverage.

It is difficult to say how SHOP exchanges changes coupled with the potential requirement to provide ACA-compliant coverage will affect participation in SHOP exchanges. CRS is not aware

[49] In 2015, the penalty will be assessed only on employers with 100 or more FTE employees. Application of the penalty to employers with 50-99 FTE employees is not effective until 2016.

[50] States have the option to use this definition prior to 2016, but as noted earlier, all states are using the 50-employee threshold in 2014.

of data that estimate the number of small employers that early renewed or opted for the transitional policy and therefore may need to purchase ACA-compliant coverage in 2015 or later years. It is also difficult to predict whether the requirement to offer ACA-compliant coverage will incentivize small employers to stop offering coverage or to continue offering coverage. If small employers continue to offer coverage, does the increased functionality of the SHOP exchanges incentivize them to offer through the SHOP, or would they obtain coverage outside the SHOP exchanges?

Appendix. Employer Contributions to FF-SHOP Exchange Coverage

This appendix explains the methods an employer purchasing coverage through an FF-SHOP exchange may use to determine its contributions toward employees' and their dependents' health insurance premiums.[51] **Table A-1** illustrates how an employer's contributions to health insurance coverage obtained through an FF-SHOP in 2014 may be determined. For the purposes of the example, the employer offers coverage to all of its employees and their dependents, and none of the employees or the dependents use tobacco products. Because this example is in the context of an FF-SHOP in 2014, and employee choice is not allowed in FF-SHOPs in 2014, the employer may select only one QHP to offer to its employees.

In the example in **Table A-1**, an issuer provides an employer with per-member premiums based on the base rate of the reference plan selected by the employer and the age of all enrollees (column D multiplied by column C to obtain the per-member premiums in column E). According to regulations, either state law or the employer may require that the FF-SHOP base the employer's contributions on separately calculated composite premiums rather than the per-member premiums;[52] however, HHS has indicated that FF-SHOPs are able to accommodate composite ratings for employees only.[53] Provided composite premiums are used for employees only, the resulting employer contribution toward each enrollee's coverage is determined by multiplying the employer contribution percentage (column G) by the composite premiums for employees (column F) or the per-member premiums for dependents (column E). The employer then pays the resulting contribution (columns H, I) toward each enrollee's premium.

Table A-2 illustrates how an employer's contributions to health insurance coverage obtained through an FF-SHOP that allows employee choice in 2015 may be determined. As in the previous example, the employer offers coverage to all of its employees and their dependents, and none of the employees or the dependents use tobacco products. Because this scenario takes place in an FF-SHOP that allows employee choice in 2015, the employer can select more than one QHP to offer to its employees.

In the example in **Table A-2**, the employer selects one plan to serve as the reference plan on which contributions are based (but employees will have the option to select other plans according to the FF-SHOP's particular employee choice arrangement). As in the 2014 example, regulations provide that either state law or the employer may require that the FF-SHOP base contributions on separately calculated composite premiums, but HHS has indicated that FF-SHOPs are able to accommodate composite ratings for employees only (column G). However, different from 2014, an FF-SHOP may permit employers to define different contribution percentages for different employees (full-time and part-time) and their dependents (columns H, I). Provided the composite premiums for employees and per-member premiums for dependents are used, the resulting employer contribution toward each enrollee's coverage is determined by multiplying the

[51] These methods are also briefly described in the "Methods for Determining Employer Contributions to Premiums" section of this report.

[52] For definitions of per-member and composite premiums, see the "Premiums Charged by Health Insurance Issuers" section of this report.

[53] Centers for Medicare and Medicaid Services (CMS), *Federally-facilitated Marketplace for SHOP: Frequently Asked Questions*, October 2, 2013.

applicable employer contribution percentage by the applicable premiums. The employer then pays the resulting contribution (columns J, K) toward each enrollee's premium for the QHP selected by the enrollee.

Table A-1. Illustrative Example for Health Insurance Coverage Obtained Through an FF-SHOP in 2014

A	B	C	D	E	F	G	H	I
Enrollee Information			**Reference Plan Information—Annual**				**Resulting Employer Contributions—Annual**	
Enrollee	**Age**	**Age Rating Factor[a]**	**Base Rate[b]**	**Per-Member Premium[c]**	**Composite Premium for Employees[d]**	**Employer Contribution Percentage**	**Employees**	**Dependents**
Employee 1	44	1.397	$5,500	$7,684	$8,485	60%	$5,091	
Dependent A	45	1.444	$5,500	$7,942		60%		$4,765
Dependent B	13	0.635	$5,500	$3,493		60%		$2,096
Dependent C	11	0.635	$5,500	$3,493		60%		$2,096
Employee 2	35	1.222	$5,500	$6,721	$8,485	60%	$5,091	
Employee 3	26	1.024	$5,500	$5,632	$8,485	60%	$5,091	
Dependent D	27	1.048	$5,500	$5,764		60%		$3,458
Employee 4	33	1.198	$5,500	$6,589	$8,485	60%	$5,091	
Dependent E	31	1.159	$5,500	$6,375		60%		$3,825
Dependent F	1	0.635	$5,500	$3,493		60%		$2,096
Employee 5	62	2.873	$5,500	$15,802	$8,485	60%	$5,091	

Notes: This table shows the resulting employer contributions toward employees' and dependents' premiums based on the contribution methods allowed in an FF-SHOP in 2014. In 2014, employers may develop composite premiums for employees only (not dependents), and employers are not allowed to vary contribution amounts based on the status of the enrollee (i.e., whether the enrollee is a full-time or part-time employee, or whether the enrollee is a dependent).

Dollar amounts are rounded to the nearest dollar.

a. Based on the federally established age curve created for the purpose of implementing ACA's rating restrictions. Some states opted to establish their own age curves and may have different rating factors for the ages shown in the table. For more information about state-specific age curves, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-08-09-2013.pdf.

b. For purposes of this example, the rate, which refers to the price of the unit of insurance, is already adjusted by the geographic rating factor as allowed under ACA rating restrictions.

c. The per-member premium is calculated by multiplying the health plan's base rate by any allowable rating factors (for purposes of this table, the only allowable rating factor is the individual's age). In other words, (column C x column D) = column E.

d. The composite premium for employees is calculated by summing the per-member ratings for each employee and dividing the total by the total number of employees.

Table A-2. Illustrative Example for Health Insurance Coverage Obtained Through an FF-SHOP that Allows Employee Choice in 2015

A	B	C	D	E	F	G	H	I	J	K
Enrollee Information				Reference Plan Information[a]—Annual			Employer Contribution Percentage		Resulting Employer Contributions—Annual	
Enrollee	Status	Age	Age Rating Factor[b]	Base Rate[c]	Per-Member Premium[d]	Composite Premium for Employees[e]	Full-time	Part-time	Employees	Dependents
Employee 1	Full-time	44	1.397	$5,500	$7,684	$8,485	60%		$5,091	
Dependent A		45	1.444	$5,500	$7,942		60%			$4,765
Dependent B		13	0.635	$5,500	$3,493		60%			$2,096
Dependent C		11	0.635	$5,500	$3,493		60%			$2,096
Employee 2	Full-time	35	1.222	$5,500	$6,721	$8,485	60%		$5,091	
Employee 3	Full-time	26	1.024	$5,500	$5,632	$8,485	60%		$5,091	
Dependent D		27	1.048	$5,500	$5,764		60%			$3,458
Employee 4	Part-time	33	1.198	$5,500	$6,589	$8,485		55%	$4,667	
Dependent E		31	1.159	$5,500	$6,375			55%		$3,506
Dependent F		1	0.635	$5,500	$3,493			55%		$1,921
Employee 5	Full-time	62	2.873	$5,500	$15,802	$8,485	60%		$5,091	

Notes: This table shows the resulting employer contributions toward employees' and dependents' premiums based on the contribution methods allowed in an FF-SHOP in 2015 (columns J and K). In 2015, employers may develop composite premiums for employees, but HHS has not yet indicated whether employers will be able to develop composite ratings for dependents (The table does not include composite premiums for dependents). In 2015, employers may vary contribution amounts based on the status of the enrollee (e.g., whether the enrollee is a full-time or part-time employee).

Dollar amounts are rounded to the nearest dollar.

a. In this example, the FF-SHOP allows employee choice. This means employees have a variety of plans in which they may choose to enroll. However, an employer's contributions toward employees' premiums are not based on each plan selected by an employee. Instead, an employer's contributions are based on one reference plan selected by the employer.

b. Based on the federally established age curve created for the purpose of implementing ACA's rating restrictions. Some states opted to establish their own age curves and may have different rating factors for the ages shown in the table. For more information about state-specific age curves, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-08-09-2013.pdf.

c. For purposes of this example, the rate, which refers to the price of the unit of insurance, is already adjusted by the geographic rating factor as allowed under ACA rating restrictions.

d. The per-member premium is calculated by multiplying the health plan's base rate by any allowable rating factors (for purposes of this table, the only allowable rating factor is the individual's age). In other words, (column D x column E) = column F.

e. The composite premium for employees is calculated by summing the per-member ratings for each employee and dividing the total by the total number of employees.

Author Contact Information

(name redacted)
Analyst in Health Care Financing
/redacted/@crs.loc.gov, 7-....