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Wakely
Consulting Group

# Operational Guide for Vermont's Small Business Exchange

## Wakely Consulting Group

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## Executive Summary

Administrative Functions

We have identified six major sets of functions that the Vermont exchange will need to deliver. They are: on-line shopping and initial application (employer and employees); eligibility and verification; enrollment; premium billing and collections; broker election, management and compensation; and appeals.

In our assessment of these key functions, Wakely tried to identify all required functions as well as some optional administrative features not necessarily required by federal regulation. We recognize that just doing the minimum required to launch the exchange for 2014 will be a challenge, so we prioritize below a few of the most important optional features identified in Section I for consideration, in order to make the exchange relatively easy for employers, employees and brokers to use.

1. Provide multiple methods for an employer or broker to build an employee roster in the exchange (including uploading a file) to make this task as easy as possible.

2. Provide the capability for small, low-wage paying employers and their brokers to "preview" small business tax credit eligibility, use a tax credit calculator to illustrate the employer's net premium contribution, and provide the tax filing forms required to do so; in addition, the exchange should consider promoting a list of brokers and tax accountants who have experience filling out these forms for qualifying small employers and are committed to doing so.

3. Provide the capability for an employer or broker to generate a packet of information to distribute to the employees on the employee choice model that the employer has selected, and how employees can compare and select a QHP.

4. Include a provider search function (hospital, doctor and MH/SA providers), which will facilitate plan comparisons.

5. Provide as much online support to brokers as possible, to make it easy for them to use the exchange, e.g.: provide marketing/sales materials and FAQs to brokers via a self-service portal; and calculate broker compensation for the employer who opts to pay a broker.

Models of Employee Choice

A "gating" decision for Vermont's exchange is what degree of *employee* choice to offer to small employers in the exchange. The exchange may offer qualified small employers and their employees a choice of qualified health plans arrayed on four tiers of actuarial value ("AV"), ranging from 60% to 90%. Issuers on the exchange must offer Silver (70% AV) and Gold (80% AV), and may offer Bronze (60% AV) and Platinum (90% AV) as well. Catastrophic coverage will not be available as an option under group insurance to small employers.

How these plans are designed, and what model(s) of employee choice the exchange offers to small employers -- and through them, to their employees -- is largely at the state's discretion. We explore four models of employee choice in this guide. So long as Vermont requires pure community rating across the small-group market in 2014, the exchange will be able to offer any of these employee-choice models without either needing to switch to "list billing" or developing new, complex rating methodologies to allocate premiums between carriers.

MODEL I: Choice within an Issuer, Across Actuarial Tiers

A choice of multiple QHPs at different actuarial levels, from just one issuer selected by the employer, to which the employer must make the same minimum contribution required by that carrier of small employers in the outside market for a similar choice of health plans;

MODEL II: Choice within an Actuarial Tier (required by CCIIO)

A choice of QHPs from all issuers at the actuarial value selected by the employer, with a requirement that employers make a minimum contribution toward a "benchmark" plan (e.g. 50% of premium for single coverage);

MODEL III: Full Employee Choice, Across Issuers and Tiers

A choice of multiple QHPs and issuers at different actuarial values, subject to the employer's ability to select the actuarial levels to be made available to his/her employees, and a requirement that the employer make a minimum contribution toward coverage for a benchmark plan; and

MODEL IV: Single Issuer and Product (prevailing in current market)

One group health plan selected by the employer.

Model I is increasingly being offered by insurers across the country as a choice of health plans from a single carrier. This approach does provide meaningful choice, it eliminates inter-carrier risk selection, and it allows a single carrier to "own" responsibility for servicing the entire group. However, carriers typically offer a circumscribed package of options for a group, to minimize adverse selection. Similarly, if the Small Business exchange does offer QHPs on all four actuarial levels, it might consider restricting employees' choice to a subset of QHPs from one issuer.

Model II is required by CCIIO. That is, the exchange *must* make this model available to employers. While this model is far from pure "defined contribution," it offers several appealing features. First, this model does offer employees more choice than is conventionally offered by small employers. Second, adverse selection in this model should generate very little, if any, upward pressure on premiums, while claims-based risk adjustment will partially correct for inter-carrier adverse selection.

Model III, the "full menu" of employee choice among all QHPs, comes closest to the preference expressed by many employers to provide a defined contribution and let their employees select and relate directly to the health plan of their choice. This model also facilitates portability of coverage between small-group and non-group coverage.

One problem with the full menu model is that one carrier may receive a disproportionate share of risk relative to another carrier. This problem should be partially mitigated by risk adjustment under the ACA.

A second problem is the premium-increasing impact of risk selection when enrollees can choose the richness of coverage. (This problem applies as well to the model of employee choice within a single carrier.) It can be mitigated by constraining employee choice among QHPs and actuarial tiers and/or setting a relatively high minimum employer contribution. Wakely estimates that the range of premium impact from adverse selection under a "full menu" of choice can be reduced from about 9% to 6% by increasing the minimum employer contribution from 50% of Bronze to 80%, and it can be reduced to 2% with a minimum employer contribution of 90% toward Bronze.

A third issue is the confusion that can result from a welter of choices. The literature on consumer choice and the experience in Massachusetts suggest that the problem is real. (The same argument applies to the individual exchange.) However, if only two issuers participate in Vermont, there may be considerably less choice and confusion than in other states. The exchange could further reduce confusion by standardizing QHP designs and/or limiting the number of QHPs and actuarial tiers from which employees can select.

Because Model IV offers employees no choice among different health plans, arguably it does not fit the exchange model, nor does it respond to employer and employee preferences for choice. However, just because employers and employees are accustomed to this model, and it is simpler to administer than employee choice, it may retain considerable appeal.

## How Many QHPs and Which Cost-Sharing Designs Should Issuers Offer?

The number of distinct plan designs at each actuarial level should take into account how much meaningful choice is possible. Because there is relatively little cost-sharing at Gold and Platinum, one or (at most) two plan designs may ultimately suffice, even if more

options are allowed initially to accommodate the transition from existing market-based preferences. At the Bronze and Silver levels, where there is more "room" for variation in cost-sharing, the exchange could "stake-out" the extremes in its standardized plan designs, as described above, plus an "in-between" cost-sharing formula. This would offer employers and employees eight or nine plan designs across the two carriers and the four actuarial values, plus a catastrophic plan design for eligible individuals.

| Actuarial level/Issuer | Number of BCBSVT QHPs | Number of MVP QHPs |
|---|---|---|
| Platinum | 1 | 1 |
| Gold | 1 - 2 | 1 - 2 |
| Silver | 3 | 3 |
| Bronze | 3 | 3 |

Vermont could request of each carrier its "market-leading" designs at each actuarial level i.e., the largest or fastest growing small-group designs, updated to cover all EHBs and comport with the prescribed actuarial values. (Some exchanges will offer different QHPs from the same carriers to individuals and small groups. If Vermont prefers to offer the same set of QHPs to both segments, in order to simplify QHP certification and increase portability, then using current market volume as a criterion in selecting QHPs should include both non-group and small-group enrollment.)

Alternatively, Vermont might use the key cost-sharing features of the most popular one or two small-group plans on each AV level to align benefit designs across the issuers i.e., the same cost-sharing across issuers for deductible, maximum out-of-pocket, inpatient, day-surgery, ER, office visits, and Rx. This sort of benefit alignment would facilitate employee comparison shopping across carriers on other variables, including price, network and service. However, designing cost-sharing is a task that carriers are far more familiar with than government, and prescribing cost-sharing, even if based on "popular" designs, may discourage innovation.

A hybrid approach is also feasible i.e., a mix of standardized and unique benefit designs. By requiring one standardized design per actuarial tier, the exchange could offer employees the choice to view this apples-to-apples comparison in order to simplify shopping on a single tier; and employees who prefer to see all QHPs on a tier could view those as well. Moreover, the exchange could simplify its "full menu" offering by showing only these standard designs.

## How Can Vermont Maximize Tax Advantages for Employers & Employees?

Promote the Small Business Tax Credit: The small business tax credit, which in 2014 will increase from current levels and be available exclusively for group insurance purchased by small employers on the exchange, can be promoted by Vermont as a way for small employers to save money. However, given the relatively small number of firms in Vermont

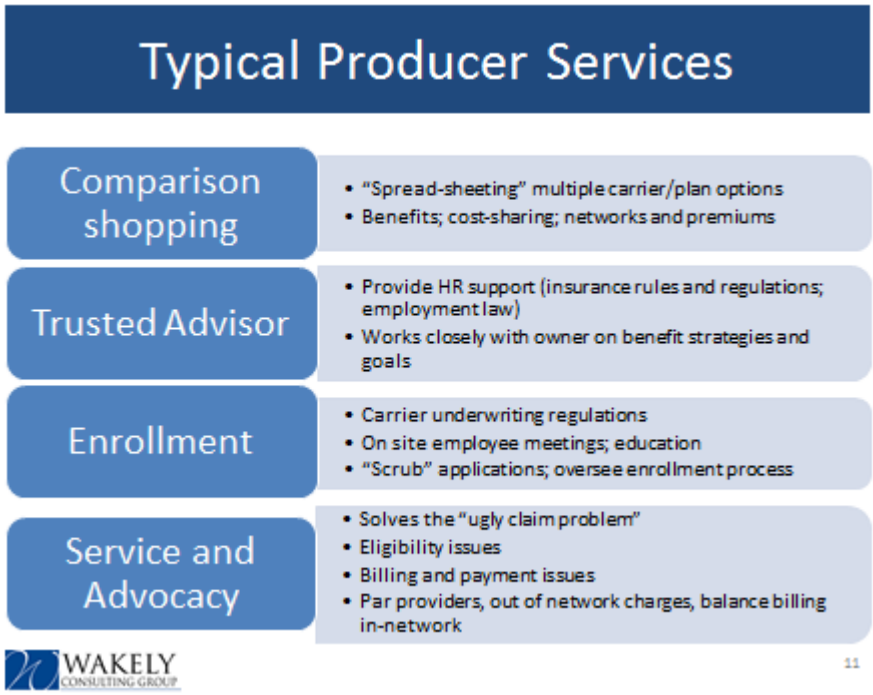
that Wakely projects would qualify for the full tax credit, the relatively small credit available once a firm exceeds the thresholds of 10 FTEs or $25,000 in average wages, and the difficulties experienced to date by small employers in filing tax forms, it may not behoove the exchange to promote these savings aggressively.

Promote the Employer-sponsored Insurance (ESI) Affordability Screen: The ESI affordability test can save employees and small employers (<50 FTEs) premium dollars. It can also reduce out-of-pocket spending for employees who qualify for Medicaid or cost-sharing reduction (CSR) subsidies in the exchange. Because the exchange will handle only small employers in 2014 and 2015 (≤ 50 'ees) -- who are not subject to mandates and penalties -- the affordability test benefits both employer and employees. As a subset of these small employers will also qualify for the small business tax credit, the exchange can serve its mission, fulfill the requirements of the ACA, and target a particularly vulnerable niche of the small-group market by promoting the availability of employer and the individual tax credits through the exchange.

The Non-Group Exchange as Vehicle for Defined Contribution: For employers looking to make a pre-tax contribution toward subsidizing their employees' purchase of individual coverage, a Health Reimbursement Arrangement (HRA) might be used to promote pure "defined contribution." The HRA is a flexible vehicle for employers to reimburse employees' medical expenses, including insurance premiums. If the exchange were to arrange for an easy, routine transfer of payments on behalf of employees toward non-group premiums, this would free employers from the burden of picking a plan, explaining it to employees, and getting involved in coverage issues. However, there is considerable uncertainty regarding IRS policy on this, and further guidance is expected.

## How Should the Exchange Work with Brokers?

Brokers typically provide the following kinds of services to employers:




As of 2014, carriers will no longer pay brokers in the small-group market, but employers may decide to do so. Especially in 2014, with all the changes wrought by the ACA, small employers will need the advice and expertise of brokers to make a smooth transition into Vermont's exchange.

The exchange can make it easier and more effective for employers to engage brokers. First, if the small employer decides to engage a broker, some sort of agreement as to what services the employer has purchased, and what services are outside that relationship may be advisable. Second, the exchange can facilitate the selection of a broker by posting their information and informing employers of the option. Third, the exchange can also handle collection and payment of broker fees, by adding this as a separate item on the employer's monthly invoice and remitting fees paid to the brokers. Finally, the exchange can determine the optimal fee level that attracts brokers and yet encourages the greatest number of small employers to retain a broker.

Wakely suggests three options for establishing broker fees in the exchange: (1) simply adopt the average prevailing market rates, approximately 3.5 to 4 percent of premiums; (2) set a somewhat reduced fee to reflect migration of some of the function that brokers currently perform into the exchange; or (3) ask brokers to bid and select a cut-off point that accommodates most or many brokers.

## A Role for Associations in the Exchange?

Given that most small employers in Vermont currently buy group coverage through an association, we describe the role of such associations and consider how they might work with Vermont's exchange. One point of cooperation, if the associations are willing to play this role, is as Navigators to explain national reform and promote the exchange to constituent employers. Another would be for the exchange to outsource transactional operations and customer service functions which intermediaries already perform, through an RFP process to which some of Vermont's business associations may wish to respond.

The advantages of doing so include: (1) the potential speed and efficiency of adapting existing functionality, rather than building it anew; (2) leveraging the market knowledge, influence and experience of an existing intermediary, including the trust that their client brokers and employers already have in them; and (3) employing a Vermont business organization (and its employees) as part of the universal exchange. The most obvious disadvantage of outsourcing would be the need to integrate operations for employers with those for direct purchasers in the exchange.

## Call Center

This section provides some guidelines and advice on Call Center availability, the hub of customer service, and IT support for the Call Center, plus the following specific recommendations:

1. The Call Center should make it easy for employers to engage a broker, even encourage this practice, particularly in the first year of exchange operations.
2. The exchange should consider subsidizing the cost of utilizing brokers in the first year of operation to encourage more employers to hire this specialized assistance.
3. If not outsourced, create a dedicated unit of customer service representatives in the Call Center who have experience working with employer groups and who will need to be compensated appropriately.
4. Have the employer identify employees who will not have access to web site for enrollment, for whom the exchange should provide a package of printed materials that the employee can have in front of them when they contact the Call Center for assistance.
5. The broker portal should allow certified brokers with a "broker of record" letter for a given employer group to view virtually any information the exchange is maintaining on that employer group.
6. The Call Center must provide experienced, highly specialized service support to brokers, and preferably, dedicated support to each broker certified by the exchange.
7. Call Center services should be outsourced for 95% or more of expected volume and a very small, in-house unit might be put in place to address "exception" or highly escalated issues.

How to Ease the Transition in 2014?

Given the substantial volume of small employers who may enroll in the exchange for January 1, 2014, the transition challenge should not be under-estimated. The following steps could help reduce disruption:

1. Consider offering plan designs that mirror popular (high-enrollment) plans in the pre-2014 market, in order to minimize the amount of required "change" and benefits disruption.
2. Consider offering a limited number of existing HDHP plan designs on the Bronze and Silver levels with deductibles that exceed the $2,000/$4,000 limits, but meet these actuarial levels with the appropriate HSA or HRA employer contributions.
3. Consider working with the two carriers in Vermont's small-group market today to map pre-2014 plans to the closest options in the exchange.
4. For existing groups switching into the exchange, consider pre-populating the exchange's enrollment system with existing enrollee data from carriers.
5. Consider the advantages and challenges of staggering renewal dates for small employers in order to avoid stressing all resources with a January 1st enrollment date.
6. Consider beginning to educating employers, brokers and the public as soon as possible on how the exchange will work and what they can expect in 2014.
7. Consider initiating regular forums to share detailed operational information, ideas and questions with carriers and brokers, two of the stakeholders that will inevitably help shape the success of the exchange.

## Section I: Administrative Functions for Small Businesses

The Vermont exchange must develop and execute as smoothly as possible the administrative functions needed to sell insurance to small businesses and enroll employees into plans. Interviews conducted in May 2012 with fifty small Vermont employers found that a majority are skeptical at best over the requirement to use the exchange for employer-sponsored insurance. The employers who either view this requirement as somewhat (28%) or very negative (35%) will likely need to experience a well-run exchange in order to overcome their hesitation.
In this section, we detail the six key functions that the exchange will need to deliver. They are:

- on-line shopping and initial application (employer and employees);
- eligibility and verification;
- enrollment;
- premium billing and collections;
- broker election, management and compensation; and
- appeals.

Many functions, such as those related to plan management, financial management, marketing and outreach, are common to both the individual and the small business exchange, although some may be carried out quite differently for small businesses than for individual purchasers. We focus here on functions that are specific or particularly relevant to the needs of the small business side of the exchange. In some places, we have also included functions and features that we think would be desirable, though not strictly necessary at start up.

### 1. Shopping experience and application

Vermont will have one exchange and a merged non-group and small-group market, but it must support certain functions for employers and employees that do not pertain to individuals buying direct on the exchange. For ease of distinguishing the functions that are appropriate to serve small employers from those for individuals buying direct, we use the term "small business exchange." Like the individual exchange, the small business exchange will have a website which will be a key source for information as well as the main point of entry for most purchasers. Unlike the individual exchange, however, the small business website must accommodate the needs of both employers and employees. While the website should allow both employers and employees to browse and obtain general information, the application process itself will need to be two-phased: the employer (or a broker on his/her behalf) must first complete an application and submit the group's employee census information before his/her employees can select their plan(s) and enroll.

Two visio diagrams are provided at the end of this section; one covers the employer set up work flow, which must (under federal regulations) be made available as early as 90 days

prior to the effective date, and the second overviews the employee shopping process. Under federal regulations, it appears that employees must have 30 days to enroll, which requires that employer shopping cease and employee shopping begin no later than approximately 38 days prior to the effective date, so that employees can complete their 30-day shopping period by about eight days prior to the effective date. (Section 155.725(e) Annual employee open enrollment period.)

However, another state recently raised this issue with CCIIO, and was told that this requirement applies only to renewals and could be operationalized "flexibly." Wakely suggests that Vermont raise this issue and get confirmation from CCIIO. Otherwise, it will be critical to educate small employers on the need for additional lead time to allow for employee shopping. Both documents provide additional detail on how the exchange, carriers and employers/employees interact, including this 30-day interval for employee shopping.

For the application process, the Department of Health and Human Services (HHS) will develop model employer and employee application forms that the small business exchange may use. These are not yet available. The small business exchange may use an alternative application form if it collects the required information and has been approved by HHS. HHS requires that the small business exchange must use a single application to determine employer eligibility (§155.730). The application must collect the following information:

- Employer name and address of employer's location(s)
- Number of employees
- Employer Identification Number (EIN)
- A list of qualified employees and their tax identification numbers

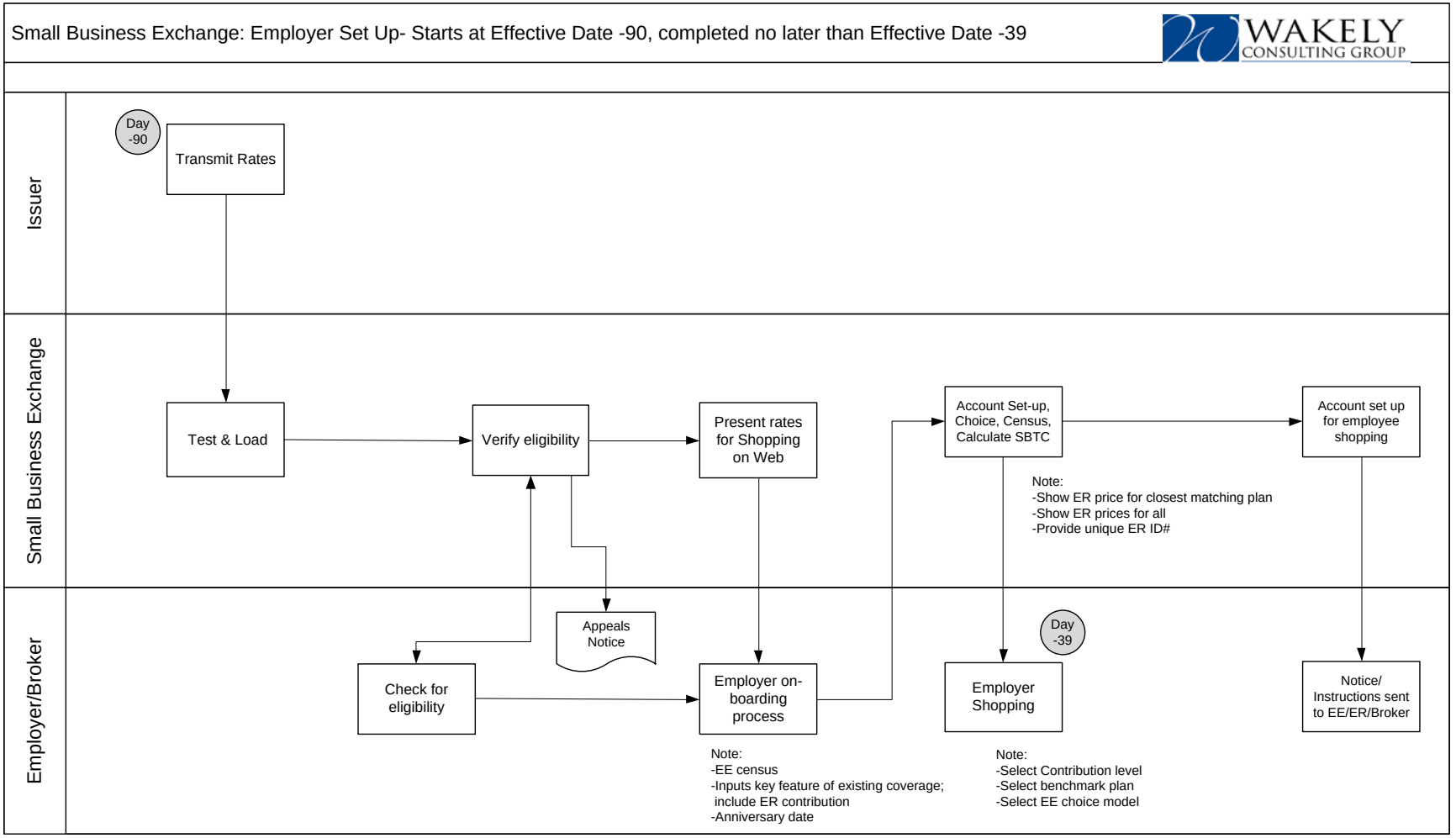
The small business exchange must use a single employee application form for eligibility determination, selection of a qualified health plan (QHP), and plan enrollment. Information collected must be sufficient to establish eligibility and complete enrollment (e.g., plan selection information and identification of dependents).

Federal regulations state that employer and employee applications may be submitted via the internet, by phone, by mail, or in person, and therefore the small business exchange will need to accommodate all of these communication channels.

| **Employer shopping experience and application *(italicized elements denote additional features that would be desirable):*** |
|---|
| Provide a single, online employer application |
| *Provide field level help for each application data element* |
| *Provide access to in-depth on-line help as well as chat support* |
| *Provide decision support tools to help and educate employers on services provided in the exchange* |
| *Provide capability to request further assistance from customer service representatives during preliminary questionnaire* |
| *Provide multiple methods for an employer to build an employee roster (manual entry, file upload)* |
| Provide capability to accept paper documents from small businesses, such as employer/employee applications and verifications |
| Allow verified individuals to complete or update employer application on behalf of the employer (i.e., administration or finance department staff, assister, or broker of record) |
| Prompt employer to enter business name associated with the EIN |
| *Include an option for employers without an EIN to proceed with the application process; allow for suspension of eligibility if EIN remains unverified* |
| Make employers aware of the availability of brokers certified by the exchange who are available to help the employer use the exchange |
| Advise employers of the added cost of using a broker (i.e., cost is not part of the premium) |
| Confirm (when applicable) employer's selection of a broker and intent to pay the additional fee/commission |
| Be able to differentiate/track full-time versus part-time/hourly employees in the employee roster |
| Validate field-level information for correct data format and completeness |
| Conduct validation of mailing addresses provided in application |
| Provide capability to create a single client identifier for each employer |
| *Return user to the last screen they were working on when they log back in* |
| Prior to creating a new employer account, determine whether there is an existing user account present based on matching criteria provided in the application (i.e., EIN, name) |
| Provide capability to validate employee identification information submitted through the employer application |
| Generate a request to initiate the employer selection of qualified health plan(s) during the application process |
| Display plan cost and availability based on initial questionnaire completed by the employer |
| Provide capability to display a detailed quality and cost comparison of available plans |
| Allow employers to select plans/tier and initiate the participation process |
| Allow employer to enter contribution amounts, test different contribution levels and percentages, by rating tier, against different QHPs |

| **Employer shopping experience and application *(italicized elements denote additional features that would be desirable):*** |
|---|
| Provide information to employers about the small business tax credit, including form and (high-level) filing instructions |
| *Provide a tax credit calculator to illustrate employer's net premium contribution* |
| Update employer's account to reflect plan selection and effective plan year |
| *Provide capability for employer to generate a packet of information to distribute to the employee* |
| Upon submittal of employer application, provide notification to employees to elect or opt-out of employer sponsored coverage |
| Provide instructions about open enrollment period and small business website/customer assistance |

| **Employee shopping experience and application (additional functions discussed in section on enrollment):** |
|---|
| Produce notification to employee to initiate employee selection of qualified health plan (QHP) |
| Create user name and password for each employee listed on employee roster |
| Allow user to define a password |
| *Provide field level help for each application data element* |
| *Provide access to in-depth on-line help as well as chat support* |
| Each account should include unique identifier, demographic information, application status, participation status, existing program eligibility |
| Single identity management for each consumer involved with the individual exchange: the small business exchange should integrate with this identity management service |
| Allow employee to enter information about employee dependents, if employer elects to include dependent coverage |

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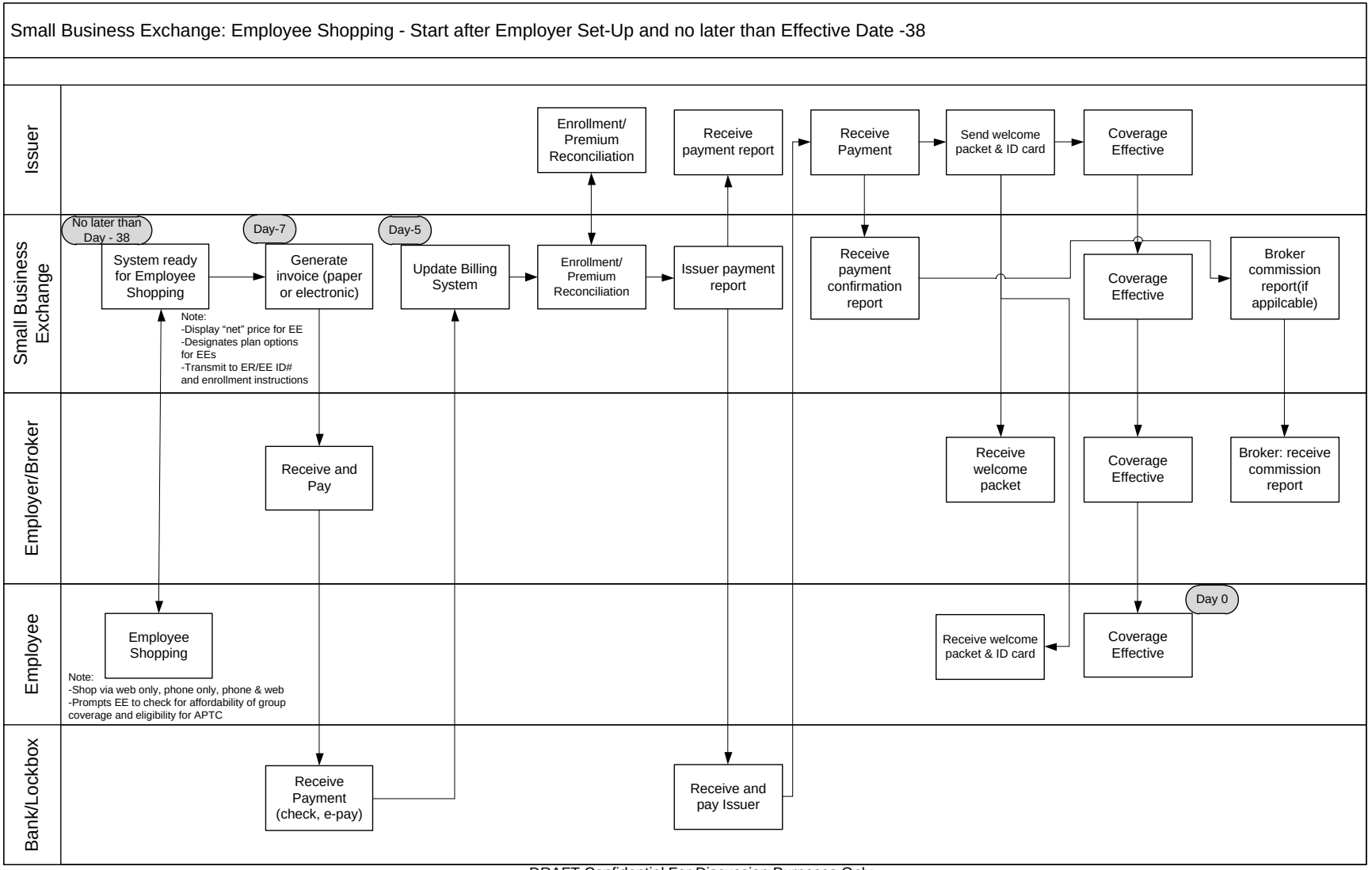


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### 2. Eligibility and verification

Vermont is taking a single integrated eligibility approach to determine eligibility for individuals, families, and small employers/employees. Small business eligibility and verification will use this shared technology approach which also supports eligibility determination for Medicaid and individuals.

To purchase coverage for employees through the small business exchange, employers must meet the following criteria:

- Be a small employer (defined as having 50 or fewer employees in Vermont)
- At a minimum, offer all full-time employees coverage in a qualified health plan through the small business exchange
- Either have its principal business address in the exchange service area and offer coverage to all its employees through that small business exchange, or offer coverage to each eligible employee through the small business exchange serving that employee's primary worksite

If an employer purchasing through the small business exchange increases the number of employees beyond the definition of a small group, they must be allowed to continue small business participation, unless they elect to discontinue or become ineligible for another reason.

The small business exchange must develop a process to determine the eligibility of employers and employees to purchase coverage through the exchange, including the acceptance and review of employer and employee application forms. The regulations indicate that employer eligibility could be based on self-attestation of employer size and of offer of coverage to all full-time employees. The small business exchange must provide notice of approval or denial of eligibility to employers and employees and must inform employers and employees of their right to appeal such determination.

The small business exchange must verify that individual applicants are identified by the employer as employees that have been offered coverage. The small business exchange may choose to establish additional methods to verify the information provided by individual applicants.

If the small business exchange doubts the veracity of information on either the employer or employee application, it must inform the applicant employer or individual and allow 30 days for the provision of additional information. If satisfactory documentation is not received, the small business exchange may deny eligibility and provide notice to either the employer or employee. If enrollment pending verification took place, the small business exchange may discontinue coverage at the end of the month following the month in which notice was provided.

| Eligibility and verification |
| --- |
| Provide capability to generate request to sources of information to verify employer size, business address/worksite (possible source documents might include State Directory of New Hires or the State quarterly wage database) |
| Provide capability to initiate a manual verification process |
| Provide document imaging capabilities |
| Create document repository accessible to exchange staff |
| Track status of employer verification |
| Produce mailed, written notice to employer and broker to provide additional verification |
| Provide on-screen notification to employer and broker to provide additional verification |
| Provide capability to allow employer participation upon initial application, but to terminate participation if original eligibility information is in question and is not verified within 30 days |

### 3. Enrollment

The enrollment process for the small business exchange is more complex than that of the individual exchange. The small business exchange by definition must accommodate employer groups, as well as special requirements related to enrollment periods. We first discuss general enrollment processes, then special enrollments and employer and employee termination functions.

General Enrollment

The small business exchange must process the applications of qualified employees to the applicable QHP issuers and facilitate the enrollment of qualified employees in QHPs. The small business exchange must establish a uniform enrollment timeline and ensure that the following activities occur before the effective date of coverage for qualified employees:

- Determination of employer eligibility
- Employer selection of health plan
- Provision of a specific timeframe during which the employer can select the level of coverage or health plan offering, as appropriate
- Provision of a specific timeframe for qualified employees to provide relevant information to complete the application process
- Determination and verification of employee eligibility for enrollment through the exchange
- Processing enrollment of qualified employees into selected health plan
- Establishment of effective dates of employee coverage

The small business exchange will also need to provide quoting and rating functions and must require all health plan issuers to make any change to rates at a uniform time, whether that is quarterly or monthly. Rates for qualified employers may not vary during the employer's plan year.

The exchange must adhere to the initial open enrollment period (October 1, 2013 through March 31, 2014), ensure that enrollment transactions are sent to health plan issuers in a timely way, and ensure that issuers adhere to required coverage effective dates. Unlike individuals seeking to purchase insurance through the individual exchange, employers may elect to purchase coverage at any point during the calendar year. The employer's plan year must consist of the 12-month period beginning with the employer's effective date of coverage.

To enroll employees, the exchange must ensure employees are notified of the effective date of coverage and transmit enrollment information on behalf of employees to health plan issuers within the established timeline for employee selection.

The exchange must reconcile enrollment information and employer participation information with health plan issuers at least monthly.

| General enrollment process |
|---|
| Display plan cost and availability, taking into account the employer contribution |
| Display only plans that have been selected by the employer, are open to additional enrollment, and are available in the employee's geographic area |
| Allow employers to use wage information to compare coverage options to alternatives available to their employees in the individual exchange. |
| Allow employees to assess affordability of the employer coverage options, and navigate to individual coverage options where appropriate. |
| Inform employees that may be eligible for subsidized coverage at a lower premium and allow for an individual eligibility determination. |
| Have capability to display a detailed comparison of available employer-selected plans based on employee preferences |
| Allow access to provider directory |
| *Include provider search function* |
| Provide decision support tools to assist employer with contribution strategy |
| Provide information about premium tax credits or exemption from the individual mandate; provide |

| General enrollment process |
| --- |
| link to individual exchange and/or other entry point to eligibility determination for Advance Payment Tax Credits (APTCs) |
| Update employee account to reflect plan selection and effective plan year |
| After plan selection, send enrollment information to carriers *(automated enrollment submissions processed upon receipt)* |
| After plan selection, send calculation of final cost to employee |
| Send automated confirmation of plan selection |
| Receive and maintain records of enrollment in QHPs |
| Reconcile information with QHPs at least monthly |
| Provide capability to make changes to employee contact information, report changes to issuers, and communicate with employee about changes |
| *Make self-service changes available via web-based portal or secure email, with real-time reconciliation of data with systems* |

Enrollment Changes (open enrollment, renewals, terminations)

Prior to the completion of the employer's plan year and before the annual employee open enrollment period, the small business exchange must provide an annual election period for *employers*. During this time, employers will have the opportunity to change their participation in the exchange for the next plan year. The exchange must provide employers with notification in advance of this period. Possible changes made during this period include:

- The employee choice model
- The employer premium contribution
- The level of coverage offered
- The plans offered

The small business exchange must also establish an annual open enrollment period for *employees* prior to the completion of the plan year. Employees hired outside of the initial or annual open enrollment periods must be allowed a specified period to seek coverage beginning on the first day of employment.

At open enrollment, employees will remain enrolled in their plan as long as they remain eligible, unless they disenroll or enroll in another qualified health plan, or if their current qualified health plan is no longer available.

Another distinctive feature for the small business exchange is management of qualifying events. Qualifying events are life event changes that affect a person's eligibility for coverage, and might include change in family size (such as marriage, divorce, or birth of a child), changes to employment status, and changes to access to other insurance coverage. A qualifying event would allow an employee to participate in a special enrollment period, outside of open enrollment. For example, if an employee gives birth to a child, the employee would have a chance to both add coverage for that dependent and select a difference health plan, rather than having to wait until the next annual enrollment period to make these changes.

The small business exchange must also be prepared to handle employer and employee withdrawal from the exchange, and under both voluntary and involuntary circumstances. If a qualified employer discontinues coverage through the exchange, the exchange must ensure that each health plan issuer terminates the coverage of the employer's qualified employees and ensure that the employees receive notification prior to termination. Similarly, if any employee terminates coverage from a health plan, the small business exchange must notify the individual's employer.

| **Enrollment changes (special enrollment, renewals, terminations)** |
|---|
| Generate notice to employers of annual election period |
| Allow employer to look up or reset login information |
| Track annual renewal date |
| Determine eligibility for renewal |
| *Provide capability to review small business tax credit eligibility* |
| *Calculate a year-to-date average for premiums paid, and (if eligible), calculate illustrative small business tax credit for the year* |
| Within the small business exchange, seamlessly transition participation and removal of participation between plans and programs as plan selection changes |
| Allow employee to look up or reset login information |
| Produce notification to employee of annual open enrollment |
| Produce notification to employees regarding the number of days left for open enrollment |
| Provide capability for employees to submit changes to key eligibility factors |
| Determine availability of employee's current plan for renewal |

| Enrollment changes (special enrollment, renewals, terminations) |
| --- |
| Allow employees to submit changes to plan participation, selected plans, covered dependents, on-line and paper forms |
| Report changes to health plan issuers |
| Notify employer of changes in coverage |
| Determine if an update to an employee account qualifies as a qualifying event |
| Allow employees to submit changes to employee plan, including add/remove dependents, due to qualifying events |
| If reported changes do not qualify an employee for a special enrollment, store the changes for use during the next available open enrollment period |
| Initiate enrollment or disenrollment process for the employee or employee's dependents, depending on the nature of the qualifying event |
| Prepare and send communication to the employee regarding changes to the employee's account due to a qualifying event |
| Ensure that monthly report/insurance bill to employer reflects changes due to employee's reporting of qualifying events |
| Provide the capability for an employer to request a voluntary termination from QHPs at any time |
| If an employer initiates a voluntary termination through the exchange, produce an electronic notification to the issuer to terminate the employer |
| If an employer initiates a voluntary termination, produce an electronic notification to the employer's employees to inform them of the termination |
| Provide capability to image and store documents sent to the employer regarding the employer's termination |
| Receive electronic notifications from issuer regarding involuntary terminations and initiate termination process |
| If involuntary termination initiated by the exchange, notify the issuer to terminate the employer |
| If involuntary termination, produce electronic notification to the employer to inform the employer of the termination |
| If termination, produce electronic notification to employees, with capability to differentiate between actual or potential termination |

| Enrollment changes (special enrollment, renewals, terminations) |
|---|
| Update user accounts based on termination notification |
| If an employee disenrolls through the exchange, produce an electronic notification to the employee's employer to inform them of the employee termination |
| If employee disenrolls through the exchange, notify issuer to terminate the employee |
| Inform disenrolled employees of option for extended medical benefits (e.g., COBRA, any applicable Vermont specific programs) and direct disenrolled employee to issuers for such coverage |
| Update user accounts |

### 4. Premium billing and collections

The small business exchange will play an important role in premium billing and collections. Because employees can have a choice of plans, this means that a given employer's employees may be enrolled with several different carriers. It would be impractical for the employer to pay bills from multiple carriers. Federal regulations require the small business exchange to provide employers with a single bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due. The exchange must collect payments from employers and distribute them to issuers.

| Premium billing and collections |
|---|
| Automated data exchange between enrollment and billing systems |
| Bill generation (paper and/or electronic) |
| Calculate employer premium |
| Generate cost of using a broker on the employer invoice when applicable |
| Provide pro-rated invoices for late adds/terminations |
| Provide simple, easy to understand invoice |
| Produce and send employer invoice. Invoice should include employer identifying information, monthly balance due and any outstanding premium payments due |
| Allow employer to flag concerns/discrepancy with bill and to initiate a discrepancy resolution process |
| Identify unpaid employer premiums, notify employers of payment discrepancies (either unpaid amounts or incorrect payment amounts), and produce report notification for employers. Update the |

| Premium billing and collections |
| --- |
| employer account (for an invoice discrepancy), or the employer may remit the premium payment (for a payment discrepancy) |
| Employer account support available via Call Center, email, *and live on-line chat* |
| Allow employers to make electronic payments (EFT *and credit card*) as well as payment by check |
| *Allow walk-in centers to accept payments* |
| Receive and process premium payments |
| Record receipt of payment in database |
| Allow employers and brokers/assisters to view and track the premium payment. |
| Suspense accounts cleared weekly |
| Bank lockbox activity transmitted daily |
| Daily sweep of lockbox into interest bearing account |
| Aggregate payments to issuers |
| If employee is enrolling through COBRA, the system must be able to determine if COBRA option exists for the employee and allow employee to select COBRA and make COBRA payments |
| Delinquent accounts identified upon each payment due date |
| Collections efforts tracked in premium billing system |
| Immediate outstanding payment opportunity available |
| *Flexible payment plans to accommodate hardship accounts* |

### 5. Broker Management

The employee-choice model is a complicated employer set-up feature and the use of brokers could assist the exchange in explaining this new method of purchasing to employers, especially those "micro- groups" without a human resource function. Depending on if and how the exchange decides to utilize brokers, the small business exchange will need to provide a number of administrative functions.

| Broker management |
|---|
| Define day-to-day broker "rules of the road" for interfacing with the exchange |
| Establish and administer broker compensation/fee manually or through spreadsheets *(or via dedicated sales compensation system)* |
| Provide training to maintain and grow broker skill sets |
| *Online delivery of sales, product, and compliance training* |
| *Sharing of sales techniques and knowledge from top-performers via sales calls and forums.* |
| Ensure that brokers meet licensing, certification and compliance requirements (as applicable) |
| Ensure that verification indicates that broker represents a given employer |
| Calculate broker fee/commission for each account |
| Inform employer of broker fee/commission (assumes fee/commission will be additive to premium, pursuant to Act 171 |
| Arrange for payment to brokers (flow: from employers to exchange to brokers) |
| Provide consistent broker evaluations to identify skill gaps and training needs |
| Provide marketing/sales materials to brokers via paper *(or self-service portal)* |
| Provide paper-based compensation information in monthly statements *(or online compensation information through emails/web-portal)* |
| Handle disputes and inquiries manually |
| *Operate self-service portal to address inquiries via broker FAQs* |
| Provide outbound notifications and communications via mail/fax |

| Broker management |
|---|
| Establish metrics and key performance indicators to track sales performance and broker effectiveness |
| Report broker information on monthly basis |
| *Provide web-based visibility for brokers to view daily sales and incentive results.* |

### 6. Appeals

Both the individual and the small business exchange will be responsible for appeals-related functions. Vermont will need to determine if all eligibility/enrollment related appeals, regardless of whether they are employer, employee, individual, or Medicaid, should be facilitated by a single technology solution and if so, how they can be performed as an integrated function (given the single payer vision, we assume this approach is desirable in Vermont but it is not required). Outside of this decision, the main appeals-related responsibility specific to the small business exchange is appeals of employer eligibility to purchase coverage through the small business exchange. The exchange must provide an employer applying for coverage with a notice of approval or denial of eligibility and the employer's right to appeal such determination. The regulations require that the exchange notify both employer and employees of the eligibility determination and the right to appeal.

| Appeals |
|---|
| Exchange should maintain an audit trail of all determinations (positive or negative) |
| In all notices produced by the exchange regarding eligibility determination, notify employers of their rights and responsibilities (including a right to appeal eligibility decisions) |
| Provide the capability to capture information and details of an employer complaint |
| Provide the flexibility to extend interim coverage or manage disenrollments based on events such as (a) Flexible grace periods during enrollments and disenrollments (including during appeals process where final eligibility determination is not confirmed) (b) Retroactive eligibility or enrollment/ disenrollment based on appeal results |
| Provide the capability for an employer to request an appeal to the employer eligibility decision |
| Provide the capability to differentiate between appeals and complaints; default requests to complaints when received by employers |
| Provide the capability to capture, track, and disposition appeals (including status, assignments, and relevant case notes) |
| Provide the capability to refer or route appeal requests to entities outside of the exchange as |

| Appeals |
| --- |
| appropriate |
| Provide capability for an employer to view key employer account information (includes employer details as well as key eligibility factors used to determine eligibility) |
| Provide the capability to record the detailed results and supporting documentation that result from or support an appeals decision |
| Generate a formal written notice informing an employer of the details of an appeal decision |
| Allow employers to request and receive a second appeal review process, providing very similar, if not the same, steps in the second appeal process as the first appeal process |

## Section II: Employee Choice Dynamics

A "gating" decision for Vermont's exchange is what degree of employee choice to include in its small business exchange. The exchange must offer qualified small employers and their employees a choice of qualified health plans arrayed on four tiers of actuarial value, ranging from 60% to 90%. (Catastrophic coverage will not be available as an option under group insurance to small employers.) How these plans are designed, and what model(s) of employee choice the exchange provides employers-- and through them, to their employees -- is largely at the state's discretion.

This guide discusses the pros and cons for Vermont of several inter-related decisions on the choice of health plans available to employers and their employees. The four key aspects to these design decisions are:

1. *The models of "employee choice"* i.e., how many health plans can/must small employers make available to their employees on the exchange? Of the four models of employee choice described below, CMS requires one and the exchange can decide to offer one or more of the other three. These four models of employee choice are discussed below.

2. *The number of QHPs available on the exchange at each actuarial value*: as Vermont's non-group and small-group markets are currently served by two carriers, the exchange is expected to certify these two issuers for 2014—BCBSVT and MVP. (New carriers, CO-OPs or Multi-State Plans authorized under section 1334 of ACA and deemed certified by the Office of Personnel Management are additional possibilities.) The exchange will have the discretion to certify one or more QHPs from each issuer at each actuarial level. If Vermont certifies just one QHP per AV level from each carrier, this would generate eight options for small employers; and even that degree of choice can be further "streamlined" for purchasers by standardizing the cost-sharing and other plan design features across the two issuers. This would yield four plan designs, each offered by two carriers. Whether and how much to standardize QHP designs is addressed in the section on consumer choice dynamics.

3. *The rating method used by carriers and the allocation of group premiums based on employee choice.* While this design issue presents a major technical challenge to exchanges in markets with age- or geographically-based rating, if Vermont uses pure community rating in 2014, it can accommodate broad employee-choice among health plans without modifying conventional composite rating. This issue is summarized in the section on rating.

4. *The adverse selection impact of various employee choice models*: adverse selection can affect relative costs for plans in the exchange versus the outside market, one carrier versus another, and premium levels across the market. Because there will be no outside market for the risk pools served by Vermont's exchange, the first concern is irrelevant. The other two issues are discussed below in the section on adverse selection and estimates are provided for its likely premium impact.

## Four Models of Employee Choice

Federal regulations require the exchange offer to employers the model of employee choice whereby the employer picks the actuarial value and employees can choose among QHPs at that level (model #2 below). The regulations do allow exchanges to offer additional models of employee choice, such as the choice of QHPs at various actuarial levels from a single carrier (model #1), employee choice of any plan in *any* tier (model # 3), or just one QHP from one issuer (model # 4). These models are illustrated in the Figures below:

**1. Employer selects issuer, employees pick plans on different AV tiers.**


**2. Employer picks tier, employees pick different plans.**


**3. Employee picks any plan, any tier.**

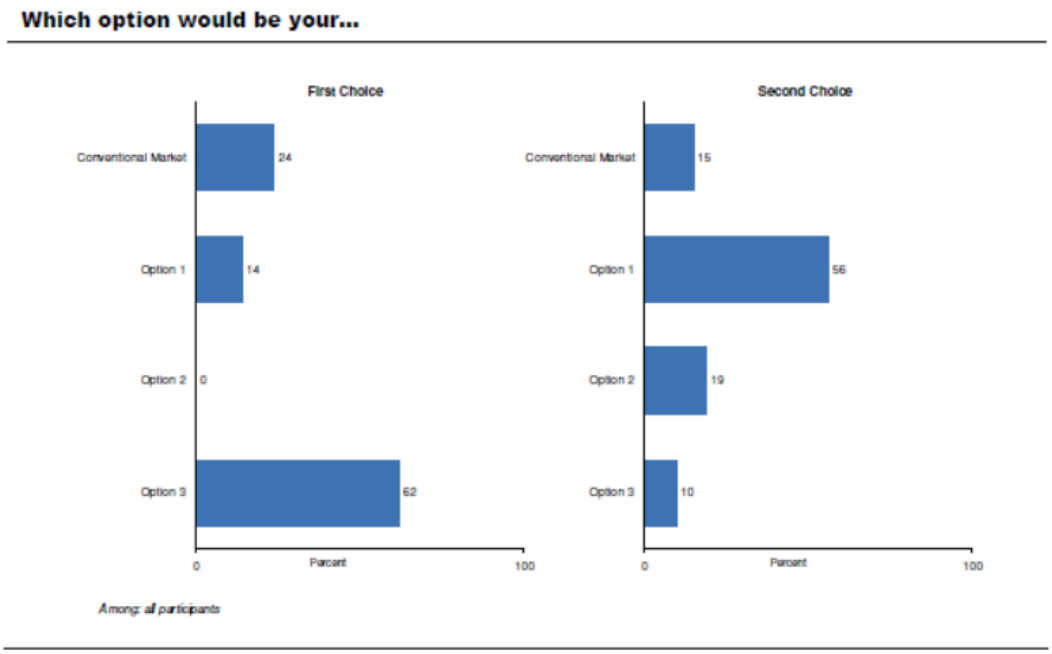

**4. Employer selects single plan.**


Employee choice of plans is typically not available today in Vermont's commercial market, and therefore may add value for employers and employees. There is considerable evidence that consumers do prefer a "reasonable" degree of "meaningful" choice, even though they generally do not enjoy shopping for health insurance. The challenge for the exchange is to set the right balance between meaningful choice and a confusing welter of options.

To inform Vermont's decision of how to structure employee choice, Wakely conducted a review of the literature and the experience with consumer choice of health plans, and RKM Research and Communications (RKM) conducted in-depth interviews in May 2012 with 50 small employers that offer group insurance in Vermont. The results and the review are

summarized below, and a full report from RKM is appended. We review these models in order of their ranking by employers.

**Any plan on any actuarial tier (Model 3).** RKM's employer interviews reveal stronger interest in this model than any of the other three. When asked initially about this model, eighty percent of employers view this model either *somewhat* (40%) or *very* (40%) *favorably*, while 20 percent of employers view the model *somewhat* (8%) or *very* (12%) *unfavorably*. Moreover, when asked after reviewing all four models to select their favorite, 62% chose the full menu of plans as their favorite and another 10% chose it as their second favorite.




Facilitating comparison shopping and choice is one of the principal policy rationales for an exchange, and this model offers employees the same full choice of plans that they would enjoy as individual buyers. As a result, full choice among all QHPs would, as some employers recognized, facilitate portability of coverage. Households could retain their current coverage when they switch from one small employer to another, or to individual coverage (except for catastrophic coverage). While 100% portability is not possible, because all (or even most) of the QHPs available on Vermont's exchange will probably not be offered by larger employers, nor will they necessarily match the coverage under Green Mountain Care for Medicaid and CHIP enrollees, full choice of QHPs would *improve* portability. Clearly, the full menu of employee choice fits Vermont's vision and resonates well with most small employers.

On the other hand, many small employers are wary of being forced to purchase group insurance exclusively through a new state agency. Sixty-three percent of employers said that they view the plan for Vermont's exchange *somewhat* (28%) or *very* (35%) *negatively: a*mong employers who view the plan negatively, many said that the reason is because they

do not like being forced to do something, especially by the government. Their fears relate to (a) not knowing how (or how well) the exchange will work, (b) whether it will cost them more, and (c) the prospect of more complexity and paperwork in a choice environment. The common theme underlying their anxieties is fear of a new, unknown process and having the existing market taken away.

One way the State might address these anxieties would be to offer employers different models for purchasing group coverage in the exchange. (We describe some other ways to address employers' fears in the sections on brokers and on customer service.) As such, the exchange can legitimately claim to be expanding, rather than narrowing, options for small employers and their employees. We discuss below reasons that Vermont might consider offering one or more of the other three models that fall short of full employee choice (model #3 below).

**One issuer, all actuarial levels (Model 1).** In fact, based on fifty interviews, small employers' second most favored model is to allow a full choice of QHPs and actuarial levels from one carrier. Several employers suggested that the difference among actuarial values is likely to be more "meaningful" than the difference between the existing carriers, especially as the two offer comparable provider networks. Seventy-two percent of employers view this model either *somewhat* (64%) or *very* (8%) *favorably*, while 28 percent of employers view the model *somewhat* (16%) or *very* (12%) *unfavorably.*

Allowing employers to select one carrier, define their premium contribution, and give their employees a choice of different levels of coverage also preserves the employer's ability to rely for customer service on a single, private-sector firm. For small employers nervous about how well the government exchange will operate, how responsive and knowledgeable its customer service will prove, and leaving a trusted relationship with their existing group insurer, this model offers considerable advantage. And by "containing" the choice of QHPs to a single issuer, the consequences of adverse risk selection are also muted. (See discussion below of risk selection.)

**One QHP only (Model 4).** Offering one health plan to employees is the conventional model in place now. Were the exchange to offer small employers the opportunity to select one QHP *in addition to* other employee-choice models, plus the federal tax credit for small employers (<25 employees) of lower wage workers, this would represent a meaningful *expansion of options* and cost-savings for small employers. While the employers interviewed suggest that most do want to offer more choice to their employees, some of the most anxious employers cling to a conventional, single-plan approach. Of those employers (35%) who are most negative about Vermont's exchange, well over half (58%) prefer the conventional single-QHP model as their favorite. For them, this model represents the least change.

In light of small employers' concerns about being forced into the exchange, one coping strategy might be to offer employers lots of QHP options and various models for offering employee-choice, including the conventional singe-plan method, just because that is what

they now use for group insurance. When asked to rate the conventional single-plan model, fifty-five percent of employers view it either *somewhat* (51%) or *very* (4%) *favorably.* By comparison with the other three models, 24% chose it as their favorite model. Even if offered as a transitional option only for 2014 -- until the employee-choice models prove their worth and practicality -- this might take some of the "sting" out of shutting off the outside market.

**Multiple QHPs at the same actuarial value (Model 2).** Federal regulations require exchanges to offer qualified small employers the (restricted) choice of all QHPs on the same actuarial tier. The theory behind this requirement is that it offers a range of options among multiple carriers and encourages competition. With just two carriers in Vermont's small-group market, this model offers so little choice that it was actually ranked far lower than the conventional, single-plan model by the overwhelming majority of small employers interviewed. Compared with the other three employee-choice models—including just one health plan—this seems the least appealing model for Vermont's employers. Twenty-eight percent of employers view this model either *somewhat* (26%) or *very* (2%) *favorably*, while 72 percent of employers view the model *somewhat* (43%) or *very* (29%) *unfavorably.* The only reason to offer this option would be to meet the federal requirement.

Finally, we note that the number of different employee-choice models offered also has implications for the operations of the exchange. Employee choice of health plans adds complexity, and multiple models of employee choice will be more challenging to administer and explain to employers and employees. This can add to the operational costs of the exchange and to employer confusion. Unfortunately, the only way to offer one model would be to offer the federally prescribed choice of QHPs on one actuarial tier, and ironically, this provides less employee choice and less portability than all but the conventional single-QHP model.

## Choice Dynamics & the Number of QHPs Certified

Too much choice can overwhelm consumers. Research into consumer choice, the experience of the Massachusetts Health Connector and experience with various Medicare options all suggests the need to simplify choice for consumers. Otherwise, in the face of complex choices, consumers can be overwhelmed and tend to resort to familiar concepts that make the decision easier, often sacrificing thoroughness and ending up with a plan that may not be in their best interest.

A second problem occurs when people struggle to discern any difference across their available choices. Options may vary only in name or differences may be inconsequential even if they are being marketed as substantial. [i] Significantly, similar choices also present another problem, and that is the illusion of choice. Just as too much choice can undermine the quality of the decision making process, options that are too limited can cause a consumer to feel stuck in a plan that may not suit their needs. Employees who receive

insurance from a large employer for example, often have limited or no choice of health benefit plans[ii].

Consumers place a high value on the availability of choice, but can be overwhelmed by too much or "meaningless" choice. With the likelihood of only two issuers participating on Vermont's exchange in 2014[iii], Vermont can simplify choice by standardizing the design of QHPs and limiting their number at each actuarial level to one, two or three.

Experience to Date

Consumers have shown increasing interest in becoming more active and involved in the management of their own health care. In a 2004 General Population Survey conducted by the Kaiser Family Foundation, the number of respondents who reported actively seeking information on health plans increased from 27% in 2000 to 35% in 2004. Of those that found comparative information on health plans, nearly half reported using that information.[iv] Exchanges should significantly enhance consumer engagement related to health plan selection and comparison shopping.

Recent research on consumer decision making suggests that the average consumer has two goals: (1) to reach a quality decision, and (2) to limit the cognitive effort required to do so.[v] For example, a study for the California HealthCare Foundation found that, "too many choices can lead to an inability to make decisions; people experience a kind of decision overload where they become incapable of acting upon any information."[vi] Recent consumer testing by Consumers Union (the advocacy and policy arm of *Consumer Reports*) confirms the widely held perception that people struggle to understand their health insurance choices.[vii]

Consumers Union conducted three studies between September 2010 and May 2011 to explore consumer understanding of health insurance. They found that consumers are challenged to assess the "value" of health plans and need a "manageable" number of choices. Consumers dread shopping for health insurance and often take short cuts to complete their decision.

During the studies, participants were typically asked to compare just two health plans at a time. Most struggled with this exercise due to a large number of variables and differences across the two plans. The author concluded that making a decision amongst a large number of choices with multiple differences across plans is beyond the cognitive ability of most people.

Consumers Union makes four recommendations to improve customers' choice and decision-making abilities. The first is to increase the standardization of health plan designs that consumers must compare and choose. This aspect is partially addressed by the ACA's requirement that qualified health plans must be standardized into four distinct actuarial categories (plus catastrophic coverage). However, even on Bronze or Silver, there is room for considerable variation in cost-sharing among plans. Consumers Union's findings

suggest that a total of 6-9 distinct plan designs may be optimal, but recommends that further consumer testing

Second, presentations of health plan information, including format, design, order and source, are all important features that impact consumer decisions. Again, the ACA prescribes certain requirements that will facilitate presentation, such as standardized coverage comparisons. However, exchanges will have the leeway to determine presentation and navigation features, including look-ups for key plan characteristics including deductible, copayment, coinsurance, tiered cost-sharing, out-of-pocket maximum, pre-authorization, and out of network benefits.

Third, timely and well executed consumer education will help consumers during the decision-making process. The notion of a teachable moment is important i.e., that consumers receive education and outreach when, where and in a format that they are ready to use. This generally occurs at the point where they recognize a need to make a decision or otherwise act, but may also require information to motivate them to act. Many people under 65 are not experienced making informed decisions among different health plan options. A 2010 survey conducted by the Kaiser Family Foundation shows that 84% of firms that offer health benefits to employees only offer one type of plan.[viii]

Fourth, personal assistance by well-trained representatives to help both consumers and employers is required, regardless of the exchange's design effectiveness. This last recommendation applies to the exchange's own customer Call Center as well as to navigators and brokers who provide assistance to individuals, small businesses and employees enrolling through the exchange.

As emerging research continues to support the notion that too many choices often hamper or halt the purchasing process, it is also important to note that consumers place a high value on the availability of *meaningful* choice. Lessons learned from the Massachusetts Health Connector and the Medicare market support the Consumer Union findings and provide further insight as to how exchanges should organize health plans choices to ensure consumers can make informed decisions.

*Commonwealth Choice (MA Health Connector): Comparison Shopping Experience*

The evolution of the visual layout and shopping experience for Massachusetts's Commonwealth Choice program can serve as model for other exchange design decisions. Massachusetts users are given a simple "intuitive" choice of Bronze, Silver or Gold actuarial levels for benefit plans to select from. From inception (2007), the plans offered on each tier were all comparable on several important elements:

1. all are HMOs, the dominant form of coverage in the Massachusetts market
2. all cover the same basic set of services commonly covered in the commercial market,

3. all include state mandates and the Connector's definition of Minimum Creditable Coverage, with maximum deductibles and out-of-pocket spending limits comparable to those under ACA

However, consumer research subsequently unearthed considerable confusion, so the Connector took additional steps to standardize plan designs and simplify consumer shopping in 2009.

The actuarial tier system originally showed comparisons of unique benefit packages from each issuer, all of whom designed their own Bronze, Silver and Gold plans. User focus groups conducted by the Connector in early 2009 reported considerable confusion amongst the different plan options. Consumers had trouble translating and giving full credence to the concept of "actuarial equivalence" – i.e. that different designs on "Bronze" all provide comparable levels of coverage. Ironically, many thought the most expensive premiums indicated the richest coverage. As a result, price was being interpreted as a proxy for coverage and even quality, instead of simply a cost measure. The confusion seemed to have generated perverse buying behavior.

Consumers in these focus groups stated that they wanted "apples-to-apples" comparisons. They wondered why similar benefits were not offered across plans on the same actuarial tier, so that price for the same coverage could be compared more easily. In response to consumer preferences expressed through both the focus groups and follow-up surveys of enrollees and non-enrollees, the Health Connector made two important improvements to simplify and enhance the shopping experience in Commonwealth Choice.

First, the Health Connector selected the most popular plans already being offered on the exchange, based on enrollment and distinct cost-sharing and coverage designs. The selection resulted in three Bronze plans, three Silver plans, and one Gold plan. (Subsequently, the Connector has reduced the number of Silver plan designs to two.) The Health Connector then solicited bids for all seven plan designs from the issuers, so that every carrier offered the same seven benefit designs. As a result, the number of plans offered decreased by two-third -- from twenty-seven to nine, including two catastrophic plan designs. Consumers were then able to select the cost-sharing design of their choice, and focus on a comparison of price, brand, and network.

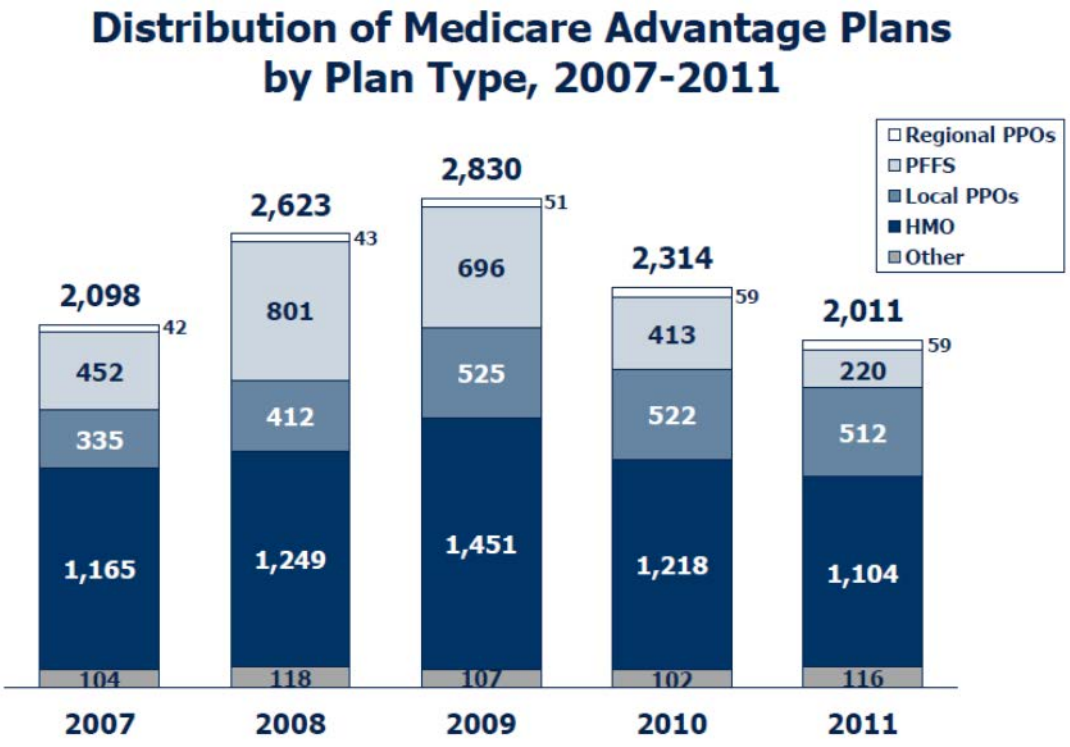
The Health Connector also added a physician and hospital finder to make comparisons of provider networks and quality easier. Consumers were then able to look up which plans include specific providers in their networks, and also view how the plans are rated by NCQA.

Consumers responded favorably to this further standardization and simplification of choice dynamics. One of the most notable trends has been a steady increase since 2009 of enrollment in lower-priced, less recognized brands, displacing enrollment in the most expensive plans. At one end of the price spectrum, Neighborhood Health Plan has more than doubled its enrollment share in Commonwealth Choice to over 40%, while the share

for the most expensive plans have fallen by half, to less than 20%. This trend seems to be a consequence of standardization by making it easier for consumers to isolate price from coverage variations while comparing plans.

*Medicare*

The majority of Medicare beneficiaries have access to Medicare Advantage plans as an alternative to traditional Medicare. Eighty-eight percent have access to more than ten plans, and 25% have an average of twenty four plan options.[ix] Variations across plans include differences in premiums, cost sharing, extra benefits, and provider networks, and the number of such variations increased following the introduction of Part D in 2006. Because of concerns that the large number of available plans overwhelmed some beneficiaries' ability to make informed choice, new CMS rules in 2009 encouraged a reduction in low enrollment and duplicative plans. As the table below indicates, after increasing by one-third, the number of plans has since declined to below the 2009 level, and further declines are expected in the future. [x]
The Medicare Rights Center postulates that a lack of information on the differences among numerous plans causes Medicare beneficiaries to choose health plans that did not suit their financial or medical needs.[xi] Increased standardization across plans and better comparative information about them would allow Medicare enrollees to make intelligent purchasing decisions.




**NOTE:** Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, and plans for special populations (e.g., Mennonites). HMOs include Point of Service (POS) plans. Includes MA-PDs that now operate under sanctions that prohibit enrollment of new beneficiaries.
**SOURCE:** MPR/KFF analysis of CMS's Landscape Files for 2007 - 2011.

xii

Medigap is supplemental insurance which covers coinsurance and deductibles that Medicare does not cover. Medigap was initially regulated by states, but the proliferation of confusing options and negligent oversight led to federal intervention. To bring order to the chaos of Medigap market, carriers can only sell ten standard Medigap insurance plan designs. This reduction and standardization across plans was found to decrease customer confusion and increase comparison shopping abilities.[xiii]

The Medicare Prescription Drug, Improvement, and Modernization act (MMA) of 2003 created a new prescription drug benefit program for Medicare beneficiaries known as Medicare Part D. This new drug benefit is provided through stand-alone prescription drug plans (PDPs) or Medicare Advantage plans that include prescription drug coverage (MA-PD) and administered exclusively through private health insurers. [xiv]

Consumers' experiences with the Medicare Part D marketplace provide further insights into choice dynamics. The goal of Part D is to "encourage private sector organizations who meet the law's requirements to offer a range of Part D plan options…by providing flexibility in plan design and management".[xv] Research from 2005 to 2009 suggests that beneficiaries' understanding of Part D's benefit structure and design is not good.

In the initial planning phase for Part D, there was a high level of uncertainty as to whether insurance companies would participate in the new market. However, in 2006, the market was immediately flooded. There were a total of 1,429 stand-alone Part D plans, providing a choice in each geographic region of 40 - 70 different plans. Beneficiaries often did not pick the lowest cost Part D plan and were reluctant to switch plans to improve their benefits. Knowledge gaps, enrollment issues, and plan choice difficulties were most apparent when Part D was first implemented (2006), but these issues persisted.

Many Part D-eligible beneficiaries reported feeling overwhelmed by the number of plan choices. Less than half of survey respondents reported actually making a comparison of the costs and benefits of different plans; and of those who did so, most compared four or fewer plans.[xvi] Plan choices seem to be based on name recognition or low premiums, and beneficiaries often chose plans based on a prior relationship with an issuer or information received from a plan representative or advertisement.

As of 2011, the average number of Medicare Part D plans in a region has decreased to 33 plans. CMS has also developed a Prescription Drug Plan Finder, which allows consumers to enter drug information, select a pharmacy**,** and refine coverage options by choosing plan rating, drug coverage, or deductible criteria. However, the large number of Medicare drug plan options is still problematic for beneficiaries. Previous research has suggested that decision quality deteriorates as the number of plans increases.[xvii] Although CMS has started to encourage consolidation of the Part D market in order to reduce confusion for seniors, some healthcare policy makers have recommended plan standardization measures to help seniors make informed decisions about Part D plans.[xviii] In addition, Medicare Part D beneficiaries rely on their physicians to help them choose the best plan, but studies have

demonstrated than even educated physicians have trouble choosing the most beneficial plan for their patients.[xix] Overall, Medicare beneficiaries have trouble understanding the complexities of Part D plans and as a result they do not make cost or medically effective prescription drug decisions.

In conclusion, enabling consumer choice requires balancing simplicity and usability against breadth of options to enable "meaningful" choice. Evidence from the Massachusetts Connector and Medicare markets, plus the research literature suggest that health insurance consumers do prefer options, but too many options create confusion and limit consumers' decision-making abilities. While the ACA does organize plans on actuarial tiers, the Massachusetts Connector found that further standardization within tiers was necessary for effective shopping. Analysis of the Medicare market confirms the challenge of too much choice and the benefit to consumers of increased standardization among health plan options.

### Standardization of QHPs in Vermont's exchange

The ACA requires considerable standardization among non-group and small-group plans in the exchange. As a result, much of the small-group market will experience discontinuity of coverage. Plans with (i) annual deductibles exceeding $2,000/$4,000- (single/family), (ii) caps on annual out-of-pocket cost-sharing that exceed the IRS maximum on High Deductible Health Plans -- approximately $6,000/$12,000 (single/family) in 2014 – (iii) plans which do not cover Vermont's definition of essential health benefits, and/or (iv) do not fall within two percentage points, up or down, from the four prescribed actuarial values (60%, 70%, 80%, and 90%) will be closed.

Within the four standards enumerated above, how much variation in plan design should the exchange offer? The experience with consumer choice of health plans would argue against a proliferation of options. A second reason to limit the number of plan options is the practical need for administrative simplicity, both for the exchange and for carriers. Each QHP must be reviewed, found compliant with the minimum certification requirements set by federal regulation, re-priced quarterly or even monthly for small employers, tracked for consumer complaints, analyzed and reported, reconciled for enrollment and premium changes month-to-month, and so forth.

However, there are some counter-balancing considerations. First, innovations in plan design are hard to anticipate, and specifying just a few acceptable QHP plan design can stifle innovation. Second, even modest differences in benefits and price can be meaningful to employers who are using multiple strategies to pursue a cost target or other goals at annual renewal. Third, there are "transition" issues for existing plan designs: to the extent that employers and employees understand existing plans, offering them in the exchange would reduce disruption. For this reason, Vermont's exchange may want to offer some existing plan designs that (a) fit the ACA's requirements and (b) currently enjoy high enrollment.

If so, how might the small business exchange define a "reasonable" range of options? We describe a range of approaches below.

One, the exchange invites the two carriers in its direct and small-group market to propose their most popular existing plan designs at each of the four actuarial values, adjusted for compliance with essential health benefits, from which the exchange would select two or more. This approach would at least ensure that some small employer groups and individuals could keep their current coverage while moving from the outside market to the exchange, and it should create an appealing set of options for purchasers, by comparison with the existing market.

The exchange would have the option after 2014 of reducing the number of designs over time. For example, the exchange might select the two highest enrollment designs at each actuarial value, and require both issuers to offer those standard plan designs. This is what the Health Connector in Massachusetts did. And/or Vermont might require all issuers to develop certain standard features for QHPs, such as patient-centered medical home or pay-for-performance to improve quality.

Two, at the other extreme, the exchange might specify one or two standard plan designs for each actuarial value and require both issuers to submit these exact designs. At the Platinum and Gold levels, there is relatively little room for meaningful variation in cost-sharing, so one standard design may suffice, whereas two or three at the Silver and Bronze levels would be required to provide meaningful choice.

Third, under a hybrid approach, the exchange would specify some standard plan designs at each actuarial level and invite issuers to propose a limited number of existing designs. For lower actuarial value tiers, the standard designs might represent clear a trade-off between the annual deductible and out-of-pocket maximum, on the one hand, and point-of-service cost-sharing, on the other hand, such that customers could select from a design on each actuarial level with:

1. maximum deductibles and OOP maximum (and modest or no point-of-service cost-sharing); or
2. minimum deductible and OOP maximum (and higher point-of-service cost-sharing)

In addition, the exchange would require each issuer to propose its most popular small-group plans at each actuarial level, adjusted for the state's definition of EHBs and minimum federal certification requirements. The exchange would select among the standard designs and those proposed by issuers. By offering a mix of *standard* existing designs, the exchange could offer both meaningful choice and ease the transition from the current market.

Whichever approach Vermont adopts, the number of distinct plan designs at each actuarial level should take into account how much meaningful choice is possible. Because there is relatively little cost-sharing at Gold and Platinum, one or (at most) two plan designs may ultimately suffice, even if more options are allowed initially to accommodate the transition from existing market-based preferences. At the bronze and silver levels, where there is

more "room" for variation in cost-sharing, the exchange could "stake-out" the extremes in its standardized plan designs, as described above, plus an "in-between" cost-sharing formula. This would offer employers and employees eight or nine plan designs across the two carriers and the four actuarial values, plus a catastrophic plan design for eligible individuals.

| Actuarial level/Issuer | Number of BCBSVT QHPs | Number of MVP QHPs |
|---|---|---|
| Platinum | 1 | 1 |
| Gold | 1 - 2 | 1 - 2 |
| Silver | 3 | 3 |
| Bronze | 3 | 3 |

## Rating Methodology and Employer Contributions for Employee Choice

Under federal rating rules for the small-group market, carriers are allowed to adjust community rates as much as 3-to-1 for the age and geographic location of employees. Carriers in most states are expected to operate under this 3-to-1 ratio, which allows them to charge higher premiums (for any given set of benefits) for an older (on average "sicker") group of employees and to charge lower premiums to younger (presumably "healthier") groups. In most markets, including Vermont's, premiums are not actually billed separately for each employee, but rolled up into a composite rate for single or family coverage. If one carrier covers the entire group, then each employee can be billed at the group's "composite" (average) rate, because the carrier collects all of the premium for younger and older employees. However, the introduction of employee choice among carriers complicates this picture and raises the prospect that one carrier might get older employees, while the other gets younger employees, but they each collect the same average rate for their enrollees.

Solving this problem without violating federal non-discrimination rules is actually fairly complex in a market which uses composite group rating with 3-to-1 age rate banding, unless employers contribute a percentage of premium to whichever plan the employee chooses. It is very clear from the employer interviews that Vermont's employers prefer to contribute a flat, fixed dollar, rather than a percentage of premium: eighty-eight percent of small employers said that they prefer the fixed contribution model. Most of these employers indicated that they preferred this model because it allowed them to accurately forecast their costs for the year's budget. Yet a flat dollar contribution by employers toward age-rated, list-billed premiums would violate federal non-discrimination requirements.

Vermont is one of a very few states which do not allow age-rating in the small-group market. (However, "pure" community rates are generated separately for the experience of each business association, thereby introducing variation in small-group rates despite the

ban on age-rating.) If Vermont's issuers are required to use pure community rating across the entire small-group market as of 2014, Vermont will be able to offer employee-choice models without either needing to switch to "list billing" or developing other innovative and complex rating methodologies to allocate premiums between carriers. This would simplify employee choice considerably.

On the other hand, pure community rating does increase the upward impact on premiums rates from adverse risk selection, and introducing employee choice of carriers and different levels of coverage exacerbates that potential. Other than restricting choice, there is no complete solution to this problem. However, as described in the next section on adverse selection, setting minimum levels of employer contribution, relative to the range of actuarial values employees can select, would reduce the degree of risk selection.

In employee-choice models that offer multiple actuarial levels, this can be done in one of two ways: (1) limit employees' choice of actuarial levels, such that the employer contribution is at least fifty percent of premiums for a benchmark plan on the "richest" actuarial level from which employees may choose; or (2) set a minimum employer contribution at fifty percent of the Platinum –level benchmark premium. The first approach restricts employee choice, and therefore limits the exchange's most attractive feature. For example, if an employer decides to contribute 50% of the lowest-priced Silver plan, employees would only have a choice of Bronze and Silver plans.

The second approach enables broad employee choice without significant adverse selection, but raises costs for many small employers. This may further encourage small employers to drop group insurance.

Of fifty small employers interviewed by RKM, 34 percent said that they would *drop small-group health insurance,* and 30 percent said that they are *unsure* what they will do. Setting a minimum employer contribution level relative Platinum or Gold level benefits would likely encourage more small employers to discontinue group insurance altogether, and send their employees to the non-group exchange, with or without employer subsidies. (See Section III for tax treatment of employer contributions toward the direct purchase of individual insurance.)

### Adverse Selection

Offering employee choice, particularly choice among plans on different actuarial value tiers, will increase the potential for adverse selection across plans, since people who are sicker and expect to utilize more benefits may be more likely to choose plans with "richer" benefits. The prospect of adverse selection is expected to increase premiums for health plans in the small-group market. Estimates by Wakely actuaries done in two other states suggest a potential impact within Small Business exchanges  of premiums increasing 1-6% with employee choice models, though this estimate would vary based on the specific dynamics of the market.

Working with Vermont data, Wakely estimates a range of 3% to 8% if employers have contribution levels of at least 70%. However, the impact could be as high as 11% if instead, employers on average only contribute 50% of premiums. The reason that the impact of adverse selection in Vermont is expected to be higher than in some other states is because Vermont carriers cannot vary premiums by age. It is important to keep in mind, however, that the ACA incorporates risk mitigating processes as well, such as risk adjustment, that are expected to partially offset the adverse selection impacts noted here.

Allowing plan selection by employees up or down across actuarial tiers should lead to higher users of medical services selecting the higher AV plans; this would lead to higher pricing for these plans and more aggressive rating for less rich plans. This would be the logical consequence resulting from adverse selection in the market. However, the ACA has provided for risk adjustment between carriers, which will encourage carriers to price various benefit plans based on average risk. Since the risk adjustment mechanism transfers payments from plans with low risk members to those with higher than average risks, pricing benefit plans based on the expected health status or claims experience of the employees that choose the plan may "duplicate" the effects of the risk adjustment mechanism and potentially put the profitability of the issuer at risk.

Furthermore, differences among base premium rates for a carrier in a given geographic area should be based solely on the differences in the benefit design, except as otherwise permitted under the ACA. Differences should not be based on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

Therefore, we believe that the adverse selection resulting from the employee choice model will not increase premiums only for "richer" plans, but will increase premiums somewhat across the entire merged market. To analyze the current selection in the small-group market, we looked at the relative costs by benefit plan for the Vermont carriers, as provided in the 2011 experience supplied by BCBS and MVP, to understand the existing adverse selection in the small-group and individual market. For small-group, we were looking for adverse selection resulting from selections made by small-group employers and associations. For the individual market, it is the adverse selection of each individual that leads to the selection. Not surprisingly, in both markets, we found that the allowed cost was positively correlated to the benefit richness of the plan design. That is, higher benefit plans enrolled members with higher average allowed claim costs.

Using this relationship, we have simulated the potential impact on overall premiums that would result from employee selection in the exchange. We have modeled various scenarios with the following assumptions:

- Various levels of employee choice. We evaluate the scenarios of the most restrictive (based on a single QHP employer choice) to least restrictive (based on full employee choice).

- We assume the participation and contribution requirements are applicable to the group as a whole (similar to the current environment), but not applicable to any specific carrier and QHP.
- Various levels of employer contributions. We have assumed that lower employer contribution rates result in greater adverse selection. The best estimate impacts assume average employer contribution rates of 80%.

- Distribution of small business membership by actuarial value tier and carrier. Wakely assumed that the information supplied by BCBS and MVP for small groups and association plans reflects the scenario in which employers choose the plan and carrier for employees. Approximate actuarial value tier levels were determined based on historical information supplied in order to estimate the distribution of membership by actuarial value tier when employers choose the plan offered to employees.

- Based on the experience of a large employer group that incorporated a model of full employee choice (benefit levels and carriers), generally, the health status for those enrolled in the highest premium plans were twice that of the health status for those enrolled in the lowest premium plan. It is important to note, however, that this was the case where a) rating based on age was allowed, and b) significant employer contributions as a percent of total premium were prevalent. For Vermont, we have instead assumed that the risk profile of those enrolled in the highest premium plan will be approximately *three times* that of the risk profile for those enrolled in the lowest premium plan within the full-employee-choice option. Variation in this assumption was the main driver of the resulting range of estimates presented in the upcoming table.

- We have not assumed any propensity of a group or employee to pick a specific carrier based on quality of that provider or history of coverage with that provider.

The Appendix shows the results of our analysis. Results are summarized in the two tables below.

**Estimated Impact to Overall Premiums Based on Employee Choice, Assuming the Entire Small Employer Group Market (including Associations) is Sold through the Exchange**

| | Model 4 | Model 2 | Model 1 | Model 3 |
|---|---|---|---|---|
| **Description** | One Carrier, One QHP per Employer Group | Employee chooses carrier; employer pre-selects the actuarial tier | Employee chooses actuarial tier; employer pre-selects the carrier | Full Selection of QHPs by Employee |
| **Best Estimate Impact** | 0% | 0.6% | 5.2% | 6.0% |
| **Range of Possible Values** | 0% | 0.0% - 1.0% | 2.5% - 7.0% | 3.0% - 8.0% |

As mentioned previously, the above table is based on the assumption that employers contribute 80% of total premiums for Bronze level coverage. However, that is a very sensitive assumption, particularly in a pure community rated environment such as Vermont. The following table contains the best estimates of adverse selection impact based on varying levels of employer contributions towards Bronze coverage.

| Best Estimate of Adverse Selection for Full Choice Model, with Varying Levels of Employer Contributions | | | | |
|---|---|---|---|---|
| **Employer Contribution** | 50% | 70% | 80% | 90% |
| **Best Estimate Impact** | 9.2% | 7.5% | 6.0% | 1.9% |

Again, it is important to consider that the ACA has other risk mitigating strategies that are intended to minimize the impact of adverse selection. Risk adjustment is assumed to significantly reduce the impact of adverse selection, as it is intended to adjust revenue payments for risks that are not ratable. For Vermont, this means that even though community rating will not allow for premiums to differ by age, carriers may be compensated for age bias in the form of risk adjustment.

## Section III: TAX CONSIDERATIONS

### Tax Credits for Small Employers in the Exchange

In addition to substantial tax preferences available to employees for both employer and employee contributions toward *group insurance,* and instead of the deductibility of employer contributions as a business expense, the ACA provides special tax credits to small businesses with low-wage workers who provide insurance for their employees. From 2010 through 2013, these tax credits are 35% of the employer contribution to insurance premiums, for for-profit employers with 10 or fewer employees, and with average wages of $25,000 or less; 25% for non-profits. These amounts are phased out for employers with up to 25 employees, and average wages up to $50,000.

Starting in 2014, the tax credit will increase to 50% of the for-profit employer's contribution and 35% for non-profits, but can only be claimed for insurance purchased through the exchange. It can be made available using any of the four employee-choice models, so long as the employer designates a "benchmark plan," to which he contributes at least 50% of the premium for single coverage. The tax credit can be positioned by Vermont's exchange as a real savings to a subset of small employers.

However, the tax credits will phase out based on employer size and average wage, as shown in the table below. Moreover, the *marginal* effect of the employer tax credit will be less than the amounts shown in the table, because the health expenses reimbursed by the credit cannot also be counted as a business deduction. In addition, starting in 2014, the tax credit can only be claimed for two years.

While this was thought to be a major attraction of exchanges for small employers, the take-up of the tax credit to date has been far less than expected.[1] It is hard to predict whether the changes to the credit in 2014 -- net increase in amount of credit, but credit available only for insurance purchased through the exchange and for two years only -- will have a net result of increasing or decreasing take-up, but it is likely that the appeal and applicability of the tax credit will remain somewhat limited. This presents a challenge and an opportunity for Vermont's exchange to make small employers aware of, and help them take advantage of tax savings.

A recently issued report by the United States Government Accountability Office (GAO) assesses the "Factors Contributing to Low Use and Complexity" of the Small Employer Health Tax Credit. Estimates of eligible employers range from 1.4 million and 4 million small businesses are eligible, but merely 170,300 small businesses claimed the tax credit in 2010. The GAO found that the tax credit is not large enough to influence small employers to begin offering health insurance. As for employers that do offer group insurance, the GAO report identifies three reasons why so few of those employers who might qualify applied

for the tax credit. First, the tax credit's value is actually quite limited. Its maximum value is only 25% of the non-profit employer's contribution, rising to 35% in 2014; for a taxable firm offering group health coverage, the tax credit is netted against corporate tax deductions on that same coverage, so that its incremental value can be far less than 35% (in 2010) or 50% (as of 2014) of the employer's contribution. (For a firm in a 30% corporate income tax bracket, the net value is not 50%, but 35%.) Moreover, if an employee's annual premium exceeds the state's average premium for the small-group market, as determined by HHS, then the tax credit can only be applied to the average small-group premium in the state. And the "face value" of the tax credit declines rapidly as an offering firm's FTE count increases above 10 or its workers' average income rises above $25,000. For example, firms with 12 FTEs and a $40,000 average wage, or with 21 FTEs and a $25,000 average wage would qualify for only a 13% tax credit.

*Phase-out of small business tax credit in 2014 by average wage and firm size*

| Firm Size | Up to $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
|---|---|---|---|---|---|---|
| **Up to 10** | 50% | 40% | 30% | 20% | 10% | 0% |
| **11** | 47% | 37% | 27% | 17% | 7% | 0% |
| **12** | 43% | 33% | 23% | 13% | 3% | 0% |
| **13** | 40% | 30% | 20% | 10% | 0% | 0% |
| **14** | 37% | 27% | 17% | 7% | 0% | 0% |
| **15** | 33% | 23% | 13% | 3% | 0% | 0% |
| **16** | 30% | 20% | 10% | 0% | 0% | 0% |
| **17** | 27% | 17% | 7% | 0% | 0% | 0% |
| **18** | 23% | 13% | 3% | 0% | 0% | 0% |
| **19** | 20% | 10% | 0% | 0% | 0% | 0% |
| **20** | 17% | 7% | 0% | 0% | 0% | 0% |
| **21** | 13% | 3% | 0% | 0% | 0% | 0% |
| **22** | 10% | 0% | 0% | 0% | 0% | 0% |
| **23** | 7% | 0% | 0% | 0% | 0% | 0% |
| **24** | 3% | 0% | 0% | 0% | 0% | 0% |
| **25** | 0% | 0% | 0% | 0% | 0% | 0% |

Second, many small businesses were deterred from filing for the tax credit due to complexity of various eligibility requirements, data collection and recording requirements, and the number of work sheets that must be completed. A tax preparer from a discussion group noted, "Any credit that takes 25 lines and seven work sheets to complete those 25 lines is too complicated." A major complaint from employers was the need to gather information: employers did not have the requisite information readily available on the number of hours worked for each employee, their associated annual wages, or the required

health insurance information. The amount of time and effort required to claim the tax credit creates substantial burdens for employers.

Third, employer awareness is limited. As of May 2011, The Kaiser Family Foundation estimated that 50 percent of small businesses were not aware of the tax credit. To raise awareness, the IRS ran extensive outreach and communications programs, but it is unclear if their efforts successfully raised awareness.

Vermont's exchange could help qualified small employers overcome some of these obstacles, although not all of them. While exchanges cannot influence the value of the tax credit, because Vermont's exchange will serve all eligible small employers in the State, it can certainly increase their awareness of the tax credit. Indeed, by promoting the availability of the Small Employer Health Tax Credit, Vermont can simultaneously promote its role in saving some employers money, and ensure that the maximum number of qualified firms take advantage of this opportunity. We estimate below that the number of small employers in Vermont that might qualify for the maximum tax credit ranges from 850 to 1,700, and for any tax credit ranges from 3,602 to 1,705.

Vermont's exchange may also be able to provide useful information and reduce the complexities of filing for the credit. Many employers find it difficult to calculate the expected amount of their tax credit. The GAO suggests that an employer's previously reported tax return can be used to gather employee and wage information for estimation purposes. By estimating the relevant group insurance information (number of FTEs and employer premium contribution at enrollment), plus the wage information (off the employer's prior tax filing), Vermont could provide a relatively easy means for employers to determine eligibility and a calculator to estimate the value of their credit. If, at year-end, the exchange were to pre-populate for each employer likely to qualify some of the actual data needed on the application, small employers may be more willing to claim the credit.

*Estimating the Number of Firms Qualifying for Special Tax Credits*

We identify three key determinants of eligibility for the Small Employer Health Tax Credit: (i) number of FTE employees, (ii) average wage, and (iii) employer contribution toward group insurance. Drawing information from studies conducted by Families USA and the Vermont Department of Labor, we estimate the number of Vermont small businesses that may be eligible for the Small Employer Health Tax Credit by satisfying all three criteria. In Table 1 we estimate the number of Vermont small businesses that might qualify for the maximum tax credit or any amount of tax credit, if they offer coverage and contribute at least 50% toward premiums. In Table 2 we estimate how many of the firms in Table 1 currently offer group insurance.

*Vermont Small Businesses Eligible for Tax Credit*[xx]

| | # of VT small businesses | % of VT small businesses |
|---|---|---|
| **Total number of small businesses** (fewer than 25 employees) | 14,900 | 100% |
| **Small businesses eligible for maximum credit** (fewer than 11 FTE employees and less than $25k Avg Wage) | 3,400 | 23% |
| **Small businesses eligible for any amount tax credit** (fewer than 25 FTE employees and less than $50k Avg Wage) | 13,100 | 88% |

To determine the number of Vermont small businesses that are eligible for tax credits that also currently offer health insurance to their employees, we applied estimates from the Vermont Department of Labor 2011 Fringe Benefit Study. This study reports that 47% of businesses with 1 to 9 employees offer health insurance.[xxi] The larger the firm, the more likely it is to offer health insurance, so for firms sized 2 to 10 (excluding sole proprietorships) we assume as an upper limit estimate that 50% offer group insurance, and we use 25% as a lower limit estimate. This yields an estimated range from 850 to 3,603 firms in Vermont with under 11 FTE employees, paying on average $25,000/employee or less and also offering group insurance i.e., the number of small businesses that would be likely to qualify for the maximum tax credit.[xxii]

The Fringe Benefit study was also used to estimate the number of small businesses that are eligible for any amounts of tax credit that also currently offer health insurance to employees. The study divides small businesses into different groups based on number of employees; 1 to 9, 10 to 19, and 20 to 49. Small businesses that are eligible for any tax credit must have less than 25 employees. We applied a weighted average methodology to the Fringe Benefit study information to determine an estimated range for this group. For this, we use an upper estimate of 55% and a lower estimate of 27.5%.

The following table estimates the number of small businesses eligible for the maximum, or for any amount of tax credit which currently offer their employees health insurance. We estimate that of the 3,400 Vermont small businesses that qualify for the maximum tax credit, between 850 and 1,700 currently offer health insurance to their employees. Of the 13,100 Vermont small businesses that are eligible for any amount of tax credit, between 3,603 and 7,205 currently offer insurance.

*Eligible Small Business that Currently Offer Health Insurance*

| | Lower Estimate | Upper Estimate |
|---|---|---|
| **Small businesses eligible for maximum tax credit, that currently offer insurance** | 850 | 1,700 |
| **Small businesses eligible for any amount tax credit, that currently offer insurance** | 3,603 | 7,205 |

## Tax Preference for Non-Group Insurance in the Exchange

Of fifty small employers who currently offer group insurance in Vermont, one-third indicated that they will drop it in 2014 and another 30% were unsure whether they would offer coverage through the exchange. Whether one-third will actually drop coverage two-plus years from now, and how that compares with "normal" entry/exit from the small-group market is unclear. Nevertheless, given the significant percentage of Vermont's small employers who indicated in interviews that they might drop group health benefits, and the State's vision for ultimately breaking the tie between health insurance and employers, it is worth considering how Vermont's exchange might enable preferential tax treatment for non-group insurance.

Of course, the ACA provides substantial advance payable tax credits for households up to 400% of FPL, and cost-sharing reductions for households up to 250% of FPL. Beyond these, to what extent can employers and/or employees contribute toward non-group premiums and out-of-pocket spending on a tax-preferred basis? A legal analysis of the options is appended, and the conclusions are summarized below.

In general, there are three vehicles recognized and defined by the IRS for funding accounts on a pre-tax basis to help meet the costs of premiums and of out-of-pocket spending by subscribers:

1. Health Reimbursement Arrangement (HRA): HRAs are employer-sponsored benefit plans – individuals may not establish an HRA on their own — and HRA benefits are paid for solely by an employer. HRAs can be structured to roll over unused funds at year-end, but employers typically do not allow roll-overs or cap the amount that can be carried over to the next year. Any unexpended funds in an HRA account at year-end belong to the employer, not the employee. They need not be tied to a specific kind of group health plan and do not constitute group insurance. HRA funds can be used to pay insurance premiums, out-of-pocket spending by the subscriber and

other qualified medical services. No employee salary reduction or other employee contribution through a section 125 plan is permitted.

2. Health Savings Account (HSA): HSAs are tax-advantaged medical savings accounts available to individual taxpayers who are enrolled in an HSA-qualified high-deductible health plan (HDHP). (HDHPs are defined by the IRS, and some QHPs on the lower actuarial levels can be designed to qualify as HDHPs.) HSAs may be established either by an individual (employee) or an employer; and funds may be contributed by either an individual tax-payer or the employer. Funds in an HSA do not have to be used in the year they are deposited; unspent funds roll over for future use. The funds contributed to the account are not subject to federal income tax at the time of deposit, but their uses are limited to reimbursing expenditures not covered under a HDHP, and generally NOT for premium contributions.
3. Flexible Spending Account (FSA): FSAs are employer-sponsored benefit plans – individuals may not establish an FSA on their own. Health FSAs can be used to fund qualified out-of-pocket spending for medical services not covered fully or at all by insurance, but may not reimburse premiums for accident and health insurance. Funds are deducted on a pre-tax basis from employee payroll through an IRC section 125 plan; any unused funds at year-end are lost to employee, and cannot be rolled over for use in the next year.

In many respects, HRAs are the most flexible vehicle for employers to use in subsidizing premiums and out-of-pocket spending for non-group coverage. They are widely used in Vermont and the two carriers that serve Vermont's small-group market work with various third-party administrators (TPAs) of HRAs. Were the Vermont exchange to facilitate employer contributions on behalf of their employees, it could arrange with one or more TPAs, or with the each of the two issuers, to have individual buyers debit an HRA to help pay monthly premiums for non-group coverage on a pre-tax basis.

This mechanism could be used by either small employers or large employers to contribute on behalf of their employees toward *non-group* premiums in the exchange. (Because HRAs do not constitute group insurance, the small employer using an HRA instead of group insurance would not qualify for the special small-business tax credit described above.) In addition, unused HRA funds could be used by employees to help meet uncovered out-of-pocket costs.

Of course, a complicating factor with employer subsidization of non-group coverage for employees is the variable level of federal tax credits (APTCs) and cost-sharing subsidies (CSRs) available to qualified individuals at different income levels. Whereas an employee earning 200% of FPL would qualify as an individual for extensive APTCs (and CSR) subsidies, a colleague earning over 400% of FPL would not. In effect, the employer offering $5,000 per employee per year toward premiums and uncovered expenses would be "over-

funding" lower-paid employees. But the HRA is a very flexible funding mechanism. Because any unused employer commitment to fund an HRA "reverts" to the employer at year-end, the employer could "level-fund" HRAs for all his/her employees, and those who qualify by income for extensive subsidies would presumably not use that full commitment, which would revert to the employer. This "efficient" use of employer subsidies makes it secondary to federal tax subsidies.

While making it easy for employers to use an HRA vehicle to help fund non-group coverage in the exchange sounds appealing, two caveats should be noted. First, employee contributions toward non-group premiums would be made with after-tax dollars. While individuals can fund HSAs with pre-tax dollars to cover out-of-pocket spending under HDHPs and FSAs to fund out-of-pocket spending more generally, neither HSAs nor FSAs can be used to pay premiums (except in special circumstances, such as COBRA coverage.) Therefore, employee contributions toward non-group premiums will be after-tax spending.

A second caveat about using the HRA vehicle to facilitate employer subsidization of non-group coverage is that federal policies regarding future use of this funding mechanism are currently unsettled. Until the IRS and other federal agencies resolve the use of HRAs under PPACA, the approach described above can be proposed, but its viability in 2014 is not guaranteed, and is subject to federal review.

## Section IV: Broker Strategy for Small businesses

How the exchange uses, certifies, reimburses and generally relates to brokers for small employers is an important and fairly complex issue. To inform this thinking, we first provide a description of the range of services that brokers typically provide small employers today. Second, we set forth some key considerations for the exchange in developing productive working relationships with brokers and offer three "models" for developing broker compensation in the small-group market. In doing so, we recognize that brokers' compensation and relationships to carriers and small employers will change significantly in 2014, because Act 171 makes their services in effect a voluntary contract between the small employer and the broker, for which the employer must pay extra.

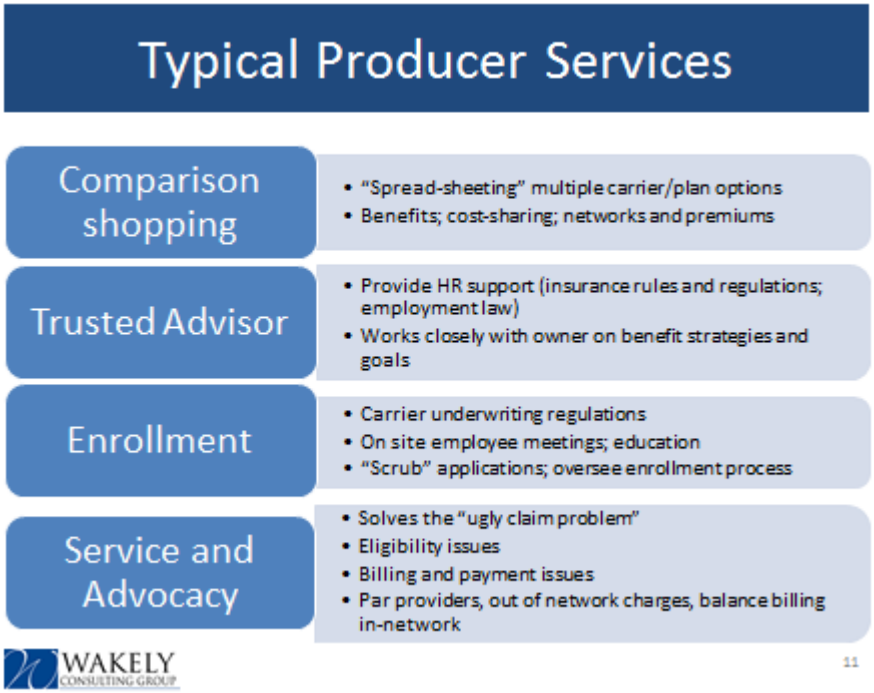
A review of producer (otherwise referred to as a broker in this brief) licensing data on Vermont's Department of Financial Regulation's (DFR) webpage suggests that a producer acting as a broker (as opposed to an agent) may charge a separate fee: "In addition, where a Producer is acting as a broker, representing the purchaser, additional fees to any commission received by the issuing insurer can be charged, so long as the fees are reasonable in connection to the service or expenses and all commission received by the Producer is clearly disclosed prior to entering into the agreement. Note, Vermont law requires a Producer to obtain a prior written agreement with a client, policyholder, or other member of the public concerning the fees or charges made by that Producer for procuring, servicing, or providing advice on insurance contracts." Nonetheless, DFR may need to consider changing regulations to accommodate these new relationships in the small-group market and/or the exchange will need to develop certification standards, training, and contractual terms to do the same.

Background information for this section was drawn from interviews with several brokers (and associations) in Vermont that all work closely with employers in the small-group market, interviews with fifty small employers conducted by RKM Research and Communications in May 2012, Vermont specific surveys as noted, and research and interviews that Wakely has conducted on the broker channel in several states over the last 6-8 months.

### Typical Broker Services Today

One of the implications of Act 171 is that those small employers who prefer a private "advisor" may decide to engage and pay for a broker, whereas others may well look to the exchange and/or carriers to provide services otherwise available from brokers. One of the consequences of giving employees a choice of carriers in the exchange will be to break the tie between each employer and just one carrier that serves their entire workforce: for example, an employer's questions about the eligibility of part-time workers, billing issues or COBRA questions do not "belong" to one carrier. Therefore, small employers are likely to look to the exchange for such service, especially if they are not paying "extra" for a broker.

In any event, the exchange will need to recognize and define such services, so that it can set expectations appropriately for small employers, carriers and their brokers, or supply those services itself. Understanding current broker services is an important starting point for re-defining the division of labor as of 2014 between the exchange's customer service, issuers, and brokers. A summary overview of broker services today is shown below and then further expounded upon in the paragraphs that follow.




All brokers "spread-sheet" benefit plan options and premium costs for clients on an annual basis. A "spread-sheeting" exercise entails comparing different benefit plans side-by-side, for premium costs and key benefit features of the different plans. "Spread-sheeting" can be fairly complex in the current world of choice between associations, direct market, and dozens of plan designs.

> *When interviewed, 100% of Vermont small employers said they receive spread-sheeting services from their broker; this was the most valued broker service provided with 58% of the small business owners saying they valued this service more than any other service.*[xxiii]

In addition to cost sensitivities, brokers generally look at any proposed benefit plan design and carrier network with an eye toward the personal needs of the business owner and his/her dependents. This kind of personalized attention from the broker to the owner directly addresses one of the biggest perceived difficulties with health insurance, which is that most people have great difficulty understanding their health insurance policy. Hiring a broker is a short-cut to understanding the multitude of available choices in the small-group market. Brokers almost always are referred to as the business owner's "trusted advisor"

and this terminology directly addresses the underlying needs of the business owner. In their absence, the employer may look to the exchange's customer service representatives for some of this advice.

If the exchange limits the plan designs to a dozen or fewer, standardized for actuarial value, EHBs, maximum annual deductible and out-of-pocket limits, this should reduce confusion and simplify the spreading-sheet exercise considerably. Indeed, organizing, automating and simplifying plan comparison is one of the exchange's most important "value-add." Even so, if the exchange offers different models of employee choice, employers may seek advice as to which model best meets their needs and how to structure their contributions, including funding an HRA or an HSA in conjunction with high deductible health plans (HDHPs). Approximately 67% of Vermont's small-group enrollment (including both association and direct through carriers) is now enrolled in high deductible health plans.[xxiv]

Brokers universally state that providing Human Resource guidance is a typical service and one that requires time and attention throughout the policy year. Small employers, and particularly those with 25 or less employees, generally do not have any staff dedicated to staying on top of HR matters, insurance rules and regulations, and employment laws. Most small business owners generally have only two outside professionals at their disposal: an accountant and an insurance broker. In addition to health insurance, most brokers provide their small business clients with additional services from the following list: life insurance, dental, AD&D, property & casualty insurance, Health Saving Account (HSA)/Health Reimbursement Account (HRA), 401K or pension administration, COBRA administration and voluntary products (i.e., voluntary products are 100% employee paid benefits such as vision or legal services).

> *When interviewed, 50% of Vermont small employers take advantage of advice from their broker but only 16% said they value advice provided by their broker more than any other service.*[xxv]

Therefore, even in the context of an efficient, well-run exchange, small employers are likely to seek additional services. Whether they will pay brokers for them or the brokers will provide these services in return for (much smaller) commissions from non-health lines of insurance remains to be seen.

Brokers generally provide at least one on-site group benefits presentation each year at renewal (or open enrollment) time. If the employer has employees in remote locations, the broker may also accommodate these employees through webinars or phone-in meetings. All in all, this is a fairly labor intensive shopping and enrollment process, which would be costly and may be impractical for exchange to provide.

> *80% of Vermont employers rate employee meetings and seminars as effective or very effective benefit communication methods; 80% also rate one-on-one enrollment meetings as effective or very effective; email announcements were rated as the next*

*most effective communication method with 72% of employers rating them as effective or very effective.*[xxvi]

Many brokers report that they act as a clearinghouse for enrollment applications for initial enrollments or new sales, annual renewal periods, new hires, terms and dependent changes. The brokers in Vermont confirm that the vast majority of the small-group market is still on paper enrollment and the broker scrubs the paperwork for accuracy and thoroughness. This is a service which will be required of the exchange, if it is not provided by a broker.

*When interviewed, 83% of Vermont small employers said they receive support from their broker on eligibility determinations and 71% receive assistance with COBRA.*[xxvii]

All brokers are required to administer the underwriting guidelines of carriers. Underwriting guidelines are a critical tool employed by every carrier and they are primarily intended to reduce adverse selection, or the likelihood that the carrier will incur unmanageable risk that could reasonably be anticipated and therefore prevented. These guidelines may vary by carrier and product, and can cover a host of possible requirements, including but not limited to:

- minimum participation rules
- valid waivers
- minimum employer contribution requirements
- availability of coverage to 1099 consultants (and other non-employees)
- determination of eligibility based on full time versus part time employment status
- availability of dual choice and/or triple choice plan offerings (i.e. when more than one plan option can be made available within an employer group)
- common ownership and multiple company requirements
- multi-site guidelines

While the carrier is the final arbiter of underwriting decisions, the broker is nonetheless expected to know and support the carrier's rules. (Of course, under a small business exchange and given federally compliant small-group underwriting guidelines, these decisions should be much more standardized in 2014 than currently, and under Act 171, the broker is really functioning as the employer's representative, not the carrier's.) Though infrequent, one of the most important services brokers provide is resolution of claim issues that cannot be easily resolved by a call to Customer Service. Virtually every broker is accustomed to dealing with the claim problem that requires escalated contact at the carrier, or persistence, to get resolved. Resolving such claim issues often represents a key opportunity for the broker to demonstrate his value to the small business owner who has neither the time nor inclination to pursue the issue with the carrier.

*When interviewed, 48% of Vermont small employers said they receive assistance from their broker on claim issues; assistance with claims was the second most valued broker*

*service when employers were asked "Which two services that your broker provides do you value the most?"*[xxviii]

In the absence of a broker, employees or employers are likely to seek assistance from the exchange in working with carriers to resolve claims payment problems. This could become a core competency of the exchange, and a service that it assumes as part of its QHP management function, even when the employer engages a broker.

Other common interventions include: resolution of premium billing issues, obtaining "prior approvals" in time sensitive situations, notifying employee groups of pending network terminations, reviewing Explanation of Benefits (EOBs) for employees, intervening with providers to determine why a service was billed a particular way, recruiting needed or desired providers to the network, addressing out of network or out of area questions, helping with provider referrals, addressing inaccurate provider directories, and resolving balance billing issues. Where the employer has not "hired" a broker to supply them, these services will need to migrate in 2014 to the exchange's Call Center staff or directly to the carrier.

### Key Considerations in Developing Productive Working Relationships with Brokers

Brokers "drive" much of the buying behavior in Vermont's small-group market today. While estimates vary on the specific percent of the small-group market that is brokered, most estimates suggest that it is at least 70% brokered.[xxix] Fifty-six percent of the small employers interviewed in May 2012 by RKM said they would still want to use a broker to help them choose the best option if they purchased health insurance directly through the exchange. Their reasons for wanting to use a broker ranged from valuing the expertise of the broker, to having a good rapport with this individual, to valuing the other services they provide (i.e., life, dental, AD&D, etc.). However, 78% said they would forego broker services if they had to pay 4% of premiums and 57% would not even pay 2%.

Since the majority of small employers appear to be unwilling to pay brokers, the exchange must prepare to provide most of these services directly and/or assign responsibility for some of these services to participating issuers. The exchange should define (if allowed under Act 171 or insurance regulation) the range of services that brokers will provide, according to where their compensation is set. For example, if commissions are reduced significantly from today's market standard, brokers may try to limit their services to assistance at renewal time and refer service or "maintenance" issues throughout the policy year to either the exchange or the issuer(s).

Initially, it is more complex to move an employer into the exchange under an employee-choice model than to renew conventional group coverage, or to tweak the group benefits and "spread-sheet" comparative costs from competing carriers as is done in the market today. The element of employee choice actually complicates enrollment, case installation, the explanation of employer and employee contributions to multiple plans at different premium levels, and subscribers' claims adjudication issues that can arise for multiple carriers. Brokers will likely want to redefine their services in a new model of direct

payment from small employers. An effective small business exchange will take on some of the added complexity of an employee-choice model, but probably not all of it. For example, the exchange will make it easier to compare different plans by standardizing plan designs and facilitating an easier "apples to apples" comparison, but the employer (and employee) still need to decide what plan best meets their needs. If employees are struggling, they will ask their employer for help, and most employers prefer to have the broker address specific questions and concerns.

As two of the choice models allow employees of the same company to select different health insurance carriers, differences between carriers will add some complexity, even though many elements of plan design across carriers will be standardized. For example, the exchange can require carriers to structure their prescription drug plans so that cost-sharing features are the same or easily comparable but the exchange should not necessarily expect that their formularies will be the same. Or, carriers may have different processes to approve continued coverage for handicapped dependents…all carriers may do it, but the paperwork and decision-making process may be different. So, while expanding choice has many advantages, it will also create employee and employer questions that the employer may ultimately decide are worth paying a broker to answer.

Therefore, Vermont's exchange may want to encourage small employers to use brokers, especially in the first transition year to the exchange. First, there is likely to be considerable confusion for employers and employees, which well-trained brokers can assuage. Second, Call Center or other exchange staff will have to perform some of the brokers' functions, so their retention should also mean net operational savings for the exchange, as presumably employers will contact the broker for assistance and not the exchange staff. Of course, the exchange will need to train and support brokers, but it is generally more efficient for an entity to support one broker handling 25 clients than to handle the 25 clients directly.

The exchange can make it easier and more effective for employers to engage brokers. First, if the small employer decides to engage a broker, some sort of agreement as to what services the employer has purchased, and what services are outside that relationship may be advisable. This will help clarify the broker's role, the carrier's responsibilities, and the exchange's responsibilities. The alternative may be a lot of "finger-pointing" and missed hand-offs. If so, Vermont must decide whether this set of services and the level of broker's fees for small employers will be defined by the exchange or by DFR.

Second, the exchange can facilitate the selection of a broker by posting their information and informing employers of the option. The exchange can also handle collection and payment of broker fees, by adding this as a separate item on the employer's monthly invoice and remitting fees paid to the brokers. Not only will this service be far more efficient than brokers billing employers, but it puts the exchange in a position to monitor broker' services, employer satisfaction, etc.

Finally, the exchange can determine the optimal fee level that attracts brokers and yet encourages the greatest number of small employers to retain a broker. In the RKM

interviews, 78% said they would not if the cost equaled 4% of annual premiums, while 57% said they would not if the cost equaled 2% of premiums. So, at least one out of five employers will pay a 4% commission while 43% will pay a 2% commission. This data suggests that employers will want to make this decision based on price and perceived value. The exchange will want to make brokers readily available to those employers who wish to use them.

***Current (and evolving) broker compensation rates in the market today***

Broker commissions represent a significant piece of administrative costs today. In response to an RFI issued by the State of Vermont on 2/22/12, BCBSVT reported that broker commissions for small employers averaged 3.5% of premiums in 2011 and 5.4% of premiums for association business. Presumably, the broker "piece of the pie" in both direct and association business averages about 3.5% and the difference between 5.4% and 3.5% for association business likely represents payments for administrative services performed either by the association itself or by a general insurance agency who acts as an intermediary.

The state's other small-group carrier, MVP, declined to estimate their commissions as a percent of premium, citing proprietary interests, but other evidence suggests that it is in the same neighborhood. The MVP commission schedule also reflects a growing practice nationally to set the commission as a flat fee per enrollee instead of a percent of premium. In fact, BCBSVT commissions for the largest association product (Vermont Association of Chamber of Commerce Executives or VACCE) are also paid on a fixed fee basis.

We set forth below three different "models" for paying brokers and managing the exchange's relationship with them. The models are predicated on broker compensation as a transparent, voluntary, add-on fee. (Although discussed below as a percent of premiums, payments would be converted to a flat fee per enrollee per month, based on average projected small-group premiums.) Under all scenarios, a common collection/distribution function would be set up by the exchange, and employers would pay the exchange, which would pass on the monies to the brokers.

1. <u>Compensation generally mirrors average fee in the pre-2014 small-group market.</u> This model promotes "market-driven" broker compensation and is the most likely to attract the greatest number of brokers to the exchange. As all costs are borne by the employer, the exchange might be tempted to adopt this approach, particularly in the early years when broker support of the exchange is most meaningful. However, given that current commissions appear to average 3.5% of premium, the RKM 50 employer interview results suggests that only 22-43% of employers would be willing to pay a directly incurred fee at this amount. Pre-2014 small-group commission levels may simply be untenable in a new world order where employers pay for broker fees directly.

2. Compensation reflects a reduced fee as compared to the average fee in pre-2014 small-group market. Under this model, brokers receive less compensation, but arguably provide less service during the annual plan selection process, at least after the first year (2014). In a full employee choice model, which was the favorite option 62% of small employers, the employer's annual selection decision is simply how much to contribute as a percent of a benchmark plan. The employer interview results suggest 43% of employers would pay 2%. As the drop from 3.5 to 2.0 represents better than a 40% decrease in compensation, perhaps something more along the order of 3% would be more tenable for all parties.

3. Exchange issues an RFP for a limited number of brokers in each geography and request bids. Under this approach, the exchange would certify the low bidders and either fix all of their fees at the cut-off point (highest bid accepted) or post each broker's bid and allow employers to select among qualified brokers at the price they bid. Under this approach, fewer brokers would have access to a captive market and presumably would be willing to discount their fees for greater volume. By limiting the number of brokers in the exchange, this model would also ease the associated administrative burden of training and oversight.

Additional operational specifics will need to be worked out by the exchange. Of course, all brokers participating in the exchange will need detailed training on how the exchange works, the various models of employee choice offered to small employers, transition issues for 2014, etc. Other elements of broker management need to be fleshed out, such as how to solicit, train and certify brokers , and how best to incorporate their market knowledge into small business exchange design and customer service. The exchange will also want to ensure that any broker selected to represent the exchange is recognized as an appointed broker both carriers represented on the exchange.

As will be discussed in more detail in the section on Call Center (customer service) strategy, the exchange should consider hiring as senior customer service representatives personnel with experience performing the functions typically executed by brokers. In order to serve employers who do not elect to engage their own broker, and to reduce the service load (fee) for independent brokers, this would assure the exchange access to the kind of knowledge and experience that will be critical to a smooth transition for 2014.

## Section V: The Role of Associations in the Small-Group Market Today

A significant number of small business employers (50 and under) enroll in health insurance purchased through association groups rather than directly through carriers. One key difference between certain association and direct carrier offerings is in the risk pool on which their community rating is based. Some associations (such as the one for Chamber of Commerce members) have an exemption that allows them to apply community rates across the their own membership's aggregate claims experience, while direct carrier plans (and certain other association plans) base community rates on the experience of their entire book of small-group business. Various associations have different membership requirements, and access to health insurance generally requires payment of membership dues or some type of administrative fee by qualifying employers. (In the post-exchange world, many of these fees will no longer be paid and employers will save additional administrative dollars. In some cases, employers will continue to pay membership fees for other services or benefits derived from association membership.)

At the present time, all association business is insured with BCBSVT but this has not always been true. The Vermont Association of Chamber of Commerce Executives (VACE), the largest association with more than 3,500 enrolled employer groups, was insured through CIGNA for seventeen years but changed over to BCBSVT on 1/1/12[xxx]. Other association groups with small employer membership[xxxi] include: Associated Industries of VT Insurance Services (AIVIS); Business Resource Services (BRS); Vermont Ski Area; Vermont State Dental Society; and the Vermont Health Services Group (VHSG) with more than 500 small employer groups who are members of one of six association entities supported by VHSG. A summary of the VACE program is provided as an example of how one association currently serves the needs of the small business community. It is a good example of how one intermediary, by far the largest in Vermont, works to connect small businesses with health insurance.

Eligible employers must be a member of one of 44 chambers that are a member of VACE, be domiciled in Vermont and actively in business, and have 1-50 employees. Employers can select from two products, offering a total of seven different cost-sharing options: the BCBSVT PPO product has four cost-sharing options and the BCBSVT High Deductible Health Plan (HDHP) product has three cost-sharing options. All seven are HSA compatible. Employers may select two options and give their employees a choice between the two plans. Only 570 employers (16%) do so. The enrollment agreement asks employers if they plan to contribute to either an HSA or HRA, and if so, to indicate the range of their contribution (either 0-50% or 51-100% of deductible). VACE also makes dental coverage available to employer groups.

Over 90% of the small employer groups cover three employees or less. The vast majority of employers use a broker to enroll in the plan. Employers primarily need the broker's help to determine the best plan(s) to offer employees, and also use the broker for claim assistance when needed, although some chambers assist with issue resolution. The association

website makes a list of 250 brokers available to employers (220 are in state and 30 are out of state), including contact information. Broker commission rates are on a per subscriber basis, and averaged 3.7% of premiums in 2011. They increased by $1 per policy per month as of 2012:

VACE Commission Schedule
As of 1/1/2012

| | |
|---|---|
| Single coverage | $17 per month |
| Two-person coverage | $25 per month |
| Family coverage: | $33 per month |

VACE handles all commission activities (tracking and payments), including the payment of bonus monies that are made available by BCBSVT for all new business sold (direct and non-direct business). The association is set up to manage all group billing and enrollment at the employer level. While employee enrollments are forwarded on to BCBSVT to be entered into BCBS systems, employer data is maintained by VACE only.

## Intermediary Models and the Vermont Small Business Exchange

Vermont's exchange should consider various strategies for tapping into the substantial expertise that exists in its small-group market, and which will be displaced under Act 171 as of 2014. One option for doing so would be to outsource a significant set of its functions to an existing business association, general agency (GA) or other type of intermediary that currently distributes health insurance and works with small businesses on other employee benefits. The advantages of outsourcing are:

(1) The potential speed and efficiency of adapting existing functionality, rather than building it anew: working in alignment, an experienced intermediary can provide the Vermont small business exchange critical advice on which services to develop, how to reach over hundreds of small businesses, how to support brokers as an effective field sales staff to the exchange, and so forth.

(2) Leveraging the market knowledge, influence and experience of an existing intermediary, including the trust that their client brokers and employers already have in them.

(3) Employing a Vermont business organization (and its employees) as part of the universal exchange and larger health care solution that will evolve after 2014.

Vermont should consider carefully which functions potential intermediaries are best at performing and which functions should be retained in the exchange. For compliance and strategic reasons, the exchange should retain such functions as reporting to the State and to the US Secretary of Health & Human Services, adjudicating appeals, and certifying qualified health plans. On the other hand, transactional and customer service functions which intermediaries already perform are obvious candidates for outsourcing.

The challenge in doing so, of course, is to contract at competitive rates for performing such functions well, and coordinating outsourced functions with other retained elements of the exchange. For example, eligibility determination in the individual exchange and reporting to employers when their employees qualify for tax credits will require information interfaces between the two exchanges. This is just one example of the multiple points of integration that would be required between outsourced functions and the exchange. Should the Vermont decide to explore outsourcing some functionalities to an intermediary, we offer a preliminary list of candidate functions:

- **Broker management**: this function entails the training, certification, sales support, and performance tracking of brokers who are working with small employers considering and/or purchasing through the exchange.

- **Employer qualification (eligibility determination)**: working with the employer's broker or directly with the employer, an intermediary could quality check and function as an authoritative source of information on whether the employer meets size, location and other eligibility criteria. (Employee qualification or eligibility determination remains the exclusive responsibility of the exchange and cannot be outsourced.)

- **Customer service**: just as brokers and employers have many questions for carriers throughout the enrollment period and the ensuing year, they will have similar inquiries of the Vermont small business exchange. In an employee choice model, because there is no single carrier for the employer (or broker) to ask for assistance, even more issues are likely to find their way to the exchange Call Center than would be the case for sole-source, group insurance in which one carrier handles each entire group of employees.

- **Marketing and Outreach:** educating thousands of small businesses across the state on a limited budget about the exchange, employee choice, and other relevant elements of the ACA will be a major challenge, particularly since employers will have no alternatives outside of the exchange if they wish to continue offering health insurance to employees, and intermediaries bring an understanding of employers' issues to this task.

- **Premium billing, collection and enrollment**: invoicing each employer on behalf of multiple carriers, ensuring timely collection or remedial action when payment is delayed, and remitting and reconciling employer payments to each carrier monthly is a critically important function.

- **Ancillary employee benefits lines**: small employers will look to their broker or some other source for life, disability, and other insured benefits, as well perhaps for 401(k), FSA, and other related services. For the broker's and employer's convenience, encouraging an intermediary working with the exchange to supply and manage these ancillary employee benefits lines (outside its exchange responsibilities would create the option for small employers of one-stop shopping.

A competitive procurement may attract interest from inside and outside Vermont, and selection criteria should include such factors as local market knowledge and established relationships with brokers, in addition to scale economies, systems capabilities and breadth of experience.

## Section VI: Call Center (Customer Service)

In this section, we highlight strategic and tactical recommendations to ensure the successful enrollment of small business employers and their employees. While the numbers below[xxxii] should be updated and refined in 2013, they suggest the scale of Call Center demands from small business enrollees.

- Businesses with 50 employees or less:
  - 16,060 FIRMS (2009 MEPS)
  - 7,514 FIRMS offer insurance (2009 MEPS)

- Number of lives (from 2012 carrier data call by Wakely):
  - 40,332 – current small-group
  - 20,716 – current association groups
  - Total: 61,000 (includes grandfathered plans)

The small business exchange will serve three constituencies: employers, their employees and brokers engaged by some small business owners to facilitate the purchasing decision, enrollment process and potentially, all other interactions with the exchange. Not all employers will hire a broker, so the exchange must be prepared to support all of the needs of employers (and employees) interfacing with the exchange directly. Similarly, the exchange must support the needs of brokers as they work on behalf of the exchange in educating and enrolling their small business clients.

The Call Center will be the primary point of contact for serving the needs of these three groups and the exchange website is a critical tool for delivering these services efficiently. Employers, employees and brokers have different needs and customer service issues than individuals and households buying directly. First, the small business client represents a far more complex "sale" than an individual buyer because the former is a two-step sale – first to the employer and then to his/her employees. Second, as a regulated entity under ERISA, the IRS code, HIPAA, ACA and state law, employers are subject to far more oversight, rules and reporting requirements related to fringe benefits than individual insurance buyers. Third, the small employer is generally accustomed to face-to-face, personal assistance with the health insurance buying process and is likely to be both demanding and somewhat confused about who does what in the new model of employee choice.

For example, before employees can interact with the exchange, it must first establish the employer's identity, validate eligibility, receive a census of eligible employees -- along with their identifiers, qualified waivers and full-time versus part-time employment status -- assign a unique identifier to the group, work with the employer/broker to select an employee choice model and levels of employer contribution for employees and dependents, establish HSA/HRA/FSA accounts, determine those funding levels, and so on. Then the exchange must display options for the employees and enroll them, which requires confirming the employee's identity, "populating" and pricing the employees' QHP options,

and enrolling them according to such application components as: plan choices available to employees, FTE employment status, premium rates net of the employer's contribution, any applicable HSA/HRA set up, affordability tests, and billing set up. Finally, the exchange must confirm and close enrollment for the group, generate invoices for multiple QHPs, transmit the group's enrollment to multiple issuers, and begin the collection and billing reconciliation process. Changes throughout the year and at renewal only add further complication.

For the employer who elects to hire a broker, the face-to-face support will likely continue and the broker will walk the employer through this process. For the employer who chooses not to incur the additional cost of broker assistance, the exchange should strive for a comparable level of assistance and decision-making support, using a combination of telephone customer service and web-based decision-support and enrollment tools. To the extent that the web portal is simple and easy to use, it can help this process, but for employers working without a broker, they will need to be guided through the web-based tool by a highly trained customer service representative. The exchange should anticipate that this process will be time-consuming and will likely require more than one interaction between the employer and the Call Center.

> *Recommendation #1:* The Call Center should make it easy for employers to engage a broker, even encourage this practice, particularly in the first year of exchange operations. For every employer represented by a broker, the exchange will need fewer highly skilled Call Center resources.
>
> *Recommendation #2:* The RKM interviews of fifty small-group businesses in Vermont suggest that more than half of the respondents will not hire a broker if they have to pay for these services outside of the premium expense; specifically, 78% will not hire a broker if the cost is an additional 4% of premium, while 57% will not hire a broker at a cost of 2% of premium. The exchange should consider subsidizing the cost of utilizing brokers in the first year of operation to encourage more employers to hire this specialized assistance.
>
> *Recommendation #3:* For those employers who do not engage a broker, the Call Center must provide specialized assistance from highly trained customer service representatives. The exchange is encouraged to create a dedicated unit of customer service representatives in the Call Center who have experience working with employer groups and who will need to be compensated appropriately for their established skill sets, to support employers and/or their broker agents.

The absence of a market outside of the exchange only serves to elevate the importance of providing sufficient employer assistance to successfully enroll in the exchange. A high utilization rate of brokers should significantly reduce Call Center demands and increase the number of successfully enrolled small businesses.

Employee contact with the Call Center has certain unique aspects but it does not involve the complexities of the employer contact. Today, the majority of small business employees are given the option of enrolling in only one plan. While additional plan choice may be a welcome advantage of the exchange, such choice will also create a certain amount of employee angst, especially for those employees who have not had experience "shopping" for a plan. Moreover, most employees today enroll on a paper application, which is generally vetted by their employer, broker or an association for completeness. Frequent omissions of key information are common and must be fixed before the application can be processed. In the exchange environment, web-based shopping will help employees compare plans, but also introduces novelty and challenges for some employees.

While many "office workers" regularly rely on a computer to do their job, there are still a significant number of small business employees who do not sit in front of a computer all day and who are intimidated by online applications. Call Center staff will need to walk the anxious employee through these processes by telephone. If the employee does not have access to a computer or will not use one, the exchange needs to provide some type of reference guide that the employee can have in front of him/her when talking with the Call Center.

> *Recommendation #4:* When an employer enrolls in the exchange, s/he should be asked if employees will have access to a computer for making enrollment choices (either at home or at work), and if yes, to indicate if the employee is reasonably computer literate. For those employees who do not have access to a computer or who are not comfortable using one, the exchange should provide a package of printed materials that the employee can have in front of them when they contact the Call Center for assistance.

Brokers are the third small business constituency. They are likely to be fairly demanding, as they are accustomed to a high level of service and attention from health insurance carriers. They will want to use their time (and limited "back office" resources) efficiently, demand immediate answers from the exchange, and hold the exchange accountable for any information they are given. . Brokers will strongly prefer to work with a dedicated customer service representative who can provide continuity of service (and knowledge of the broker's book of business) from one call to the next. Assuming that commission levels decline in the post-exchange world, many brokers will want to make up lost revenue by servicing additional clients. Call Center staff with no prior health insurance background or work experience with employers and /or brokers will fail quickly if assigned to assist this high-touch constituency.

> *Recommendation #5:* A broker portal should allow certified brokers with a "broker of record" letter for a given employer group to view virtually any information the exchange is maintaining on that employer group. For example, the broker should be able to view the progress of employee enrollments during open enrollment season, view billing and payment screens, and run a myriad of reports on client activities. To the largest extent possible, the exchange will want brokers to use self-service

portals to manage his/her book of business with the exchange, and to utilize their dedicated Call Center representative only when self-service will not resolve a need.

*Recommendation #6:* The Call Center must provide experienced, highly specialized service support to brokers, and preferably, dedicated support to each broker certified by the exchange. While an employer also requires specialized assistance, it will likely be impractical to assign a dedicated representative in a Call Center environment to each of thousands of employers.. However, dedicated broker support is recommended, especially for high volume brokers, including one representative with whom the broker can work for continuity of service reasons. (Most incoming calls will be routed to the first available Call Center agent trained to handle the inquiry, but brokers should be able to connect directly with their assigned representative. Broker reps must also be able to return a broker's call -- not all Call Centers are set up for outbound calling.

Key Questions on Call Center Operations

Defining the key features and objectives of the Call Center represents a significant strategic decision within the exchange planning and implementation process. Specifically:

1. Should the Call Center be outsourced or built as an in-house capability? What are the key elements of the Call Center strategy that impact this decision?
2. Should the Call Center be telephonically structured only or will it be a multi-channel Call Center accommodating live chat, email inquiries, US mail inquiries and walk-in traffic? If multi-channel, how will it interface with the web portals?
3. What are the critical considerations in determining regular hours of operation and seasonal staffing considerations?
4. How will the Call Center be seamlessly integrated with the core IT components of the exchange – including all website functionality, enrollment, premium billing, financial systems, reporting, generation of notices, and appeals processes?

<u>Outsourced Call Center or In-House Capability?</u> From both a cost and practical perspective, an outsourced Call Center offers many advantages. Given the limited amount of time the state has to stand up an exchange, a Call Center is an excellent example of a commoditized service that is better bought than built…outsourcing to an industry leader ensures speedy availability of process expertise, Call Center management know-how, fewer barriers in hiring (and downsizing) staff, cost efficiencies, and greater ability to respond to fluctuations in the Call Center volume. Exchange leadership can focus on defining the desired customer service experience (and the training requirements to achieve it), and the outsourcing partner can execute this strategic vision for the vast majority of calls. Within this structure, there is also a reasonable cost and quality argument to be made for installing a narrowly defined in-house capability to address either highly escalated or specialized inquiries. While the outsourced solution should be aimed at handling 95% or more of expected interactions, the exchange might wish to employ a small tactical unit for "exception" inquiries, particularly those from employers or brokers.

*Recommendation #7:* Call Center Services should be outsourced for 95% or more of expected volume and a very small, in-house unit might be put in place to address "exception" or highly escalated issues.

Defining the Call Center strategy is a key starting point for defining the desired customer service experience. At a high level, the strategy should establish very different work streams for each of the three Call Center constituencies. Each work stream should "bucket" anticipated inquires by level of ease or difficulty in resolving the inquiry on the first call. Triaging calls ensures that level one staff receive the simplest inquiries and are expected to handle the most volume while level two staff handle more complex needs and are evaluated accordingly. Determining the right number of work levels will ultimately be determined by exchange staff work in identifying the various types of inquiries and assessing how each may ultimately be facilitated by how core IT systems interface with Call Center technology. In the interim, an assumption of two levels is reasonable for planning purposes. The table below offers a sample list of typical inquiries each of these constituencies might make as well as an initial indication of the level of difficulty each might entail. All broker and employer inquiries are bucketed as level 2 work, while employee inquiries might fall into either level 1 (majority of calls) or level 2. While employee inquires will be somewhat different from individual or household inquiries from the direct pay market, they share sufficient commonality to considering training staff to work on both.

| Tiered Call Center Support by Type of Small Business Constituency: Sample Inquiries | | |
|---|---|---|
| Level 2<br>Broker Inquiries<br>• Fulfillment materials needed<br>• I lost the contact information for Joe's Auto and I am on my way there now…<br>• John Jones of ABC Plumbing needs a replacement ID card (cold transfer to QHP issuer but first remind broker to call them direct for replacement cards in the future)<br>• Sally's Hair Salon got their first bill and all the rates are wrong…<br>• All of the employees at Peter's Bookstore are enrolled through the exchange but 3 of them just received notices saying they will have to pay a penalty b/c they have no health insurance. How do I | Level 2<br>Employer Inquiries<br>• I employ an average of 67 FT employees throughout the year – can I enroll them in the exchange?<br>• How do I enroll my business and set up my employees to choose a plan?<br>• How can I get a broker to come out and help me?<br>• Am I eligible for the tax credit?<br>• I forgot to term an employee who left my employ 3 months ago and he's still using his coverage…how do I remove him back to the date of termination?<br>• I have 2 locations…one in VT with 3 FT employees and one in NH with 3 FT | Level 1<br>Employee Inquiries<br>• What plan choices are available to me?<br>• How are my plan choices different?<br>• Is my child/spouse eligible to go on my policy?<br>• How much does each plan cost me each month?<br>• Do I still have an HAS/HRA?<br>• I don't make a lot of money and my employer's plan will cost be a lot of money. An I eligible for a tax credit instead? |

| | | |
|---|---|---|
| get this fixed?<br>• Tom's Car Wash set up his employees with the full choice model last week but now he wants to change it so that all of his employees are on the same plan…his original decisions are already reflected on the website…how do I change this? | employees….which exchange do I use?<br>• I hired an employee six months ago and thought he enrolled in a plan. He's in intensive care and the hospital is telling his family that he doesn't have coverage. What can I do to get this fixed fast? | Level 2<br>Employee Inquires<br>• My current wife is on my policy but the judge said I have to cover my ex-wife too…can I put them both on my family policy?<br>• I just got a bill from my doctor who said that my insurance rejected my claim – why are you refusing to pay my claims??? (Explain to employee that claim question must be directed to the QHP issuer and offer to transfer him over)<br>• I put in my identification number on the website but someone else name comes up on the next screen… |

While the exchange might consider outsourcing employer and/or broker support to a vendor other than the one selected for employee and individual/household Call Center support, working with two different Call Center vendors is awkward and inefficient. It is only advisable if an entity exists today with very compelling experience and a cost effective value proposition. In the absence of such an option, the exchange should select and negotiate with the Call Center vendor to hire and manage staff for a specialized unit that can handle more complex employer and broker issues. Because some experienced workers serving the existing small-group market may be displaced as that market moves into the exchange, the Call Center vendor can ease their displacement by targeting this experienced work group for interviews.

Of course, exchange staff should also develop a mission statement, Call Center goals, performance measurements, and instill in all concerned the need for relentless documentation of each of these guideposts. Attention to training requirements will be a critical task.

Telephonic Call Center or Multi-Channel? The ACA requires the exchange to accept eligibility inquires and enrollment applications through the website, over the phone, in person or by mail. By establishing a multi-channel Call Center strategy, the exchange can optimize service delivery at all points of entry and can better plan for technology and staffing needs that encompass all means of communicating with the exchange. For example, the exchange should plan on the need for Call Center staff to provide "real time" assistance for callers needing to be "walked" through web-based, self-service activities. In Massachusetts, the Connector staff frequently needed to provide user assistance to callers

trying to navigate the web application. This literally involves the Call Center representative "walking and talking" a caller through a web application while both are simultaneously viewing the same screens and navigation prompts on their computers.

Some thought should be given to housing the small in-house staff for escalated issues in a location where employers and employees are invited to visit for face-to-face assistance or problem-solvingVirtually all employers use email to address business issues and the exchange will need to address related questions. What staff will respond to incoming employer emails? What about broker emails? Will the exchange accept employee email or will employees be required to call the exchange with inquiries? How will complaints and appeals be heard – by email or US mail or both? Will the exchange web site feature live chat sessions? Live chat sessions have the added advantage of moving the inquiry into the web portal functionality with greater ease than a phone call or email.

Call Center Availability. While the gold standard for many retail Call Center operations is 24X7, this is not required for the exchange. Rather, the Call Center will need to staff up and extend hours to accommodate the bulk of initial enrollments, and the high-volume season for renewals, and something akin to a standard business day (7 am-5 pm or the like) for Call Center operations during other seasons. For high-volume seasons, and especially the first three to six months of operations, live coverage for some extended period of time (perhaps something like 6 am to 9 pm) during the week, plus Saturday hours, will likely be warranted to meet the needs of the initial enrollment. Assuming a finite amount of staffing budget dollars, the exchange must evaluate whether the needs of the larger community are better served with greater staff availability during peak calling periods or fewer staff during peak periods but minimal coverage some greater number of hours. As a point of reference, the Massachusetts Health Connector has live staffing from 8 am to 5 pm Monday through Friday, and extended hours during heavy open enrollment periods.

Call Center Integration with Core IT Systems. While some amount of Call Center planning for both the individual and small business sides of the exchange can be accomplished now, a significant amount of development will be contingent upon the business requirements of the core IT systems and the plans for integrating all such systems with Call Center functionality. Key questions relate to how the IT systems and processes will support Call Center functions performed on a regular basis? We offer the following list to initiate this discussion:

- Customer Relationship Management (CRM) – robust and flexible CRM capability will be important for the exchange to track each employer and employee as they interact with any exchange process or system from their initial point of contact. Any exchange staffer, Call Center employee or broker with a "need to know" should be able to look in one system and know when an employer or employee contacted the exchange, why they did so and how the inquiry was resolved. The CRM tool should allow the exchange to track and manage employer interactions, employee touch points, and aggregate employee information at the employer level and aggregated exchange level contacts. Ideally, the

CRM tool should also have a series of screens where the broker can input data and the exchange can track the broker's work for any given employer and his/her employee.

- Tiered or Multi-level Call Center Support and IVR Functionality - the Call Center strategy should be based on a tiered operation to promote the most efficient use of Call Center staff on each inquiry. At the point of entry, callers should be voice-prompted to explore self-help options to reduce the need for unnecessary live assistance, and if the issue is not addressed, voice prompted to identify the reason for their call so that the inquiry can be forwarded to the most appropriate level of support.
- Knowledge Management – while comprehensive training must be provided before any Call Center representative takes even one call, an online knowledge management system will be needed to help representatives stay current with new information and to provide access to online manuals. Examples of online manual content might include: process flows for eligibility, enrollment, and premium billing; frequently asked questions and answers; timelines for various activities, plan rating methods; information on plan designs, explicit information on when (and how) to refer callers to QHP issuers, the appeals process, complaint procedures, tax credits (for both individuals as well as employers), how to refer an employer to a broker, available support tools for brokers, navigator assistance, how to assist callers with website troubleshooting; contact information for both internal and external departments and entities, and virtually anything else that an employer, employee or broker might call and inquire about.
- Web Portal – the web portal represents the heart of the exchange and Call Center staff will want to encourage callers to explore and utilize website functionality whenever possible.
- Enrollment – Call Center staff will need to access employer applications as well as the applications of individual employees.
- Billing – Call Center staff will need to access basic billing inquiries from employers and brokers. More complex billing inquiries can be warm transferred to an exchange employee in the billing group of the exchange (warm transfers involve putting the caller on hold while Agent A calls Agent B and explains who is calling and why, and then returns to caller to announce that Agent B is also on the line and take over the call). The need for such transfers should be very low.
- Financial Management systems: appeals application; and reporting systems(s): Call Center staff may have a "need to know" access reason to one of these systems.

## Section VII: Transition plan strategies to ease disruption

The State's requirement that small employers use Vermont's exchange if they wish to offer group health insurance in 2014 creates significant transition challenges. In addition to all the normal "start-up" issues that any new organization and process must confront, we list here some of the special challenges that effective transition planning should anticipate and address:

- Discontinuity in coverage, assuming that many existing small-group health plans will no longer be available in the exchange;
- The administrative and communications burden on carriers, employers and brokers of closing some plans and amending others;
- Premium increases, sometimes significant, for employers currently offering coverage that does not meet the ACA minimum requirements for actuarial value, caps on deductibles and out-of-pocket spending, and/or Vermont's definition of EHBs;
- Explaining to brokers and employers the new employee-choice models offered by the exchange;
- Explaining the new models of choice to employees, and guiding them through a new enrollment process
- Making brokers and employers aware that they must renew coverage well in advance of the their annual effective dates, to meet minimum timeframes for employee shopping, and a host of other differences from "business as usual";
- The elimination of "free" brokerage services and the consequent need for small employers to evaluate and decide whether to engage and pay for broker services; and

As noted in the RKM interviews, a majority of fifty employers contacted view the state's plan to require use of the exchange as either somewhat (28%) or very negative (35%). Among employers who view the requirement negatively, many said that they do not like being forced to do something, especially by the government. A significant number of other employers said there negatively is mainly due to how little they know about it. With so many potential clients already expressing resistance to the exchange, Vermont will want to plan ahead to overcome this early skepticism by giving employers as few reasons as possible to validate their early concerns.

We list below several possible strategies that Vermont should consider to ease both employee and employer transitions from the current distribution channels to the state's exchange:

(1) As suggested in the section on Employee Choice Dynamics, the exchange should consider offering plan designs that mirror popular (high-enrollment) plans in the pre-2014 market, in order to minimize the amount of required "change" and benefits disruption. This may mean offering more plans in the first few years of the exchange than is otherwise ideal, but if it alleviates employer and employee concerns about transitioning to the

exchange, it may be worthwhile to trade-off less standardization for more continuity. It also demonstrates flexibility in accommodating current market and buyer preferences.

(2) High deductible health plans (HDHPs) are common in Vermont today, with two out of every three small business plans qualifying as an HDHP. However, many of these plans currently have deductibles and/or maximum out of pocket (MOOP) limits that exceed the ACA allowable cost-sharing limits for 2014. For example, Table 3 below demonstrates that 91% of VACE enrollment is in plans with cost-sharing requirements that exceed the ACA's 2014 limits. Initial federal guidance, however, suggests that employer contributions to HSAs and HRAs can be included in the actuarial value (AV) of a plan. The exchange should consider offering a limited number of existing HDHP plan designs on the Bronze and Silver levels with deductibles that exceed the $2,000/$4,000 limits but meet these actuarial levels with the appropriate HSA or HRA employer contributions. (The annual out-of-pocket spending limits in excess of IRS requirements, which should approximate $6,000/$12,000 in 2014, will not qualify for preferential tax treatment and therefore are less attractive than the other HDHPs.) Employers and employees will be looking in 2014 for plans that look the same as what they have in 2013, and cost less. If forced to abandon such plans and pay far higher premiums, this will generate a major backlash.

**Table 3: Vermont Association of Chamber of Commerce Executives (VACCE): Enrollment by Plan at 1/1/12**

| Product | Cost-Sharing (Deductible) | Cost-Sharing (Max Out of Pocket - MOOP) | Enrollment (# Contracts) | Percentage of Total | |
|---|---|---|---|---|---|
| PPO | $1,500/$3,000 | $6,000/$12,000 | 536 | 3% | ***91% of enrollment is in plans that exceed maximums allowed by the ACA for 2014*** ***(ACA deductible limits: $2,000/$4,000 MOOP limits: $6,000/$12,000*** |
| | $2,500/$5,000 | $6,000/$12,000 | 1,512 | 9% | |
| | $3,000/$6,000 | $3,000/$ 6,000 | 4,903 | 29% | |
| | $4,000/$8,000 | $8,000/$16,000 | 1,751 | 10% | |
| High Deductible Health Plan (HDHP) – HAS Compatible | $2,000/$4,000 * | $5,950/$11,900 | 1,186 | 7% | |
| | $2,450/$4,900 * | $5,950/$11,900 | 2,305 | 14% | |
| | $5,950/$11,900 ** | $5,950/$11,900 | 4,922 | 29% | |

* Aggregate Deductible: Full individual or entire family deductible must be satisfied before benefits are paid
** Stacked Deductible: Plans pay benefits for an individual after they've met the individual deductible

(3) The exchange should consider working with the two carriers in Vermont's small-group market today to map pre-2014 plans to the closest options in the exchange. Carriers frequently do this today when they announce new product offerings (or remove existing plans from the market) and it serves to reduce member angst about finding the closest option to what they currently enjoy.

(4) As carriers and brokers will confirm, employees often do not complete enrollment applications completely and/or accurately. The exchange should consider pre-populating their enrollment system with existing enrollee data from carriers (or alternatively, the exchange could ask carriers to identify any enrollment discrepancies once application forms are submitted).

(5) Over three-quarters of small employers renew on January 1 which will be the exchange's start-up and busiest season. The exchange should consider the advantages of staggering renewal dates for small employers in order to avoid stressing all resources with a January 1st enrollment date. This could be done on a voluntary basis where interested employers request a 9-month or a 15-month rate when they renew coverage on January 1, 2013, so that their first anniversary in the exchange falls on April 1, 2014 or October 1, 2014. However, the carriers would need to adjust these policies, with regulatory approval, for their unconventional duration. For example, annual deductibles, annual out-of-pocket maxima, annual caps on benefits, HRA/HSA funding, and premiums would all need to be adjusted for a "stump" or extended year beginning January 1, 2013.

Estimated Small Group Enrollment in 2011 by Renewal Month

| # Employers | # Employees | Renewal Month | % Employers | % Employees |
|---|---|---|---|---|
| 8,388 | 30,752 | Jan | 77% | 75% |
| 366 | 1,405 | Feb | 3% | 3% |
| 378 | 1,384 | Mar | 3% | 3% |
| 162 | 462 | April | 1% | 1% |
| 171 | 622 | May | 2% | 2% |
| 155 | 721 | Jun | 1% | 2% |
| 204 | 716 | July | 2% | 2% |
| 148 | 557 | Aug | 1% | 1% |
| 212 | 1,231 | Sept | 2% | 3% |
| 140 | 569 | Oct | 1% | 1% |
| 166 | 755 | Nov | 2% | 2% |
| 346 | 1,691 | Dec | 3% | 4% |
| 10,836 | 40,865 | Total | 100% | 100% |

Not only is January 1st the most common renewal date for small groups, it is also "opening day" for the exchange. Given the already considerable time constraints in standing up an exchange for January 1, 2014, the State may want to minimize start up "hiccups" by spreading out enrollment dates in the first year (or first six months) of operation. In addition to minimizing opening day operational issues, staggering enrollment dates also allows brokers, navigators, Call Center personnel, and enrollment staff to distribute the work effort more effectively.

(6) An outreach campaign to begin educating employers, brokers and the public as early as this summer on how the exchange will work and what they can expect in 2013 and 2014 will go a long way toward allaying fears and concerns. A primary focus of the early campaign should be to dispel myths about reform in 2014 and to explain the new employee choices that the exchange will enable. In the summer of 2013, as the plans are certified and the date for shopping in the exchange gets closer, the focus of communications will shift to detailed explanations of how and when to use the exchange. Another important focus for a concerted outreach effort will be to tie increases in premiums to increased benefits, so that the exchange itself is not "tagged" with raising costs. (The state should consider getting this general message out early, rather than waiting until premiums are actually set for 2014.)

The state might consider launching the exchange website in as early as August 2012 in order to familiarize employers with the address and to promote the state's desire to inform early, often and easily. Other components of the outreach campaign should be kicked off at the same time, with a goal of establishing the State of Vermont as being the best source of information about the exchange. While not all policy decisions will be made by this summer, the exchange can promote the ones that have been made as well as address other procedural items pre-emptively (i.e., intent to use one enrollment form for enrollment). In the absence of timely communication, others will fill the information void with half-truths and angst producing uncertainties.

(7) The state should consider initiating regular forums to exchange detailed operational information, ideas and questions with carriers and brokers, two of the stakeholders that will inevitably help shape the success of the exchange. Carrier staff and brokers want the state to benefit from the lessons learned in their respective spheres of expertise. For example, BCBSVT recently prepared a presentation that summarized how their experience with the Catamount program offers "lessons learned" for the benefit of the exchange. Catamount customer inquiries per thousand members are 1,304 while TVHP (BCBSVT subsidiary) inquiries per thousand are 348. The most frequent reason for contacting customer service is benefit inquiries, and a primary driver is the perception that claims have been denied, when they count toward the deductible. The exchange (and carriers) can use this information to better educate members on how deductibles work and hopefully reducing unnecessary call volume. As both the exchange and carriers will have customer service functions and encounter similar kinds of issues, the exchange will want to learn from the carrier's experience and coordinate Call Center functions closely. At a minimum, the exchange and carriers must clarify (eventually by contract) and communicate consistently to staff, brokers and customers where common questions should be directed for first-call resolution.

For example, who should an exchange enrollee call for the following questions: (1) what plan am I in?; (2) where's my ID card?; and (3) am I covered? Should the enrollee call the exchange or the carrier? What does the ID card advise the member to do? Anticipating these types of questions early on will go a long way toward minimizing customer service issues for employees and employers alike and will reduce misdirected inquiries coming into the exchange Call Center.

These are some key strategic questions that will need to be addressed in order to minimize transition issues. Inevitably there will be more as policy unfolds and operational details are discovered. The goal of the exchange should be to capture expected transition issues and to create strategies to lessen them as soon as possible.

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[iii] The Office of Personnel Management is expected to contract with at least two multi-state health plans, which must eventually (2017) participate in all state exchanges, but initially (2014) must participate in 31 exchanges. Other than Blue Cross and Blue Shield, multi-state plans will probably not cover Vermont initially and may decide to wait and see how the state's waiver for 2017 play out before trying to enter Vermont.
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[xi] "Why Consumers Disenroll from Medicare Private Health Plans". (Medicare Rights Center, Summer 2010), http://www.medicarerights.org/pdf/Why-Consumers-Disenroll-from-MA.pdf.
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[xv] Toby S. Edelman, "Oversight and Enforcement of Medicare Part D Plan Requirements: Federal Role and Responsibilities". (Kaiser Family Foundation, September 2006), http://www.kff.org/medicare/upload/7558.pdf.
[xvi] Jennifer M Polinski et al. "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present". *Journal of the American Geriatrics Society* 58, no. 5 (May 2010): 950–966.
[xvii] YanivHanoch et al. "How Much Choice is Too Much? The Case of the Medicare Prescription Drug Benefit". Health Services Research 44, no. 4 (August 1, 2009): 1157-1168.
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[xx] Families USA. (July 2010). *A Helping Hand for Small Businesses: Health Insurance Tax Credits.*
[xxi] Vermont Department of Labor. (April 2012). *2011 Fringe Benefit Study.*
[xxii] We applied information from the Vermont Fringe Benefit Study as an upper limit estimation because the study provided estimates for small businesses of all compensation levels, however businesses can only be eligible for the tax credit if they have average wages of less than $25k for the maximum and less than $50k for any credit. Due to the fact that employers with higher wages are more likely to offer insurance, we therefore used the Fringe Benefit study information as upper limit estimations.
[xxiii] Vermont Exchange, Qualitative Research (In Depth Interviews of 50 Small Businesses Offering Health Insurance). Conducted in May 2012 by RKM Research and Communications, Inc.
[xxiv] State of Vermont, Plan Design: Current Market Overview. J. Peper, Wakely Consulting, May 14, 2012
[xxv] Vermont Exchange, Qualitative Research (In Depth Interviews of 50 Small Businesses Offering health Insurance). Conducted in May 2012 by RKM Research and Communications, Inc.

[xxvi] 2011 Vermont Employee Benefits Survey. Hickok & Boardman Group Benefits. The annual survey was conducted online between June and July 2011. A total of 143 Vermont and New England-based employers responded, of which approximately 36% represented small businesses with fewer than 50 employees. Some results are based on all respondents while certain results specifically represent only the responses of small employers. When results are specific to small employers, it is noted in the text.

[xxvii] Vermont Exchange, Qualitative Research (In Depth Interviews of 50 Small Businesses Offering health Insurance). Conducted in May 2012 by RKM Research and Communications, Inc.

[xxviii] Vermont Exchange, Qualitative Research (In Depth Interviews of 50 Small Businesses Offering health Insurance). Conducted in May 2012 by RKM Research and Communications, Inc.

[xxix] The RKM 50 Employer Interviews found at least 72% of respondents used a broker (52% said they used a broker and another 20% said they used both a broker and a business association). Brokers interviewed for this guide indicated that the number was at least 80% or higher. BCBSVT stated in their RFI response that 84% of their business was brokered but they included large group business in this estimate.

[xxx] VACE enrolment data was provided in an email dated 3/21/12 to Wakely Consulting.

[xxxi] Some associations include employers with 50 or less employees as well as employers with more than 50 employees. Examples include VT Health Services Group (VHSG) and Vt Ski Area Association (VSAA). The employers with 50 or less employees in these associations will be required to purchase through the exchange in 2014.

[xxxii] This data set has been generally used by exchange leadership to approximate the size of the current small business community per R. Lunge email of 6/4/12.