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Examining a Defined Contribution Strategy in the SHOP Exchange

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) gives states the option of creating health insurance exchanges — including the American Health Benefits Exchange (AHBE) for individuals and families, and the Small Business Health Options Program (SHOP) — to facilitate the purchase of health insurance. The ACA also allows the states a great deal of flexibility in designing the infrastructure and operation of these portals. With respect to the SHOP, the ACA includes provisions that support an employer "defined contribution" model that would enable employees to select and purchase health insurance with a fixed dollar contribution from their employers. The ACA also intends (and the proposed regulations require) that the SHOP facilitate enrollment and premium billing, functions that could lessen the administrative burden for small employers of managing multiple plans and further encourage employee choice.

New Jersey's small group market, overseen by the Small Employer Health Benefit Program (SEHBP), currently operates under the employer-choice model, i.e., the employers drive the health plan selection process for their employees. The SEHBP provides a selection of standard plans from which small employers can choose coverage for their employees. Optionally, employers can use benefit riders to amend the standard plans to better meet the group needs. The current operation of the small group market is substantially supported by insurance brokers, who work closely with employers to facilitate plan selection and enrollment. In establishing the SHOP, New Jersey may decide to continue the current employer-choice model or encourage plan choice at the employee level, i.e., the "employee-choice model". If the SHOP adopts the latter and assumes the enrollment and billing functions, the market may see an increase in small business participation and a transformation of the role of brokers who have historically played an integral part in the operation of the small employer market. In addition, adverse selection remains perhaps the biggest challenge in a market that allows individual choice.

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Introduction

The Patient Protection and Affordable Care Act (ACA) calls for the creation of health insurance exchanges to promote efficient markets for individuals and small businesses to purchase health insurance coverage. Under the ACA, states have the option of establishing and operating their own exchanges, partnering with the federal government in this venture (i.e., the "hybrid" model) or allowing the federal government to create and run exchanges on behalf of the states' insurance markets. States can choose to create two exchanges, one serving individuals and families without employer sponsored coverage – *the American Health Benefits Exchange (AHBE)* – and another serving small businesses – *the Small Business Health Options Program (SHOP)*, or create one exchange serving both markets. In general, the ACA gives states a great deal of leeway in the design of the exchange infrastructure and operation, although the Department of Health and Human Services (DHHS) proposed regulations require that the SHOP perform billing and premium aggregation functions.[1]

Under the ACA, the SHOP is intended to enable easy plan-to-plan comparisons for consumers and to facilitate the enrollment process. While employers participating in the SHOP can select coverage for their groups, the ACA includes provisions that encourage employers to offer choice of plans for the employees, an approach that may prompt employers to consider contributing a fixed dollar amount toward coverage – known as a "defined contribution" approach – and letting their employees select health coverage that best meets their needs. This brief 1) explores the key issues and health reform provisions related to defined contributions and employee choice; 2) describes the rules regarding premium payments in the SHOP (in contrast with the individual exchange); and 3) discusses the benefits and tradeoffs of these policy options in the context of New Jersey's small employer group market.

[1] Notice of Proposed Rulemaking (NPRM), 45 CFR Part 155.705(b)(4). The U.S. Department of Health and Human Services' proposed regulation requires that the SHOP perform the following functions: a) Provide each qualified employer with a bill on a monthly basis that identifies the total amount that is due to the Qualified Health Plan (QHP) issuers from the qualified employer; and b) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all qualified enrollees.

The Defined Contribution Approach

In response to rapidly rising health insurance costs and frustration with managed care systems, defined contributions emerged in the 1980s and 1990s as a financing and management strategy for employers to contain costs and increase choice for their employees. When employers make a *defined contribution*, they contribute a fixed dollar amount toward the health insurance premium of each employee.[2] Health plans that are purchased using a defined contribution approach can vary greatly in form and practice,[3] but this segment of the market often presents the following characteristics and associated challenges:

First, allowing defined contributions in the group market typically signals a shift from the traditional, employer selected health coverage philosophy to an *employee-choice model*, in which employees choose among competing plans based on their individual or family needs as well as cost considerations.[4] Employees generally welcome the opportunity to choose their own coverage (or, minimally, have a significant influence on the selection process), though when faced with complex and numerous options some may consider it a burden and prefer that employers assume this responsibility. Moreover, greater choice for individual consumers can lead to a greater chance of adverse risk selection—when lower cost, more restrictive plans attract healthier and younger individuals, and higher cost, more generous plans attract people with greater health care needs. Adverse risk selection can lead to increasingly unaffordable premium for older and less healthy individuals.

Second, for employers, the defined contribution approach lessens financial uncertainty associated with premium cost increases at plan renewal. This added control over health benefits spending may make some previously non-sponsoring employers more comfortable offering health coverage to their workers. A defined contribution strategy can make the employees more price sensitive when making purchasing decisions though more vulnerable to premium increases. While this increased financial stake is intended to encourage employees to make economical purchasing choices and stimulate price competition among carriers, some individuals may forego health insurance altogether or settle for plans solely based on cost concerns, and risk having coverage that falls short of their needs, i.e., becoming "underinsured".

Finally, when a group market allows defined contributions and employee choice, some small employers—often lacking human resources support—may find it burdensome to manage

[2] While a "defined contribution" typically refers to a fixed dollar amount contribution, some expand the definition to include varied percentage contributions across products.

[3] Health plans that are often considered "defined contribution plans" range from limited offering and active management by the employer at one extreme, spending accounts (e.g., Health Reimbursement Arrangements or HRAs) and intermediary approach in the middle, and vouchers on the other extreme of the continuum of sponsor responsibility (American Academy of Actuaries 2002).

[4] Although the coverage choices of some very small groups may be heavily influenced by their employees' preferences, such "choice" is still fundamentally distinct from the employee-choice regime, in which the selection occurs at the level of the individual employees.

several plans or carriers, including processing multiple premium payments each month. This administrative burden can be eased if an intermediary (such as a third-party administrator or an exchange) facilitates the transaction with carriers and assumes the responsibility for the *premium billing functions* by aggregating employee enrollment and sending each employer one bill for the group (functions of the SHOP that would be required by the health reform law if the proposed regulations[5] go into effect). That said, there may be some reluctance on the part of insurance carriers to delegate the billing functions, as this is a responsibility that has traditionally rested with carriers and one that they have typically performed well (Cantor et al. 2011).

Lessons Learned from Other States

Defined contributions and the employee-choice model have been in practice in a few long-running group purchasing cooperatives. One such example is the Connecticut Business & Industry Association's (CBIA's) Health Connections. Launched in 1995, the CBIA Health Connections is a private purchasing mechanism serving small businesses with 3 to 100 employees. Currently Health Connections serves 6,000 small employers and covers over 80,000 lives. To be eligible, 75% of the employees in a small employer group must be insured. A participating employer chooses one of two benefit tiers ("suites") and contributes at least 50% of the lowest employee-only rate in the suite. Employees can then buy up or buy down to their plan of choice. Carriers in CBIA Health Connections follow the same underwriting rules, eligibility rules, and rating standards as the outside market, and participate in the mandatory statewide reinsurance pool (the Connecticut Small Employer Reinsurance Pool) for high-risk employees (Kaminski Leduc 2008). In addition to establishing benefit standards and actively negotiating with carriers, Health Connections provides a full range of administrative and human resources services to participating small employers including enrollment facilitation, premium billing, and assistance in complying with federal laws like COBRA. By ensuring a level playing field and robust participation of diverse small businesses and their employees, this cooperative has avoided adverse selection and remained a viable market since inception (Gardiner and Perera 2011; CBIA Health Connections 2011).

New York HealthPass, a not-for-profit exchange operating since 1999, offers another example of widespread use of employee-choice model and defined contributions (Schilling 2010; Ashton 2011). HealthPass has not struggled with adverse selection undermining its operation, perhaps owing in part to the pure community rating environment in New York State. Like Health Connections, HealthPass offers participating employers and their employees extensive administrative support, such as enrollment and premium aggregation services. Together with employee choice of coverage option, the rich administrative services help attract

[5] NPRM 45 CFR Part 155.705(b)(4).

many small businesses, particularly those without in-house human resources staff. Both Health Connections and HealthPass also maintain good relationships with the broker community, which has been instrumental in reaching and enrolling new small businesses. A large and growing pool of covered individuals is more likely to have a risk profile that resembles the larger population and to attract insurers to the market, further reducing the potential for adverse selection (Gardiner and Perera 2011; Schilling 2010).

More recently, Utah established its statewide Small Business Exchange in 2009 using the employee-choice model and encouraging defined contributions from employers. It emerged from the pilot phase in early 2011 and currently enrolls about 200 employers (Utah Health Exchange 2011). In addition, California enacted legislation in September 2010 to establish a small employer exchange that will encourage employee choice and incorporate defined contributions. Informed by its experience with PacAdvantage, a not-for-profit exchange that was in operation until 2006, the state identified choice as a key value attracting participation, and concluded that the ACA provisions against adverse selection presents the framework for a more viable small group market (Weinberg and Kramer 2011). While New Jersey's local context and the health reform law (which are explored in the following sections) form the basis of the State's exchange planning efforts, these examples may still serve as useful references.

Considerations for New Jersey's Small Employer Group Market

The New Jersey Small Employer Health Benefits Program (SEHBP) was established in 1994 to foster an accessible and viable small group health insurance marketplace in the state.[6] Overseen by a board representing various stakeholder groups, the SEHBP is authorized to set benefit standards, underwriting rules, and enrollment requirements. The SEHBP guarantees health coverage and renewal (known as "guaranteed issue and renewal") for eligible employers, and requires modified community rating based on age, gender, location, and coverage category (New Jersey Department of Banking & Insurance 2011). In addition to setting the rules and standards, the SEHBP enables basic comparisons across plans in the program; in practice, however, plan offerings remain fairly complex because of the extensive use of riders. Small employers typically trust and rely on insurance brokers to help facilitate the plan selection and enrollment processes. The ACA requires rating rules and guaranteed issue[7] similar to the SEHBP, and prohibits underwriting based on pre-existing conditions. The ACA also promotes more "transparency" in insurance purchasing by creating four "precious metal" tiers of coverage based on actuarial value and enabling side-by-side comparison of plan options based on standardized information.[8]

[6] N.J.S.A. 17B:27A-17 et seq.
[7] ACA § 1201.
[8] ACA § 1311(d)(4).

New Jersey's SEHBP currently operates under the employer-choice model whereby participating employers select health insurance coverage for their employees. While observation and anecdotal experience indicate that some employers in New Jersey have historically responded to their employee's preferences by offering multiple plans, recent federal data suggest that a majority do not,[9] perhaps restrained in part by carriers' underwriting rules or some need for administrative simplicity. The SEH Board is in the process of requesting primary and secondary underwriting guidelines from the carriers to further examine this issue. In the SEHBP, an employer must ensure that 75% or more of its employees have health coverage—either through a participating carrier, Medicare, Medicaid, NJFamilyCare, or under health plans of their spouses.[10] Under a September 2010 revised interpretation of the regulations designed to address the issue of "slicing" small groups, the SEH Board determined that if a group is covered by more than one carrier, the secondary carrier (i.e., the one that does not satisfy the 75% participation rate requirement) has the discretion of whether or not to offer additional plans to eligible small employers.[10]

In contrast, the federal health reform provisions encourage employee choice while still allowing the traditional employer-choice approach. Under the ACA, an employer purchasing through the SHOP can select one or more plans for all its employees,[11] as is the current practice in the SEHBP, or opt for the employee-choice model by selecting one of the "precious metal" coverage tiers (i.e., plans of equivalent actuarial value) and allowing the employees to choose among the plans in that tier.[12] Restricting employee choice to one coverage tier is intended to minimize adverse selection (i.e., preventing people with more substantial health care needs from "buying up" their health care coverage because they know they will utilize the benefits), although the ACA does not preclude states from expanding employee choice across tiers if deemed appropriate. While the ACA does not specify, the DHHS proposed regulations[13] require that the SHOP assume the premium billing functions in order to reduce employers' administrative burden associated with offering multiple plans (see section titled Premium Billing Functions below). Table 1 summarizes the benefits and tradeoffs of adopting the employee-choice model versus the employer-choice model.

[9] Across New Jersey, an estimated 155,000 small firms (fewer than 50 workers) employ over 929,000 individuals. More than half (52.7%) of these firms offer health insurance, but among the sponsors only about one quarter (23.1%) report offering two or more plans (Agency for Healthcare Research and Quality 2011a).

[10] Advisory Bulletin 10-SHE-04, Small Employer Health Benefits Program, New Jersey Department of Banking and Insurance. Available at www.state.nj.us/dobi/division_insurance/ihcseh/bulletins/seh10_04.pdf.

[11] ACA § 1312(f)(2)(A).

[12] ACA § 1312(a)(2).

[13] NPRM 45 CFR Part 155.705(b)(4).

Table 1: Benefits and Tradeoffs of Employee-Choice vs. Employer-Choice Models

	Employee-Choice Model	Employer-Choice Model
Administrative burden	• Employers are relieved of plan selection and management responsibilities • Employees select health plans that best meet their individual needs • SHOP (or an intermediary) must provide management support for employee choice to be feasible	• Employers select one or more plans and determine coverage and premium contributions for employees
Adverse selection	• Market may be more prone to adverse selection because of reduced employer-level risk pooling • Confining employee choice to one coverage ("precious metal") tier may reduce risk of adverse selection	• Not offering employee choice of plans reduces risk for adverse selection
Premium billing and aggregation, required by the DHHS proposed regulations[14]	• SHOP can reduce administrative burden for employers if it facilitates enrollment and assumes premium billing functions	• Employers pay carriers directly or through third-party administrators
Decision support for employees	• In facilitating enrollment, SHOP is responsible for enabling meaningful plan-to-plan comparisons and ensuring that employees have adequate information to choose based on plan features, cost, and quality • Brokers' role in the small group market may be redefined to focus on individual plan selections	• Employee choice is reduced, and less decision support is needed • Employers may provide information and assist in decision support if more than one plan is offered

Challenges of Reconciling Defined Contributions with Employer Premium Contribution Requirements

SEHBP requires that employers contribute a minimum of 10% of the total premium costs for its group to participate in the program. The ACA does not set a minimum contribution rate for participation in the SHOP, but does require a minimum contribution for eligible employers to claim the small business health care tax credit. Specifically, firms with fewer than 25

[14] NPRM 45 CFR Part 155.705(b)(4).

employees[15] and an average compensation below $50,000 (and below $25,000 after 2014) must contribute at least 50% of the group coverage costs in order to qualify for this tax benefit [PPACA §1421/IRC sec. 45R].[16] As New Jersey firms have fewer low-wage workers than the national norm (Agency for Healthcare Research and Quality 2011b), it remains unclear how many employers will be eligible for the tax credit.

If New Jersey establishes a SHOP that encourages employee choice, employers may prefer paying their share of premiums with fixed dollar amount contributions (see Table 2). Depending on the range of plans chosen by their employees, these employers may face the complication of meeting the 10% minimum contribution rule of the SEHBP, or the 50% contribution requirement to claim tax credit. Recent additions to Internal Revenue Service (IRS) guidelines offer a solution to the dilemma of calculating premium contribution requirements. Under these guidelines, an employer would choose an Employer Reference Plan (ERP),[17] and determine its group or "composite" premium rate based on the ERP. The employer would then set the amount of employer contribution at 10% or higher to meet the SEHBP eligibility criterion,[18] and 50% or higher to qualify for the federal small business tax benefit. Each employee would pay the remaining portion of the composite premium, plus (or minus) the difference in premiums between his/her plan of choice and the ERP. The CBIA Health Connections has used this approach to allow employers to establish their premium budget while providing employees the opportunity to choose plans that best meet their needs. In the SHOP, employees would pay their share of the premiums with pre-tax deductions, thus lowering their income tax liability.[19] They would not be eligible however for individual premium subsidies as long as their employers offer affordable coverage.[20]

[15] Employers with more than 25 employees but less than 25 full-time equivalents (FTEs) also meet this criterion.

[16] To the extent that a large number of employers can qualify, the lowered effective health coverage costs resulting from the tax credit should enable the SHOP to attract a large and fairly balanced pool (rather than disproportionately high risk groups), and may help mitigate adverse selection.

[17] Under the IRS “uniformity requirement” (IRS Notice 2010-82, Subsection G.4), the ERP composite premium rate must be at least 66% of any non-reference plan offered to the employees.

[18] The 10% minimum employer contribution criterion would be relevant if the SEHBP guidelines on employer contributions are applied to the SHOP.

[19] IRC sec. 125.

[20] If an employee’s share of premium (through SHOP exchange) exceeds 9.5% of his/her family income, the employee may be eligible for individual premium subsidies.

Table 2: Implications of Permitting Defined Contributions in the SHOP

	Defined Contributions Permitted	Defined Contributions Not Permitted
Cost sharing and financial risks	• Employers have less exposure to increases in health benefit costs • Employees have greater exposure to financial risks associated with plan selection and annual premium increases • Employees are at greater risk of choosing inadequate coverage due to cost concerns	• When faced with premium increases, employers may bear more financial burden, decide to adjust employer contributions, or change plan offerings • Employees have less stake in health plan choice and may bear less direct burden of premium increases over time (unless employers adjust their contributions or change plan offerings)
Choice of plans	• Employers provide employees a fixed sum and are removed from plan selection process • Employees choose plans based on cost considerations and individual needs	• Employers are more likely to choose plan(s) for employees

Premium Billing Functions

Employers offering choice of plans to their employees potentially face the increased burden of managing multiple plans each month. A SHOP that is structured to assist employers with premium contribution calculations, facilitate enrollment for the employees, and perform premium billing functions may substantially mitigate this administrative burden on the employers and ensure a streamlined process.

The DHHS proposed regulations[21] require that the SHOP issue a *"list bill"* for each employer itemizing the plan selections and pre-tax payroll deductions of all its employees, and the total amount due for the entire group. Once it receives the single payment from the employer, the SHOP can then transmit the appropriate amounts to all the chosen health plans.

With the authority to bill for premium payments from various sources, the SHOP would have the option of allowing an employee to apply contributions from different sources (e.g., multiple employers, spouse's employer) towards one plan choice, provided all sponsors offer the chosen plan or adopt the employee-choice model. The Utah Health Exchange currently offers this service and calls it "premium aggregation".

Unlike the SHOP, the AHBE is required by the ACA to comply with a few important rules regarding premium payments:

[21] NPRM 45 CFR Part 155.705(b)(4).

- The AHBE will be responsible for creating an "electronic calculator" to help purchasers determine the level of premium tax credits and cost-sharing subsidies for which they are eligible, and generate net cost estimates for various plans available to them.
- When an individual purchaser decides on a plan, the purchaser must be given the option to pay his or her share of the premium directly to the carrier, even if the AHBE has a premium billing function.[22]
- U.S. Department of Treasury is required to forward advance payments of premium tax credits directly to health plans, rather than through AHBE.[23]

Although the ACA allows the AHBE to perform the premium billing function, these payment rules imply that the insurance carriers maintain their premium collection systems, and may constrain the AHBE's ability to streamline the process. In fact, prescribing the billing functions to the AHBE may duplicate much of the carriers' efforts and is unlikely to increase administrative efficiency.

Conclusions

Largely because of more than a decade of experience with the SEHBP, New Jersey would seem to be further ahead than other states in preparing for many of the health reform law's requirements – such as premium rating and guaranteed issue – for small group coverage. The ACA's provisions regarding the SHOP's role as the portal for health coverage selection and enrollment, however, could shift the market towards the employee-choice model, particularly if the state permits defined contributions from employers. The SHOP's role as the intermediary and its functions of facilitating the selection and purchase of health coverage pose additional challenges, since these functions will be new for small employer groups in New Jersey.

This brief identifies the potentially significant implications of shifting from New Jersey's current predominantly employer-choice small group model to more of an employee-driven approach that encourages employer defined contributions. Adverse selection in the small group market is perhaps the biggest risk of moving to the employee-choice model. Experiences in other states, albeit limited in scope and under different market circumstances, have generally been positive and without reports of risk selection problems. Nevertheless, if New Jersey moves forward to encourage employee choice, policymakers should adopt available strategies to protect against risk segmentation (a separate brief addressing policy options to avoid risk selection is forthcoming). A SHOP that provides administrative support in an employee-choice regime is likely to streamline the enrollment and premium collection processes, thereby relieving some burden from small employers and potentially improving efficiency in the small

[22] ACA § 1312(b).
[23] ACA § 1412(a)(3).

group market. The creation of such administrative systems within the SHOP nevertheless would be challenging and possibly disruptive to management strategies already used by insurance carriers. This new market may also see a transformation of the role of brokers, whose knowledge about the operation of New Jersey's small employer market will no doubt remain a valuable asset. In spite of these possible disruptions and uncertainties, the defined contribution approach and enhanced employee choice would likely expand options which are generally not available to those working for small businesses today.

References

Agency for Healthcare Research and Quality (AHRQ). "Medical Expenditure Panel Survey, Table II.A.2.d." Accessed June 16, 2011a. http://www.meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp.

Agency for Healthcare Research and Quality (AHRQ). "Medical Expenditure Panel Survey, Tables VII.A.1.a and VII.B.1.a." Accessed September 12, 2011b. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_7/2010/tviib1a.htm.

American Academy of Actuaries. *Understanding Defined Contribution Health Plans*. Washington, DC: American Academy of Actuaries, 2002. http://www.actuary.org/pdf/health/dc_june02.pdf.

Ashton VC. *Recommendations Regarding the Design and Development of the New York State SHOP Exchange and its Potential to Serve New York State's Small Businesses*. New York: HealthPass New York, 2011. http://nebgh.org/wp-content/uploads/2011/05/HealthPass-New-York-Public-Forum-Exchange-Written-Testimony-05_18_11-NYC-Forum.pdf.

Cantor JC, M Koller, S Brownlee, M Michael, D Belloff, and R Hughes. *Stakeholder Views about the Design of Health Insurance Exchanges for New Jersey: Volume I: Findings from Stakeholder Forum Discussions & Survey*. New Brunswick, NJ: Rutgers Center for State Health Policy, 2011. http://www.cshp.rutgers.edu/Downloads/8980.pdf.

CBIA Health Connections. "Products and Services." Accessed August 22, 2011. http://www.cbia.com/ieb/er/default.htm.

Gardiner T, and I Perera. *SHOPping Around: Setting up State Health Care Exchanges for Small Businesses: A Roadmap*. Washington, DC: Center for American Progress, and Small Business Majority, 2011. http://www.smallbusinessmajority.org/reports/shop_exchange.pdf.

Kaminski Leduc JL. *Backgrounder: Small Employers and Health Insurance in Connecticut*. Hartford, CT: Office of Legislative Research, 2008. http://www.cga.ct.gov/2008/rpt/2008-R-0542.htm.

New Jersey Department of Banking & Insurance. "Small Employer Health Benefits Program (SEH) Buyers' Guide." Accessed May 25, 2011. http://www.state.nj.us/dobi/division_insurance/ihcseh/sehmain.htm.

Schilling B. *Purchasing High Performance Health Exchanges: Choice Without Hassle and the Heart of Reform*. New York: The Commonwealth Fund, 2010. http://www.commonwealthfund.org/Content/Newsletters/Purchasing-High-Performance/2010/April-30-2010/Case-Studies/Health-Exchanges-Choice-Without-Hassle-and-the-Heart-of-Reform.aspx.

Utah Health Exchange. *Utah Health Exchange - Summary of Activities: Small Employer Groups*. Salt Lake City, UT: Utah Health Exchange, 2011. http://www.exchange.utah.gov/images/stories/UHEJuly2011Dashboard.pdf.

Weinberg M, and B Kramer. *Building Successful SHOP Exchanges: Lessons from the California Experience*. San Francisco, CA: Pacific Business Group on Health, 2011. http://www.pbgh.org/storage/documents/PBGH_SHOP_05.pdf.

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