Health Insurance for Small Businesses

State and Local Financing Strategies

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The FINANCE PROJECT

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According to the U.S. Census Bureau, approximately 38 million Americans have no health insurance, and over half of these individuals work.[1] Families typically lack access to health insurance because coverage is either not offered through employers or is too expensive for them to afford. These families face serious health risks if they forego needed medical care and the possibility of financial crises if treatment received exceeds their financial capacity. These uninsured Americans usually receive the most expensive and most inefficient care available. Moreover, taxpayers often end up paying the costs associated with emergency room visits and other medical services for low-income Americans who are unable to pay themselves. For these reasons, lack of health coverage can impede the viability and economic growth of economically distressed communities.

Small businesses, defined here as between two and 50 employees, play an important role in financially disadvantaged communities by contributing to economic activity and hiring local residents. Thus, community development initiatives often support efforts to help increase and maintain small business activity, which can include helping small businesses offer health coverage to their employees. Nationwide, 57 percent of uninsured employees work for businesses with fewer than 100 employees;

and 40 percent work for businesses with fewer than 25 employees.[2] Reflecting this trend, less than half of small firms offer health insurance to their workers.[3] Small employers, particularly those in service or non-unionized industries, are least likely to offer coverage to their workers.[4] The number of uninsured workers has grown by roughly 10 million over the past decade, disproportionately affecting low-wage workers.[5] Increases in the number of uninsured individuals would be more dramatic but for expansions in Medicaid and the State Children's Health Insurance Program (SCHIP), two of the major federal health insurance programs for low-income Americans. (Medicaid and SCHIP are discussed in more detail later; also see the definitions box on page 6.)

Small businesses experience difficulties providing health insurance largely because of the high cost of premiums. Providing health insurance at an affordable cost to low-income workers is both economically and politically challenging. Because employees in small firms do not make up a large percentage of all employees seeking coverage, small groups are less able to leverage lower costs from health insurers. In addition, employee turnover occurs more frequently in small businesses, increasing administrative burdens both to employers and insurers. Approximately 25 percent of premiums paid by small employers (fewer than 50 employees) goes toward a health insurer's administrative costs, compared to eight or nine percent of premiums for larger coverage groups.[6] These higher administrative costs partly reflect broker commissions, as small businesses tend to have less bargaining power in the marketplace. In short, high costs aggravated by administrative barriers make it difficult for small firms and their employees to access health coverage. Exacerbating this problem is the fact that approximately 20 percent of small business employees decline coverage even when offered, often because it remains too expensive even if it is subsidized.[7]

An employer-sponsored family health plan costs approximately $529 per month on average, with $391 paid by the employer and $138 by the employee.

For single workers, the total monthly cost is $202, with employers contributing $174.

Source: *Employer Health Benefits: 2000 Annual Survey.* Kaiser Family Foundation, 2000.

Helping small businesses finance employee health coverage can be an important community development tool. This strategy brief is intended to assist policymakers, community leaders, and program developers by identifying financing strategies to help small businesses offer health coverage. Most health insurance is provided through employers; therefore, this brief focuses on strengthening employer-based avenues of coverage. To be sure, there are other possible strategies to expand coverage, like universal coverage or an expanded government provision of benefits. While these options are important to keep in mind, this brief explores strategies that can be used as part of a community development effort.

For state and local decision makers seeking to strengthen health care utilization, simply understanding the health insurance market can be frustrating. The first section of the brief explains in straightforward terms the barriers small businesses encounter when attempting to offer health insurance, highlighting federal policies that help to ease this burden. The brief then examines various ways that state and local leaders can help small businesses finance health coverage for their employees through strategies such as: subsidies for employer-sponsored insurance (ESI) with Medicaid and SCHIP funds, public reinsurance, community level partnerships, and purchasing pools. To be implemented, all four of these strategies require more money or additional policy regulation, yet they differ in funding sources and program structures. Decision makers and program developers should consider which strategy or combination of strategies makes the most sense given the priorities and needs of their communities.

Background

The cost of health insurance remains a significant barrier for both small business owners and their employees. There are currently few ways for small employers to spread risk among so few employees. Thus, small firms offering health insurance pay more per worker than larger businesses, which reduces small business revenue and gives larger firms an additional advantage in the marketplace. Attempts to spread risk among groups are complex, especially given the economic and political barriers that often exist at the state and local level.

THE PROBLEM OF ADVERSE SELECTION. When identifying health insurance cost barriers, experts usually point to problems of *adverse selection* (see definition box on page six), which occurs when an individual, with knowledge of their health risk, is more likely to purchase coverage when medical need is significant. Thus, adverse selection can lead to the problem of a coverage group being dominated by individuals at high medical risk. For example, a high cost plan would not be attractive to a person of low health risk who is able to purchase coverage elsewhere or forego coverage. Conversely, a higher cost plan would attract more individuals at high health risk who need the coverage, thereby further increasing costs. Small groups increase the risk of adverse selection: if five people are covered in a plan, and three have medical problems, the premiums for the two healthy individuals will not make up for the costs to care for the three that need more thorough care. Thus, the cost for the entire group charged by the health plan will be higher. Larger coverage groups spread the risk among more individuals; therefore, large business insurance plans are less expensive per worker covered. In general, the larger the number of insured workers in one plan, the smaller the overall risk for health insurance companies and therefore the lower the costs. Because of this, firms covering smaller groups of individuals must pay more per worker to provide coverage.

A Toolbox of Options

State and local lawmakers have employed many approaches to remove obstacles for small businesses hoping to provide employees with health insurance. The following section presents several basic "tools"

BASIC HEALTH CARE TERMS USED THROUGHOUT THE BRIEF

Adverse selection: Occurs when a program disproportionately attracts and enrolls individuals with higher than average risk of poor health, increasing anticipated program costs.

Crowd-out: Occurs when public programs substitute private coverage, rather than increase the number of insured individuals overall.

Cost-sharing: Defines how much an enrollee, versus an employer or public program, is required to contribute toward insurance costs; may include a portion of premiums, copayments and deductibles.

Employer-sponsored insurance (ESI): Health insurance for workers administered through their employer.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Sometimes referred to as the Kennedy-Kassebaum bill, this legislation sets a precedent for federal regulation of the small group insurance market, requiring that no small employer (and therefore their employees) be denied insurance coverage.

Health maintenance organization (HMO): An entity with four essential attributes: (1) an organized system providing health care in a geographic area; (2) it provides an agreed-upon set of basic and supplemental health services; (3) it provides these services to a voluntarily enrolled group of persons; and (4) the HMO is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee.

Medicaid: A joint federal-state funded program that is operated and administered at the state level. The program provides medical benefits for low-income persons. It does not cover all low-income families, only persons who meet specified eligibility criteria (generally a particular percentage of the federal poverty line). Subject to federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers and methods of administering the program.

Portability: Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between health care plans (e.g. when a person changes employers).

Preferred provider organization (PPO): A formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.

Premium assistance: See *Premium Subsidy* below.

Premium subsidy: A subsidy provided by public or private funds to decrease the cost of an insurance premium to an employee or her employer.

Reinsurance: The resale of insurance products to a secondary market—usually a state—thereby spreading the costs associated with underwriting. Reinsurance helps to protect health insurance companies from excessive losses.

Self-insured plan (self-insurance): An employer or group of employers that sets aside funds to cover the cost of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service-only agreement with an insurance carrier or third-party administrator. Under self-funding, it is generally possible to purchase stop-loss insurance that covers expenditures above a certain aggregate claim level and/or covers catastrophic illness or injury when individual claims reach a certain dollar threshold.

Stop-loss insurance: Similar to reinsurance, except covers businesses that self-insure rather than health insurers.

State Children's Health Insurance Program (SCHIP): This program was enacted as part of the Balanced Budget Act of 1997, which established Title XXI of the Social Security Act to provide states with $24 billion in federal funds to cover children ineligible for Medicaid. Children in families with incomes up to 200 percent of the federal poverty level are eligible, with states setting specific criteria.

Adapted from the *Glossary of Terms Commonly Used in Health Care: Health Care Delivery and Financing Terms.* Academy for Health Services Research and Health Policy (October 2000). Available at http://academyhealth.org/publications/glossary-healthcare.htm.

FEDERAL PROGRAMS THAT IMPACT SMALL EMPLOYERS AND LOW-INCOME WORKERS

Before considering any strategy, program developers must understand the laws and programs that currently exist for small employers and working poor Americans.

Health Insurance Portability and Accountability Act (HIPAA): In 1996, Congress passed and President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA set minimum standards for regulation of the small group insurance market so that coverage cannot be denied to small employer groups. This guarantees the availability of insurance coverage to small employers (defined as those with two to 50 employees), regardless of the medical history of employees. Note, however, that while it is mandated that insurers provide coverage, there are no price controls—coverage may be available, but at an unattainable price. Nevertheless, HIPAA marks an important first step in enhancing the small business health insurance market.

Medicaid and SCHIP: Some low-income working families can access federal health insurance coverage through two programs: Medicaid and/or the State Children's Health Insurance Program (SCHIP). Medicaid, an entitlement program established in 1965, provides health insurance to eligible low-income individuals and families. States administer the Medicaid program, including decisions about income eligibility levels, and contribute to program costs. SCHIP, enacted as part of the Balanced Budget Act of 1997, provides states with federal funds to help provide coverage to children in families with incomes up to 200 percent of the federal poverty level. Like Medicaid, states administer SCHIP and determine income levels for eligible children. Some states have been approved by the federal government to set SCHIP income eligibility above 200 percent of the federal poverty line. (Unlike Medicaid, however, SCHIP is not an entitlement—the federal government caps SCHIP funds to states.) As discussed in the next section, other states have received permission to use Medicaid and SHIP funds to subsidize employer-sponsored health insurance.

used by these leaders. These tools may be viewed as "building blocks" for comprehensive plans that can help decision makers tailor strategies to the needs of a particular community. To be effective, these tools ultimately require additional resources from some source, public or private.

- *Premium Subsidies and/or Tax Credits*—Some states use premium subsidies or tax credits to decrease the cost of health insurance for both small businesses and employees. In many states, state or local governments (and sometimes foundations or other private organizations) subsidize the cost of premiums either through a direct subsidy or a tax credit. Premium subsidies can be paid to the insurer, the employer, or directly to the employee. Tax credits can go to a small business providing coverage or to an employee who enrolls in an insurance plan. While tax credits are increasingly popular as legislative proposals, their effectiveness remains unclear (see Kansas example box). Even when combined with premium subsidies, the responsiveness of employers and employees to tax credits remains difficult to gauge. Critics assert that employer tax credits

Kansas lawmakers instituted a small employer tax credit in 1999 designed to increase the number of small employers (two to 50 employees) that provide insurance. Enrolled employers who purchase coverage receive a refundable tax credit to cover a portion of the expenses contributed to a health plan. The refund amount decreases each year, phasing out over six years. So far, credit certificates have been issued to 139 businesses in the state. Officials note that the program is too young to determine its ultimate success.

Sources: *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured.* Sharon Silow-Carroll, Stephanie E. Anthony, and Jack W. Meyer. The Commonwealth Fund (November 2000); personal communication with Craig VanAalst, Kansas Insurance Department.

simply reward the behavior of businesses already offering coverage, rather than attracting smaller firms to provide coverage. They further argue that most proposed employee credits would likely not be large enough to allow individuals to purchase coverage. Researchers note, however, that the efficiency of small business tax credits can be improved by targeting subsidies based on the size and average wage of the workforce, which are strong predictors of whether a firm offers coverage. In short, the experience of such tax credits over the long run will better determine whether these policies can effectively influence small employers to offer coverage.

- *Regulations*—Almost every state imposes some requirements on insurance companies to cover particular groups and/or a lower burden for small businesses. A few regulatory approaches are listed below.

  - **GUARANTEED ISSUE** (also referred to as mandated coverage): A number of states have gone beyond HIPAA (see previous box on federal programs), putting forth their own regulations, such as "guaranteed issue." Guaranteed issue requires insurance carriers to offer health coverage to particular groups and/or individuals regardless of their medical history. This means that insurance firms cannot turn away certain groups or individuals seeking health insurance. (Note that the premium costs are often not regulated.) HIPAA requires that insurance carriers provide all coverage plans to small businesses or organizations with two to 50 employees. Some state laws exceed HIPAA's minimum standards and require carriers to offer coverage to additional groups and individuals.[8]

  - **MODIFIED COMMUNITY RATING:** This mandate on insurance providers prohibits consideration of characteristics related to an individual's health insurance utilization when establishing premium cost. For example, if someone applies for a new insurance policy and, under her old policy, had extensive medical care related to a disease such as cancer, her premium payment *cannot* be based on her high use of services under the old insurance policy. Under "pure" community rating, premiums may be based only on geographic location, benefit package, and family size. The higher costs of less healthy groups, then, are spread across all coverage groups. Pure community rating, however, risks adverse selection since lower risk individuals (usually young and healthy) will opt not to purchase insurance coverage as premiums increase. *Modified community rating* is an attempt to contain these premium increases so that low-risk individuals do not leave the market. Under modified community rating, insurers may also take age, gender and high/low risk occupations into account when deciding on premium cost.

  - **"BARE-BONES" OR "STRIPPED DOWN" COVERAGE:** To increase affordability of health plans, some states allow small businesses and/or self-insured businesses to offer less than the state's minimum required health coverage package. The clear drawback of this strategy is inadequate coverage, limiting access to necessary services. This is important to consider, as many low-income individuals targeted by these strategies have greater medical needs than the general population.

- *Direct Public Provision of Health Insurance*—State and community leaders can choose to run a public, state- or locally-run entitlement program similar to, if not an extension of, the federal Medicaid program that provides coverage to citizens unable to purchase private health insurance (usually low-income families at a particular level of the poverty line). This would entail either: 1) increasing the income eligibility levels or opening new eligibility categories (e.g., parents) for Medicaid or SCHIP through use of state funds combined with federal matching funds (often requiring a waiver); or 2) running a parallel state-only program that gives states more flexibility in administration. While, like all entitlements, public provision of health insurance requires stable and sufficient funding, it is likely less complex than attempts to affect risk pools in the health insurance market. Moreover, expansions of Medicaid and SCHIP usually entail a broader benefit package than many small employers or low-income individuals could obtain independently. This brief does not discuss this particular approach in depth because of its focus on employer-based coverage; however, state and local decision makers should be aware that this could be one component of a larger effort to help low-wage workers (also see strategy 1).

General Considerations:

The following considerations can help policymakers and community leaders identify appropriate strategies for their communities.

- *Target Population*—Before deciding on any strategy to expand health care coverage, decision makers must clearly define the population of intended beneficiaries. For example, some programs choose to target all uninsured workers employed at small businesses, regardless of income. Others target the working poor who do not qualify for public programs. The target population that is chosen will impact the scope of the strategy employed.
- *Community Characteristics*—Program developers should know and be able to clearly articulate the health needs and characteristics of the target population. For example, what percentage of intended beneficiaries are at high risk of medical needs? How many uninsured workers have dependents that need coverage? The health needs of the community at large may also help decision makers choose a target population.
- *Political Environment*—Community leaders must be in tune with the local and state political environment when deciding on strategies. For example, in some cases, providing funds for reinsurance or premium subsidies may not be politically feasible given the priorities of state or local lawmakers. In these cases, searching for potential community partners might be a more realistic option.
- *Crowd-out*—Issues of crowd-out concern many funders, both public and private, and insurance carriers. Crowd-out occurs when coverage obtained through publicly-sponsored programs substitutes for coverage that otherwise would have been obtained privately, effectively shrinking the private health insurance market. Policymakers, administrators, and funders care about crowd-out because it raises concerns about the most efficient use of public dollars. A policy or program that minimizes crowd-out will likely use fewer public dollars per uninsured person covered. To limit crowd-out, many programs restrict eligibility to persons who have not been insured during the previous 12 months. However, policies targeting only the current uninsured create equity issues, and some argue that crowd-out can be

positive when currently insured low-income individuals receive financial relief. Depending on the priorities of a policy or program, program developers may need to examine where potential strategies could create problems of crowd-out in their communities and carefully monitor programs for crowd-out once implemented.

- *Tradeoffs Between Program Objectives and Social Objectives*—Local leaders will need to carefully consider the balance between social objectives, such as increasing the affordability of coverage, versus achieving significant market share, which would increase overall program impact. For example, many strategies include implementing a new program at the state or local level. Designing a program that health plans will want to join has the best chance of attracting a variety of enrollees and will produce greater economic efficiencies. However, such a program generally is not likely to be significantly different from the rest of the market in terms of number of health plan choices and cost, which could exclude the low-wage workers targeted by new programs in the first place. Along the same lines, different strategies may present varying options for breadth of health coverage, which can make a real difference for low-income workers who tend to have greater medical need. For example, "bare bones" coverage may reach more uninsured workers, but is limited coverage for many better than adequate coverage for a smaller number? Program developers must clearly define priorities around number of persons targeted and the extent of coverage offered by a new program.

The politics of health care reform heavily influence any expansion of coverage for low-income workers. State and community leaders must bear in mind that

GETTING STARTED: FIRST STEPS TO EXPANDING SMALL BUSINESS HEALTH COVERAGE

Familiarize yourself with the health insurance market: Many policymakers and community leaders that work on behalf of low-income workers are familiar with public programs, like Medicaid or SCHIP, that provide coverage to eligible, low-income families. However, helping small businesses access and pay for coverage through insurance carriers requires that decision makers understand how the competitive insurance market works outside of public programs. Understanding some of the complexities of the health insurance system will help program leaders develop partnerships that can lead to important sources of funding. For a broad listing of resources and links related to health care, visit the Academy for Health Services Research and Health Policy at http://www.academyhealth.org/resources.htm.

Understand current state policies around health insurance for the working poor: Before deciding on the best way to help small businesses expand coverage, program developers should gain a clear sense of public programs already working on behalf of the chosen target population. For example, a state or community initiative might be able to easily build upon coverage provided by Medicaid or SCHIP. To find out more about state health care coverage for low-income families, visit the State Coverage Initiatives web page, sponsored by the Academy for Health Services Research and Health Policy at http://www.statecoverage.org. Also, the American Public Human Services Association lists state Medicaid directors at http://medicaid.aphsa.org/members.htm and state SCHIP contacts can be found on the Centers for Medicare and Medicaid Services website at http://www.hcfa.gov/init/statepln.htm.

Identify major players in the state and local health care system: Learning more about the health insurance market can be accomplished easily by partnering or consulting with leaders that can bring the larger health policy perspective to the table. More importantly, many of these leaders can also often influence decisions at the state and local level. Reach out to important stakeholders early as both sources of information and potential partners. Major players may include policymakers, business leaders, insurance carriers, and state program administrators.

MEDICAL SAVINGS ACCOUNTS: AN OPTION FOR SMALL BUSINESSES?

Medical savings accounts (MSAs) are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies who work for small businesses (50 or fewer employees), self-employed individuals, or the uninsured. The idea is for employees to deduct payroll funds into a tax-free MSA account used to purchase routine care. MSA contributions and earnings from these deposits are never taxed if MSA funds are used to pay medical costs. MSA enrollees can purchase routine care of their choice, including dental, vision, psychotherapy, prescriptions and home health care.

MSA plans differ from typical health insurance plans in the following ways:

- MSA plans allow small employers to offer high deductible —sometimes called "catastrophic"—coverage in conjunction with an MSA account. Employers usually find high deductible plans more affordable, as they cost less per employee than traditional health insurance.
- Families pay higher insurance deductibles under MSA plans. The average deductible amount for a family under a typical employer-sponsored health insurance plan is $545.[1] In contrast, in 2001, high deductible plans must have deductibles not less than $1,550 and not more than $2,350 for individual coverage, and not less than $3,100 and not more than $4,650 for family coverage.[2]
  - For example, if an employee enrolls in a family MSA plan with a deductible of $4,000 and receives care totaling $5,000 during the year, the employee would spend $4,000 (through her MSA or out-of-pocket) and the insurance plan would cover the remaining $1,000.

Under the 1996 Health Insurance Portability and Accountability Act (HIPAA, described earlier), Congress authorized a demonstration project allowing self-employed individuals and small firms with fewer than 50 employees to purchase MSA plans.[3] Demand for these plans has been strikingly low, with only 55,000 enrollees of an allowable 750,000 under the demonstration project.[4] The U.S. General Accounting Office suggests that low participation is likely due to the fact that insurance providers and consumers find MSAs complex compared to more familiar traditional plans.[5] Proponents of MSA plans argue that the plans simply are not widely known or well understood. Critics, on the other hand, say that low participation reflects unattractiveness of the coverage, especially to the working uninsured. Many uninsured workers—largely low-income—are not drawn to high deductible policies because they cannot afford the high out-of-pocket expenditures required when crucial care is needed.

Despite low participation rates, some policymakers have championed MSAs as a tool to expand health coverage, albeit limited, to more individuals. Opponents assert that MSA plans will increase premiums for conventional insurance because healthy, high-income individuals would be more likely to use MSA plans, while less healthy, low-income workers would be left in traditional insurance plans. This split would drive up the cost of premiums for low-income or less healthy people.

For small employers, MSA plans offer catastrophic coverage to employees without imposing on the employer the higher premium costs of a comprehensive plan. However, small employers who choose to provide MSA plans and employ many low-wage workers should bear in mind the following considerations:

- MSAs have not yet proven to be attractive to low-wage employees. Low-income workers have more difficulty contributing to the accounts and would not receive as great a tax benefit as higher-wage workers.
- Use of MSA plans could ultimately cause low-income workers to forego needed care because they may not be able to afford the large out-of-pocket expenses.
- As described above, widespread use of MSAs could cause adverse selection, segmenting the market and increasing premiums for conventional insurance especially for older employees and pregnant women.

State and local leaders can help promote MSA plans as an option for small employers in their communities. Interested employers should contact local insurance brokers to find out about MSA plan options. (Note that a limited number of insurance providers offer MSA plans.) To find out more about the administration of tax-free accounts, contact the Internal Revenue Service at (800) 829-1040. Small employers can also contact the Small Business Survival Committee at www.sbsc.org.

1. *Kaiser/HRET Survey of Employer-Sponsored Health Benefits.* Washington, D.C.: Kaiser Family Foundation, 2000. Available www.kff.org

2. Iris J. Lav and Edwin Park, *Likely Medical Savings Account Amendment to Patients' Bill of Rights Could Drive Up the Price of Health Insurance and Increase the Number of Uninsured.* Washington, D.C.: Center on Budget and Policy Priorities, 2001.

3. Raymond J. Keating, *Medical Savings Accounts: The Necessary Centerpiece of Health Care Reform.* Washington, D.C.: Small Business Survival Committee, 2001.

4. IRS Bulletin Announcement 2001-99. Washington, D.C.: United States Internal Revenue Service, 2001.

5. *Medical Savings Accounts: Findings from Insurer Survey.* Washington, D.C.: United States General Accounting Office, 1997.

while important steps can be made at the state and local level, making a large impact on coverage of low-wage workers through the existing health insurance market will require more comprehensive federal reforms. As long as national level policies do not provide large-scale coverage for low-income workers, state markets will consist of a patchwork of coverage approaches for the working poor.

State and Local Strategies to Finance Employer-sponsored Insurance for Small Businesses

The following strategies use the tools outlined above in combination with other approaches to increase the availability of health insurance for working families through small employers. Each strategy requires the ability to generate additional resources, both fiscal and nonfiscal, and create clear governance structures. Example boxes highlight the ways in which many states and communities have employed these strategies.[9]

Strategy 1: Subsidizing Employer-sponsored Insurance (ESI) Through Use of Public Funds

A number of states access funds from public programs —SCHIP and Medicaid—to subsidize private employer-based insurance, creating more flexibility in the funding streams. Medicaid and SCHIP dollars can potentially provide a stable funding source for premium assistance. For example, Maryland lawmakers recently expanded SCHIP to cover children whose parents earn between 200 and 300 percent of the federal poverty line.[10] As part of this expansion, state officials implemented a *premium assistance program* for eligible employees with access to employer-sponsored insurance.[11] A parent employed at an eligible business can apply for family coverage through her employer, and SCHIP is automatically accessed for the eligible child. SCHIP advocates point to this strategy as a new way to reach uninsured children whose parents have access to ESI but are hesitant to enroll in a separate program.

Running federal entitlement programs through employers helps working families by reducing administrative hassles and ensuring that those eligible for Medicaid and SCHIP receive coverage. Some states use this strategy to try to make coverage more seamless to employees, meaning that if an employee changes jobs or is laid off, her coverage continues with little or no interruption, assuming she remains eligible. With seamless coverage, the administrative burden lies with the state to keep track of which funds should be accessed (either straight entitlement funds or state-run subsidy programs) for each enrollee.

To use funds in this way, states must apply for a Section 1115 waiver and meet a number of federal provisions. First, subsidy programs must meet Medicaid and/or SCHIP requirements, including eligibility level and *cost-sharing*. Cost-sharing defines how much an enrollee is required to contribute after premium assistance subsidies have been added. For example, the Centers for Medicare and Medicaid Services (CMS) require that enrolled families pay no more than five percent of their family's income for SCHIP.[12] Medicaid and SCHIP provisions also require that state administrators demonstrate cost-effectiveness, meaning that the cost of subsidizing ESI

OUTREACH TO UNENROLLED ELIGIBLES THROUGH SMALL EMPLOYERS

Employers can serve a vital function in reaching Medicaid- and SCHIP-eligible employees not currently enrolled. A forthcoming report by the Kaiser Commission on Medicaid and the Uninsured found that while many low-wage (often small) employers do not offer coverage to employees, 60 percent would be willing to provide information about Medicaid and SCHIP and help workers enroll in such programs. Program developers should maximize the willingness of employers to help enroll their workers.

Source: *Findings from a National Survey of Low Wage Employers: Attitudes on Health Coverage, Uninsured Workers, and Medicaid and SCHIP*. National Partnership for Women and Families and the Kaiser Commission on Medicaid and the Uninsured (forthcoming).

is less than covering individuals in the traditional public programs. Finally, states must show that employing this strategy does not produce crowd-out. To help prevent crowd-out, SCHIP provisions require that states using funds to subsidize ESI meet the following conditions: children must not have been covered privately during the six months prior to enrollment; public funds must not supplant employer contributions; states must track the amount of crowd-out, if any, that occurs; and employer coverage of health services must equal or exceed that of SCHIP. If an employer's coverage does not offer all of the services available under traditional SCHIP, states must provide these services through wraparound coverage (e.g. the state provides the coverage components not covered by the employer-sponsored plan so that the eligible enrollee receives comparable care to enrollees in the traditional public program).[13]

Considerations:

- While this strategy attempts to make coverage seamless for employees and employers, the combination and coordination of funding streams requires sufficient state administrative capacity. Seamless coverage requires much cooperation and communication among insurance program officials and Medicaid and SCHIP administrators to track employment and eligibility changes. If a program operates in a separate agency than Medicaid and SCHIP, coordination between organizations can be a major challenge.
- SCHIP and Medicaid dollars have the potential to provide a stable funding source for employer-based programs. However, recent increases in Medicaid spending and current economic conditions could threaten the viability of Medicaid and SCHIP funds as federal and state lawmakers face spending cuts. While Medicaid is an entitlement, state and local reimbursement claims face increased scrutiny as states increase spending. Note, also, that unlike Medicaid, SCHIP is not an entitlement program; SCHIP funding is capped, and states can limit access to the program when budget allocations are

gone. Thus, use of SCHIP to subsidize ESI could present an opportunity cost, limiting the state's ability to use funds for direct public assistance.
- While coordination of employer-sponsored insurance with Medicaid and SCHIP streams creates additional flexibility in many ways, federal oversight can limit state independence in decisionmaking. Some states, like Oregon, use state-only funds to maximize their influence on program design, but the tradeoff means smaller program scope and more financial vulnerability.[14]
- Low-income workers tend to have higher job turnover than other groups. Addressing and keeping up with resulting eligibility changes presents real programmatic design challenges. Massachusetts, for example, has experienced faster than expected dis-enrollment because of the mobility of low-income workers and small businesses that go out of business (see example box on next page).[15]
- Recent research on premium subsidies suggests that unless they are relatively large (over 30 percent) they will not attract enough small employers or uninsured workers to have a substantial effect.[16] For program developers looking for significant community impact, this approach could be expensive.

TOWARD SEAMLESS COVERAGE: THE MASSHEALTH FAMILY ASSISTANCE PROGRAM

The MassHealth Family Assistance Program (FAP) combines public subsidies to ESI employers with premium assistance to employees to make employer-based coverage accessible to low-income families. Fully implemented in 2000, the program has two primary components: a *Premium Assistance Program* that provides subsidies directly to low-income workers; and an *Insurance Partnership*, which provides incentives for small businesses to offer health insurance to low-income workers (up to 200 percent of the federal poverty line) by providing subsidies to small businesses and self-employed low-income individuals. The two components work together to maximize coverage for low-income families.

In order to implement the *Premium Assistance* (PA) piece of the program, the Health Care Financing Administration (HCFA) (now called the Centers for Medicare and Medicaid Services, or CMS) of the U.S. Department of Health and Human Services approved a Section 1115 waiver request for Massachusetts to use Medicaid and SCHIP funds to subsidize premiums. Beginning as a subsidy only to low-income workers with children who worked in large firms, the PA component was expanded in 1999 to include workers in small firms. To be eligible for PA, employees must: have comprehensive health insurance through their employer; have an employer who pays at least half of health insurance premium cost; and earn an annual income that does not exceed 200 percent of the federal poverty line. Enrollees with children may work for any size employer, while those with no children are limited to firms with 50 or fewer employees. Self-employed individuals are also eligible for premium assistance.

The *Insurance Partnership*, the most recent component of the FAP, assists small businesses in providing health benefits to low-income employees. To be eligible, businesses must employ 50 or fewer employees, offer comprehensive health insurance to employees, and contribute at least 50 percent of the premium.

Funding for the MassHealth Family Assistance Program comes from a combination of state and federal Medicaid funds and SCHIP funds and other state-only funds. SCHIP funds may only assist employees with eligible children who have not been insured over the previous six months and whose income lies between 150 and 200 percent of the federal poverty line. Medicaid funds subsidize remaining previously insured families with incomes from 150 to 200 percent of the federal poverty line, in addition to those with incomes up to 150 percent of the poverty line. To use federal funds this way, the state must demonstrate that it is cost-effective for the state to use SCHIP funds to subsidize private insurance rather than enrolling children in the public Medicaid and SCHIP programs. A single entity administers both IP and PA funds, making benefits seamless for employees. This means that if an enrollee loses a job or moves to a job that does not offer insurance, coverage continues through public programs like Medicaid as long as the individual remains eligible.

Implementation of such an administratively complex program was no easy task. Medicaid and SCHIP regulations and federal reporting requirements make the job administratively cumbersome, in addition to tracking the employment and eligibility status of over 20,000 enrollees. To ease part of the burden, state officials made the decision to house the program at the Division of Medical Assistance along with the state's SCHIP and Medicaid programs. Officials note that this has been key to the success of the program, particularly in terms of high enrollment numbers, because it allows for easy communication among administrators.

Officials believe that the program has encouraged more small businesses to offer health insurance, noting that approximately 60 percent of businesses that receive subsidies previously offered no insurance. Despite relatively high enrollment numbers, one of the biggest challenges thus far has been the high mobility of low-income workers and vulnerability of small businesses. Disenrollment has occurred at higher rates than expected likely because of job loss, high turnover and closures of small businesses. The state has expanded outreach efforts to identify and attract eligible businesses and employees.

Contact: Nancy Kealey, Director, Insurance Partnership, Division of Medical Assistance, Commonwealth of Massachusetts, at (617) 210.5020. You may also visit http://www.state.ma.us/dma/businesses/ipIDX.htm.

Strategy 2: Reinsurance or Stop-Loss Protection

Reinsurance, also known as *stop-loss protection*, denotes a strategy where states (or another third party) subsidize health insurers with public funds to cushion financial loss that can occur with small-group markets, thereby reducing the cost of premiums. Reinsurance and stop-loss protection strategies are usually undertaken as a small piece of a more comprehensive state health program for low-income workers, combined with regulatory or subsidy efforts. Reinsurance most often represents a "retrospective" strategy, meaning it applies after medical care has been provided, although states can assign individuals to a reinsurance pool prospectively based on set medical diagnoses. Typically, the state reimburses participating health plans for claims above a certain level and/or for losses greater than a certain portion of premiums. Funds used for reinsurance usually come from a legislative appropriation to a designated state account. Placing state money in reinsurance pools might be a viable strategy to influence state lawmakers who are hesitant to provide direct premium assistance to employers or employees or in states where public preference tends to lie with private sector solutions over public remedies. In addition, reinsurance often does not require the same administrative investments as other strategies.

The level at which a state sets reinsurance thresholds determines the amount of risk that is taken on by the small business or insurance company versus risk taken on by the state.[17]

- For example, stop-loss coverage may kick in if an individual's medical expenses surpass $30,000 or if a group's coverage expenses exceed 120 percent of anticipated costs.

The lower the threshold, the more risk that the state bears; the higher the threshold, the more risk borne by the insurer and therefore the employer. If insurers bear too little risk, they have little incentive to control cost.

States can pay for reinsurance costs by state budget allocation, withholding reinsurance premiums from enrollees, and/or collecting reinsurance premiums from all insurers in the state before costs are incurred. They may also choose to charge insurers loss subsidies if losses exceed the reinsurance pool resources (see New Mexico example box).

Considerations:

- When using this strategy, program developers must think strategically about where to place reinsurance thresholds. If businesses or insurers bear too much risk, premium costs will increase and could drive healthier individuals out of the market. This ultimately makes insurance companies less willing to participate in a state-sponsored program. Similarly, if insurers bear too little risk, the cost to the state can be quite high.

HEALTHCARE GROUP OF ARIZONA: THE NEED FOR A RELIABLE FUNDING SOURCE

In 1982, a state study found that 86 percent of uninsured adults in Arizona were employed, and that approximately 60 percent of these adults worked for businesses with fewer than 20 employees. The state legislature responded by establishing the Healthcare Group (HCG) to help small businesses that are unable to afford health coverage through the regular market.

The HCG program was funded and implemented in 1988 with state-only funds. At that time, the state contracted with three HMOs to offer prepaid health plans to very small firms and self-employed individuals. To contain costs, the HCG plans provided guaranteed issue, established premiums according to modified community rating, and provided "bare bones" coverage. In addition, employers were not required to subsidize premiums.

After a few years of operation, it became clear that the HCG was experiencing adverse selection problems, consisting largely of employees at high medical risk, which drove up the cost of premiums and made participating health plans lose money. Some insurance brokers were enrolling low-risk employees into regular health plans and high-risk employees into HCG. The legislature tried to combat this problem by restricting eligibility to employers who could enroll at least 80 percent of full-time employees (100 percent for firms under six employees)—an increase from 50 percent. This resulted in leveling out the pool among employees, but eliminated low-risk part-time employees, including students, which caused enrollment to plummet from 21,000 in 1997 to less than 13,000 in 1999.

In response to pressure from participating health care plans and their enrollees, the legislature established a funding mechanism to reinsure against losses experienced by participating health plans, appropriating $8 million in 1999 from tobacco settlement funds. The state continued this commitment by allocating $8 million per year for subsequent years from tobacco tax funds.

Despite the large cost barriers, the HCG has made some progress in extending coverage to a population that commercial insurers often avoid. Officials see the reinsurance pool as crucial to attracting health insurers that would not normally join HCG. Compared to other state-administered programs, administrative costs constitute a small percentage of the budget. In 2001, state lawmakers appointed the Statewide Insurance Task Force to make recommendations for structural improvements to help prevent future program budget shortfalls, including reinstituting eligibility of part-time employees. Task force members will look at eligibility requirements, coverage levels and premium costs. The reinsurance pool, however, will likely remain intact—the task force has already recommended future appropriations and garnered support for 2002 legislative action. Officials remain optimistic since reinsurance losses dropped during 2001 and hope that future task force changes will help to continue this trend.

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- Reinsurance requires a stable, long-term funding source. Arizona's Healthcare Group, for example, looks each year to the state legislature for additional funding as competition abounds, particularly for tobacco settlement funds.
- Since these strategies are most often employed retrospectively, costs are difficult to gauge. Decision makers must know as much as possible about the potential coverage pool in their plans to better estimate costs. Even the best estimates, however, cannot precisely predict costs, and a certain amount of uncertainty is inevitable. Because of the lack of specificity regarding costs, policymakers should consider combining reinsurance strategies with proactive ones, like premium assistance.

NEW MEXICO HEALTH INSURANCE ALLIANCE: A PIECE OF THE SOLUTION

Created in 1994, the New Mexico Health Insurance Alliance (NMHIA) aims to make private health insurance more accessible to small businesses, self-employed individuals, and individuals who lose group health coverage. The need for such a remedy is clear: 96 percent of New Mexico's businesses have 50 or fewer employees, and about 650,000 workers are employed in service industry jobs that often do not provide employer-sponsored health insurance. The alliance contracts with 11 insurance carriers to extend coverage to small businesses that have difficulty obtaining group insurance directly from insurers due to participation or health condition concerns.

Like the Arizona Healthcare Group, NMHIA mandates guaranteed issue and does not require employer contributions. To be eligible, businesses must have 50 percent enrollment among eligible employees. To combat adverse selection, and therefore higher costs, the alliance reinsures participating insurance companies against losses above 75 percent of money generated from premiums. For example, if a health insurer receives $1 million per year in premiums to cover those in the plan, and the costs of providing health care to this group exceeds $750,000, the state pays the plan any cost over the $750,000 amount. The insurance companies themselves—both NMHIA providers and others—finance the reinsurance pool through risk assessment fees and loss subsidies (referred to as "loss assessments" in the state statute). For example, when plan insurers experience a loss, each of the 400 health insurers in the state pays a loss assessment fee. The loss assessment amount is based on each company's revenues as a proportion of the total revenue of all health insurance providers in New Mexico.

Despite efforts to contain risk, the participating health plans in NMHIA find the program unprofitable, pointing to the inability to effectively attract lower-risk individuals to the insurance pool. Efforts to remedy this problem include elimination of modified community rating requirements and a discount of five percent for coverage in rural areas. It remains unclear at this early stage whether these efforts have been successful.

The NMHIA has insured approximately 13,000 individuals since the 1995 implementation, and has attracted a diverse group of enrollees, spanning age and income levels (note that most enrollee incomes do not exceed $30,000). Officials project that NMHIA has saved the state $10 to $15 million each year by covering previously uninsured individuals and surveyed enrollees are highly satisfied with the program. While the state's 500,000 uninsured workers remains relatively large compared to the roughly 13,000 NMHIA enrollees, 91 percent of enrollees report that they would be uninsured without the coverage. Between 1998 and 2000, the state's uninsured population dropped from 28 percent to approximately 23 percent, which officials attribute to NMHIA in conjunction with other state programs and SCHIP.

While the total number of uninsured workers in the state dwarfs the number of enrollees, officials are meeting enrollment projections based on eligibility and income requirements. Administrators acknowledge that NMHIA should be a piece of a more comprehensive program. They are currently working with private sector representatives and other stakeholders to provide an umbrella of programs to target the uninsured population while allowing the private health care market to remain competitive. The Robert Wood Johnson Foundation sponsors these efforts.

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Strategy 3: Community-Level Partnerships

In several communities, employers, employees, and a range of other community partners have combined local resources to provide premium subsidies to small employers or low-wage employees. Community partnerships take on a variety of forms and can include many different private and public partners, but the end result is the same: partnerships generate resources through partner contributions. Most often, community foundations, universities, businesses and other stakeholders partner with insurers and health professionals to subsidize high insurance costs to employers and employees, typically through creation of a new health care plan. Partnerships target small businesses for eligibility and enrollment and usually only offer coverage to low-wage workers below a set income. Small businesses benefit from health coverage partnerships because they can help to attract and retain employees and decrease administrative burden.

Partnerships may run a health plan using the administrative capacity of one of their members or create an intermediary organization to take on these tasks. Often, the employer, the employee, and the partnership share the cost of premiums. A mixture of private and public dollars fund operating costs of partnership health plans. Usually, programs determine employee cost on a sliding fee scale and adjust employer and partnership shares accordingly. In some cases, the health plan partners donate part of the administrative costs associated with providing coverage and/or agree to accept below-market rates for enrollees.

Community-level partnerships require adequate community buy-in and resources, neither of which can be accessed easily. Some communities simply do not have the variety or level of financial or other resources at their disposal. Moreover, implementing a community-level health plan requires sufficient start-up funds, which in most cases come from community foundations.

Considerations:

- Community leaders must be clear about the intended scope of the program. For example, one of the reasons San Diego FOCUS has been successful is provider willingness to accept below-market rates. Expansion efforts would likely require a premium increase to attract additional providers.
- The objectives of the health care partnership as well as its intended beneficiaries should be well-defined. In addition, initiative leaders must articulate these goals to potential partners and the community at large from the beginning to attract partners and increase community buy-in.
- This strategy requires clear structures of governance that reflect all community interests. For example, decision making power often rests with a community board whose members represent a wide range of local concerns.
- Community partnerships usually depend on start-up funds, often from foundations, to initially bring stakeholders to the table and implement the program. Maximizing federal, state, and local revenues to sustain plans will be a continual challenge.

SAN DIEGO FOCUS: BRINGING THE COMMUNITY TOGETHER

Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) was developed to increase the availability of health care coverage to workers in San Diego. FOCUS exists as a partnership among the Sharp Health Plan, a nonprofit health plan; small businesses; providers; and foundations. In San Diego County, 85 percent of uninsured individuals live in households with at least one worker, and 87 percent of businesses have 20 or fewer employees. Moreover, reflecting national patterns, most uninsured residents of San Diego are low-income workers. Seeing this need and building on the efforts of a community stakeholder group, the Sharp Health Plan and the Alliance Healthcare Foundation came together to explore options to provide health care access to the uninsured in San Diego. These community efforts culminated in FOCUS, which began enrollment in 1999. Today, FOCUS provides coverage for more than 200 businesses and 1,500 enrollees. Due to limited grant funding, the original phase of the FOCUS program was closed to new businesses in September 2000.

FOCUS targets small businesses (50 or fewer employees) in the county that to not sponsor health coverage for their employees. Uninsured employees with incomes up to 300 percent of the federal poverty line and their dependents are eligible to enroll. Participating businesses represent a variety of services, including restaurants, medical or legal offices, construction, retail, auto shops, and convenience stores.

Employers, employees, and foundation grants share the cost of monthly premium payments. Employers contribute at a fixed range, between roughly $25 per month for a single employee to $50 per family. Employees pay based on a sliding scale ranging from about $10 to $200 per month, depending on income and family size. Sharp Health Plan donates one-third of administrative cost. Grant funding from the Alliance Healthcare Foundation, the California Endowment, and the California Healthcare Foundation subsidize the remainder of premium with each contribution ranging from zero to $175 per month.

Other program elements help to keep premiums low. For example, local providers agreed to accept below-market rates for FOCUS enrollees and local insurance brokers agreed to support the plan with no commissions. In addition, the California Healthcare Foundation separately funds a comprehensive evaluation of the program. While FOCUS does not receive financial support from any public sources, local and state officials have lent significant political support to FOCUS.

Analyses by the evaluation team at University of California-San Diego are still being conducted. Early results suggest that businesses view FOCUS as a real opportunity to attract and retain workers, and there is some evidence that enrollees feel healthier now that they have health coverage. In addition, adverse selection does not appear to be a significant problem.

Continued funding remains a challenge for program continuation or expansion. FOCUS began initially as a two-year demonstration program. In 2001, the California Healthcare Foundation stepped in with an additional $1 million to extend coverage for enrollees for an additional year. To preserve funds, this grant requires that children who are eligible for existing public programs like MediCal (California's Medicaid program) and Healthy Families (California's SCHIP) must apply to enroll in those programs rather than continuing coverage under FOCUS. Community stakeholders are also involved in exploring ways to increase and improve upon efforts, and to reach self-sustainability. With widespread community support, the Sharp Health Plan is hopeful that FOCUS will continue to help small businesses expand health coverage.

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You may also visit www.sharp.com/HealthPlan.

SHARING THE COSTS: ACCESS HEALTH OF MUSKEGON, MICHIGAN

In 1998, thanks to a seed grant from the WK Kellogg Foundation, leaders in Muskegon County, Michigan convened to explore ways to increase health coverage in their community. These leaders developed and implemented Access Health, which aims to increase health coverage to the county's uninsured workers through their employers. Program developers learned early on that the HMO community could not provide health benefits for the $50 per month per employee that small businesses were willing to pay. Access Health, then, was established as a non-profit organization that would contract directly with providers to fill the gap between no insurance and commercial (HMO) plans.

Businesses eligible for Access Health must 1) employ 150 or fewer full- or part-time employees receiving a median wage of $10 or less per hour; and 2) have not offered coverage in the preceding 12 months. Health care must be obtained in Muskegon County. Since initial enrollment in 1999, over 300 businesses have enrolled in the program, serving more than 1,500 lives. In addition, Access Health has been successful in generating broad support from the medical community, contracting with both major hospitals and 98 percent of the county's local physicians, including specialists.

Access Health funding comes from a 30 percent employer contribution, a 30 percent employee contribution, and a 40 percent community contribution. Employees pay $42 per month for each adult and $25 per month for each dependent covered (although families are encouraged to enroll eligible children in MiChild, Michigan's SCHIP program). A combination of federal, local, community, and foundation funds support the community contribution. All federal funding comes from disproportionate share hospital (DSH) dollars, which are supplemental Medicaid payments to states to reimburse hospitals that serve high proportions of Medicaid and uninsured patients. Financing is structured in a manner such that every $2 of private money matches every $1 of public money. In addition, local community and employer contributions can leverage additional federal DSH funds.

Community buy-in is crucial to local approaches like Access Health, which look to engage multiple partners and maximize local resources. Governance for Access Health comes from a community board consisting of patients, providers, and other stakeholders. Program developers view the community-oriented nature of the program as its greatest success, meeting the specific health care needs of Muskegan County.

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Strategy 4: Health Purchasing Cooperatives (HPCs)

Health purchasing cooperatives (HPCs) are initiated by states or private business associations and often result in public/private partnerships. HPCs attempt to decrease the cost of providing health insurance by pooling the buying power of small businesses to purchase health insurance collectively. In addition, policymakers can strengthen the impact of HPCs through regulations or subsidies. HPCs generally: 1) offer coverage to small businesses (50 or fewer employees); and 2) offer a choice to employers and their employees between at least two independent competing health plans.[18] State and local decision makers may use a combination of policy tools to strengthen HPCs, including one or more of the following:

- Permitting health plans to sell small-group coverage only through a HPC (regulation);
- Mandating that insurers and health plans must agree to participate in a HPC in that state as a condition for offering coverage in a small-group market (regulation);
- Requiring that all small group coverage be through a HPC; and/or

- Subsidizing (usually on a time-limited basis) employers to buy coverage from a HPC, through direct subsidies or tax credits (premium subsidies).

Unlike the previous strategies, HPCs are directly targeted to meet the needs of small businesses. During the 1980s, large employers began to extract savings from health insurance providers by using their size to win volume discounts. Small businesses, which tend to be too small to bargain with insurance companies for lower health insurance rates and generally have insufficient funds to hire staff to manage health insurance issues, began in the early 1990s to use HPCs to try to solve their health insurance challenges.

PACADVANTAGE: OPTIONS FOR SMALL BUSINESS EMPLOYEES

PacAdvantage, formerly the Health Insurance Plan of California (HIPC), began offering coverage statewide in July 1993 from 20 different health plans. The California state legislature passed legislation establishing the HIPC, with initial financing from a government loan of $5.5 million. In 1999, the Pacific Business Group on Health, a nonprofit, took over operation of the plan, changing the name to PacAdvantage. PacAdvantage offers 1) coverage to all small employers with two to 50 employees; and 2) employee choice among relatively comprehensive HMO, point of service and PPO benefit plans. Employers are required to contribute at least 50 percent to their employees of the least costly plan available, and at least 70 percent of the eligible employees must participate. PacAdvantage had a spurt of initial growth after its launch in 1993, followed by a period of relatively slow growth. It then experienced a period of relatively stable enrollment and in 2001 began to increase membership. Currently, PacAdvantage has over 11,000 small groups enrolled, covering approximately 150,000 lives, although only achieving a two to five percent market share.

Under the HIPC/PacAdvantage, small employers could for the first time provide a choice to their employees among multiple health plans, health products (HMP, PPO or point of service), and co-payment options. In terms of price, however, PacAdvantage has been less successful: it has not been able to offer products below the outside market's price. Officials argue that the introduction of the PacAdvantage into the small-group market has had an important competitive effect, encouraging plans to reduce their prices generally. It is difficult to know how much of the increased competition in the small group market now is due to other competitive forces versus the introduction of the HIPC/PacAdvantage.

Initially, one of the problems faced by the state-administered HIPC is that the preferred provider organizations (PPO) plans, which allow greater choice by consumers of their physicians, withdrew from the HIPC because of losses due to adverse selection. Even though PPOs typically account for only about three to four percent of enrollment, the availability of a PPO plan is important to selling the HIPC to small employers because small business owners often want to have PPO coverage for themselves. In 2001, however, two PPO offerings were added to PacAdvantage with coverage designs that allow them to compete more effectively with HMO plans.

The lack of enthusiasm by insurance agents toward the HIPC was also initially a problem. Most small employers do not have a benefits manager and rely on agents and brokers for information about health coverage options. If the agent does not tell small businesses about the PacAdvantage option or specifically advises against it then small business owners are likely to choose another option. Since the HIPC initially chose to pay lower commissions to agents than those prevailing in the small-group market, this engendered hostility from the agents toward the HIPC. PacAdvantage altered the features that the agents disliked and have improved relationships with the agent community. Officials note that agents have become increasingly enthusiastic in recent years.

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Since the early 1990s, about 20 HPCs have formed in the United States. A total of approximately one million employees now receive their health insurance through these HPCs. Several of the HPCs have a small share of the total small business health insurance market, but are large in absolute terms: the California HPC enrolls about 150,000 and the Florida HPC peaked at 92,000.[19] Although most HPCs began in the early 1990s, several promising new ones started in New York City and Michigan in 1999.

Although HPCs have achieved some significant successes, they have not achieved the small group market share of 10 to 20 percent in cities across the country that proponents had hoped. In fact, only the Council of Smaller Enterprises (COSE) of Cleveland, Ohio, and perhaps the Connecticut Business & Industry Association (CBIA) have achieved more than a five percent market share. HPCs have not gained a larger market share for several reasons. Small-group reforms legislated by states and the federal government helped make health insurance coverage available on a fairer basis and have undercut the need for HPCs. Secondly, health plans in many cities resisted HPCs particularly in the beginning because they feared they would be forced to insure less healthy individuals (e.g., adverse selection). In addition, HPCs did not offer lower premiums than those found in the commercial market. Health plans were reluctant to join or offer good rates because they did not want the HPC to compete with their existing plans. For all of these reasons, HPCs have had some difficulty interesting brokers. There continue to be few incentives for health plans to bring small employers together to demand price discounts.

Because of these structural issues, HPCs have not made health insurance significantly more affordable, nor have they dramatically increased the number of individuals with coverage. Many authors argue, however, that HPCs could have a greater impact on price simply if they were larger. Despite these limitations, HPCs have increased employee choice, which previously was not a viable option for most small businesses because the administrative costs were too high.[20]

Considerations:

- HPCs are not a "quick fix" but a long-term strategy to help small businesses afford health insurance for their employees. HPCs are particularly good at providing small-firm employees the opportunity to select a health plan that matches their needs.
- State or local regulation, while useful in strengthening HPC impact, may be considered controversial in communities that are adverse to business regulation. Program developers must keep public sentiment in mind when considering this approach for their communities.
- As long as HPCs choose or are required to follow rules for accepting applicants that are significantly more permissive than those that apply to the outside market, they are unlikely to remain viable in the long run. This situation will result in attracting higher-risk groups, claims costs, and premiums or health plans declining to participate.[21] One remedy would be to require small groups to use HPCs, which would eliminate adverse selection, but this is not often politically popular.

Conclusion

Small firms play a large role in any community development effort. The strategies outlined above present a variety of options for state and community leaders to help small businesses provide their employees with health insurance. Providing adequate health insurance to low-income workers, particularly those in small businesses, challenges leaders and policymakers at all levels of government. Adverse selection, high health care costs, the inherent complexities of health insurance, and many other factors make addressing the needs of uninsured workers even more daunting. With the exception of mandating coverage or providing employers and employees with larger subsidies, state and local initiatives alone will not likely solve the problem of the uninsured.[22] However, through use of employer-based strategies such as those outlined in this brief, leaders can make a significant impact in their communities and help small employers to provide adequate health coverage for their workers.

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