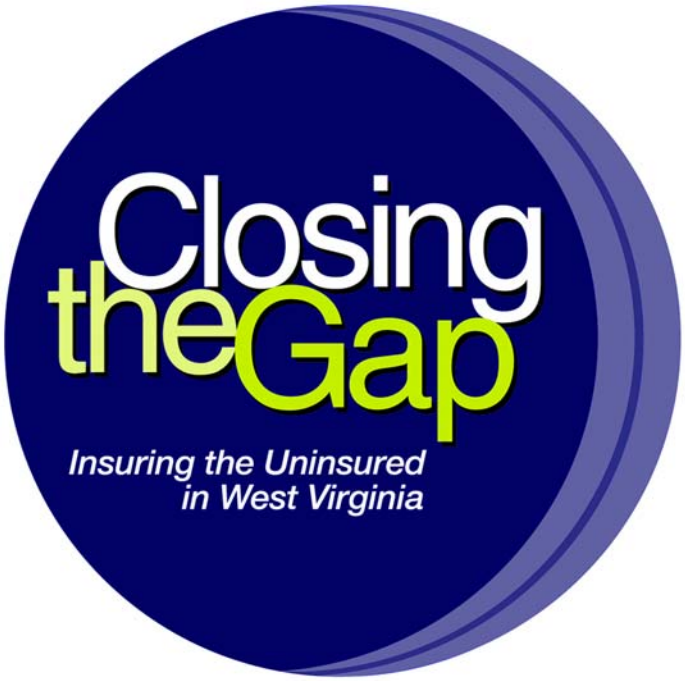

Literature Review on State Activities Related to Employer-Sponsored Insurance (ESI)

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Introduction

For the last decade, state governments have undertaken a variety of activities to support employer-sponsored health insurance in their states. For the most part, these efforts have focused on small businesses (50 employees or less), because of the greater proportion of uninsured workers in these establishments compared to workers in large businesses. Groups of one, or self-employed persons have sometimes been considered "small groups". In addition to encouraging the provision of ESI, state efforts have been directed at buying into ESI as an alternative source of coverage for low-income populations eligible for public programs.

A review of the literature was undertaken to identify activities of other state governments in the area of employer-sponsored insurance (ESI) in order to identify possible models for West Virginia as it develops a comprehensive strategy for increasing the levels of health insurance coverage in the State. The review also looks at local and private efforts for the design lessons they afford and as potential models for action in West Virginia.

Framework for Literature Review

Small groups looking to buy insurance typically encounter two major problems:

- Premiums are high, owing to the nature of underwriting risk in small groups, high marketing and administrative costs that are passed on by the carriers, mandated benefit requirements, and premium taxes.
- Coverage may not be readily available owing to the structure of the market.

Even when the small employer overcomes these obstacles and succeeds in offering coverage, the employees may not take the coverage if their contribution to premium is high. State government activities to increase insurance levels have been directed at altering these factors. The Table below identifies the major activities and highlights those that will be covered in the literature review. Small group market reforms are not covered as they were the subject of an earlier analysis.

Reason for Uninsurance	Strategy	Activity
Cost	Direct Subsidies	Premium assistance to employers
		Premium assistance to employees (ESI buy-ins)
	Indirect Subsidies	Tax incentives
		Affordable products through stop-loss insurance, product design, premium stabilization)
	Other	Health Care Purchasing Pools
		Market reform
Coverage Availability		Health Care Purchasing Pools
		Buy-ins to Public Programs
		Market Reform

The review that follows provides a broad inventory of activities throughout the country and permits the identification of programs that might be worthy of more in-depth investigation.

As will be seen, many of the activities that have been undertaken have not met with overwhelming success. The major lesson from the past decade seems to be that any one activity in isolation is not enough. Rather a comprehensive strategy with a multi-faceted approach will be needed to raise the level of health insurance in a state.

It has now common for analysts to advocate using two or more strategies in tandem. For example, in 2001, the General Accounting Office (GAO) in a review of tax credits commented:

> ***A significant employer tax credit linked to a small employer purchasing cooperative might stimulate participation and create larger market share, making them better able to secure lower-cost coverage for participants. (General Accounting Office March 2001, p. 10)***

Other analysts who advocate the development of a publicly organized and subsidized group health insurance for small with low-income workers point out the need for both employer and employee subsidies. This model is in effect in Massachusetts (described below). They also suggest using rate stabilization to subsidize the product indirectly and giving premium subsidies to the workers. (Rosenbaum et al. 2001)

Direct Subsidies: Premium Assistance to Employers

Discussion

Experience has shown that premium assistance needs to be substantial to influence employers to provide coverage to their employees, and pessimism seems to prevail in the literature regarding the impact of premium assistance on the uninsured rate.

> ***Subsidies must be substantial (subsidies of 30 to 50 percent did not generate significant responses) and subsidies must be shown to be more than a short-term program that could end once small firms sign up. (General Accounting Office 1992, p. 5)***
>
> ***Results from a pilot study of employer subsidies predict that a 25 percent premium subsidy paid to employers would cause 8.25 percent of employers that do not currently offer insurance to participate in a subsidized program. (Cited by Thorpe and Florence 2000, p. 9)***
>
> ***While a 30 percent premium subsidy would increase the proportion of small employees offering insurance by only 15 percent, the impact on the number of uninsured would actually be much smaller, with less than 3 percent of workers in nonoffering firms with fewer than 50 workers actually obtaining insurance as a result of the subsidy. (Reschovsky and Hadley 2001, p.4)***
>
> ***Based on a national study by the Center for Studying Health System Change (HSC) premium subsidies paid directly to small firms are unlikely to significantly reduce the number of uninsured". (Reschovsky and Hadley 2001, p.1)***

Employers are also suspicious that subsidies will be temporary and may be uncomfortable at the prospect of the administrative work involved.

Selected Programs

Massachusetts: Insurance Partnership

Through the Insurance Partnership (IP), Massachusetts provides a direct subsidy to small employers (defined as 1-50 workers) that employ low-income workers to encourage the provision of health insurance to workers otherwise eligible for public coverage. Massachusetts also subsidizes the workers and their families through the MassHealth Family Assistance Program. While funding for the employee component is through Medicaid and SCHIP, the Insurance Partnership was state-funded as of 2001, and Massachusetts officials were exploring the potential for federal funding. To be eligible, a company must offer a comprehensive health plan and pay at least 50 percent of premium. There is no requirement that a group be previously uninsured.

As of June 2001, 3,140 small employers were participating in the IP Program. About one-third were groups of 2 to 50 employees with the majority (66 percent) employers with one full-time employee; i.e. self-employed. At this time the program was described as growing "pretty fast". The program had had a slow start but once the marketing was ramped up the program started to take off and about 500 new employers were being added each month.

Two-thirds of the employers participating began offering insurance when they enrolled in the IP and two-thirds of the adults getting coverage through the program are covered for the first time. Thus the program appears to be effective in reaching the previously uninsured without a look back period.

For an employee with an income up to 200 percent of the Federal Poverty Level (FPL), the program will pay the employer $1000 toward family coverage, $800 toward two-person coverage and $400 toward individual coverage each year. Typically, the subsidies represent 20 percent or less of the employer's liability for each eligible worker.

An employer survey conducted as part of a state planning grant project found that 42 percent of employers who were aware of the IP program and employed low-wage workers felt that the subsidy was too low.

Sources for Massachusetts Insurance Partnership: CMS, MassHealth Annual Report, Conwell and Short 2001, GAO October 2001, Health Resources and Services Administration 2001, Institute for Health Policy Solutions 2001C, Polzer2000, Silow-Carroll et al. 2001 and Silow-Carroll et al. 2000.

New York: State Health Insurance Partnership Program (NYSHIPP)

This statewide, state-funded program, enacted in 1996, subsidized small employers (1 to 50 workers) for up to 45 percent of premium. Employee contributions were limited to no more than 10 percent, thus the employer was responsible for at least 45 percent of the cost, a contribution level that might be characterized as "low to moderate". To participate, a firm must not have provided insurance in the last 12 months. Because of enrollment limitations, preference was given to low-wage firms, and sole proprietors had to have incomes below 222 percent FPL. Not all low-income workers were required to participate but all workers in a company had to choose the same plan.

Approximately 1,100 firms were participating as of December 1999. The program will be phased out by mid 2003 and participants may transition into Healthy New York with their eligibility unaffected by their prior insurance through NYSHIPP.

Before NYSHIPP, New York State supported the Regional Pilot Projects, a group of demonstrations in limited geographic areas. This program paid 50 percent of the premium for businesses of 20 or fewer workers that had not been providing insurance. The employer paid the other 50 percent and no employee contribution was expected.

As of 1991, these projects covered some 600 firms and 3,000 enrollees. A waiting list was in effect owing to limited state funding. An evaluation of the Regional Pilot Project found that 63 percent of the eligible but non-participating businesses indicated they would at best be "somewhat interested" in participating even with a 75 percent subsidy. The pilots enrolled 8.2 percent of the target market in Brooklyn and about 13 percent in Albany. The program stopped accepting new enrollments in 1993.

Sources for NYSHIPP and Regional Pilot Projects: Andrulis and Gusmano 2000, Haslanger et al. 1998, Rosenberg 2002 and Silow-Carroll et al. 2000.

Michigan: HealthChoice, Wayne County

HealthChoice is a county-sponsored premium assistance program for businesses with up to 99 employees. This program is an outgrowth the "One Third Share" project originally funded by the Robert Wood Johnson "Health Care for the Uninsured Project". HealthChoice began in 1994 and will continue indefinitely.

As of June 2000, the program served 19,019 employees in 1,977 businesses. Since an estimated 9,000 businesses qualify for the program, this represents a market penetration rate of more than 20 percent .

Premiums are shared equally among the employer, employee and the program. In 2000, an employee's share of costs ranged from $42 monthly (single coverage) to $120 monthly (for self, spouse and 1-3 dependents). HealthChoice's share of costs is funded through a hospital indigent care pool financed by state Medicaid funds, federal Medicaid matching funds, and county general funds. Eligibility requirements include:

- Firms must not have offered health coverage in last 12 months.
- At least 50 percent of all employees and at least 50 percent of those qualifying for coverage must have an average hourly wage of $10 or less.
- Employees who are enrolling must be uninsured.

Participants may choose from five health plans that provide a full rage of coverage.

Sources for HealthChoice: Andrulis and Gusmano 2000, Rosenbaum et al.2001 and Silow-Carroll et al. 2000.

Michigan: Access Health, Muskegon County

Access Health is a community-sponsored premium assistance program that targets uninsured workers through the employers. The program began enrollment September 1999 and is available in Muskegon County. The program capacity was 3,000 individuals. As of August 2000, 155 groups (about 500 people) were enrolled.

Cost of coverage is shared among the employee (30 percent), the employer (30 percent) and the program (40 percent). The employee's share for adult coverage is $38 per month; for dependent coverage the share is $22 per month.

To be eligible, a business must not have provided health insurance during the last 12 months, and the median wage of its eligible workers must be $10 per hour or less. The program is open to small and medium firms including sole proprietors. On average, there are 3 to 5 eligible employees in the participating companies.

The program holds down premium costs by restricting use of services to providers in Muskegon County. Since the Muskegon health care system does not have the capacity to provide such highly specialized services as transplants, high-level burn care and neonatal intensive care, such services are not covered by the program. It is expected that any low-income individual needing these services will be eligible for a Medicaid spend-down.

Access Health is a not-for-profit corporation that contracts directly with the providers and uses TPAs for certain administrative services. While the program self insures, it is not subject to insurance regulations since it is not an insurer. The community match for the program includes funds from federal DSH funds.

Sources for Access Health: Silow-Carroll et al. 2001 and Silow-Carroll et al. 2000.

California: FOCUS (Financially Obtainable Coverage for Uninsured San Diegans)

FOCUS is a local, privately sponsored premium assistance program for small employers and their low to moderate-income workers in San Diego County. The program, a partnership between the Alliance Healthcare Foundation and Sharp Health Care Plan, began in 1999 and was initially funded for a two-year period with the Alliance providing a $1.2M grant. In 2001 the California Health Care Foundation provided a $1M grant to cover expanded enrollment.

While small, FOCUS appears to have been successful in enrolling its target population. As of August 2000, 1,766 employees and 232 businesses participated in the program. Program budget at that time permitted an enrollment of up to 2,000. On average, businesses have 5 covered employees and 10 covered lives. More than 90 percent of the eligible businesses that have

inquired about the program have enrolled. Many of the businesses that enrolled employed family members and had been interested in coverage for a while.

To be eligible, an employer must be a small business (50 or fewer employees) and must not have provided health insurance in the last year. A state waiver was needed to impose the latter requirement. An employee must be full-time, as defined by the employer, uninsured for the past year and with an income not more than 300 percent FPL. Eligible uninsured dependents are also required to enroll. While the enrolling businesses on average had 6 employees, only 3 on average met the income guidelines for participation.

Monthly premiums are shared among the employer, the employee, and the program. Employers pay a fixed contribution of $24.29 per month for "employee only" coverage and $48.70 per month for "employee and family". Employees pay based on income and family size with their share ranging from $10 to $194 per month. The program provides a subsidy ranging from $0 to $175 per month. Each firm is guaranteed subsidies for two years from the date of participation. While businesses had some concern about the limit, it did not keep them from enrolling.

The benefit plan is a standard commercial plan design. Premiums are kept down mainly through an administrative charge write-off by Sharp Health Plan, deep provider discounts and the willingness of brokers to promote the program on a "no commission" basis. Since it is not likely that such provider and broker support can be counted on for larger geography areas, the utility of the model for an expanded program or adoption elsewhere may be limited.

Sources for FOCUS: IHPS and NGA 2001A, Silow-Carroll et al. 2001, and Silow-Carroll et al. 2000.

Health Care for the Uninsured Project

The Robert Wood Johnson Foundation "Health Care for the Uninsured Project" established in 1986 might have been the first significant initiative to deal with the uninsured issue. The program focused on small businesses and individuals and funded 15 projects . Almost all of these sought to develop affordable products for the target populations. By October 1990, enrollment was underway at 10 projects. Most of these projects enrolled between 2 percent and 17 percent of their target markets.

The projects used a variety of strategies to create more affordable products: insurance plan innovations (limited benefits options, major cost sharing, very limited provider network), subsidy options (direct premium subsidies, indirect subsidies, provider discounts) and links to state high-risk pools. Source 13 analyzes the benefit packages in some detail. They varied widely and most were not "bare bones".

Using state funds, two programs--the Maine Managed Care Demonstration and the Health Care Access Project (One-Third Share Plan) in Michigan--offered premium subsidies for ESI to low-income persons based on a sliding scale of family income up to 200 percent FPL. Subsidies were subject to required employer contributions, 50 percent in Maine and 33 percent in Michigan.

The projects also subsidized premiums indirectly by conducting various administrative functions that would otherwise be reflected in premiums including market research, benefit designs, provider contracting, risk pooling and application processing. Information is not available on whether or not any of the projects employed reinsurance.

Source for the Health Care for the Uninsured Project: Campion et al.1992, General Accounting Office 1992, Haslanger et al. 1998, and Helms et al. 1992.

Direct Subsidies: Premium Assistance to Employees (ESI Buy-Ins)

Discussion

Overview. A number of states have taken advantage of Medicaid and SCHIP funding to develop premium assistance programs for low-income workers and families with access to ESI. Instead of covering eligibles directly in public programs, the state helps them enroll in ESI thus leveraging the private employer dollars already in the system. Other states have developed ESI buy-in programs using only state dollars. While these programs have encountered many roadblocks, the potential gains from such public-private coordination are many. The more recent HIFA regulations encourage public private partnerships and introduce the potential for heightened support of ESI by state governments.

Benefits of Premium Assistance Programs. Buying into employer-sponsored insurance has a number of advantages:

- It allows public dollars to go further as they build on the private dollars the employers are already committing to the system.

- Eligible workers may be more likely to participate since the stigma associated with public programs is avoided with ESI. The Iowa HIPP program has found that workers enrolling in the ESI program do not want Medicaid because of the stigma.

  These same people state they have no intention of using their Medicaid card for wrap-around benefits, but they needed the assistance in getting their employer plan paid for. (IHPS and NGA 2001C, p. 93)

- It provides a single source of coverage to families, making it easier to negotiate the system and perhaps promoting more appropriate use of services.

- Enrolling everyone in the same program may also encourage parents of eligible but uninsured children to enroll them in public programs. SCHIP administrators have found that working parents would rather obtain coverage for their children through the workplace than through a separate program. (Rosenbaum et al.2001)

- Private insurance can improve access to care since the numbers of doctors participating in Medicaid or SCHIP may be limited.

- It allows for continuity of coverage if the family looses eligibility for a public subsidy since the family can continue with the same insurance.

Federal Funding for Premium Assistance Programs. States have been able to provide premium support for ESI using federal funds through several authorities:

- Section 1906 of Title XIX enacted in 1990 , known as the Health Insurance Premium Payment (HIPP) Program
- State Children's Health Insurance Program (SCHIP) (Title XXI) waivers
- Section 1115 waivers
- HIFA, the Health Insurance Flexibility and Accountability Initiative, announced in 2001

The learning curve for working with the private sector has, however, been steep with the obstacles to success compounded by the complex requirements for federal funding.

Health Insurance Premium Payment Programs, Section 1906 of Title XIX (Medicaid). Section 1906 effective January 1, 1991 required states to subsidize ESI for Medicaid eligible persons when this was more cost-effective than Medicaid. States were obliged to pay the premiums as well as the deductibles and coinsurance so that the costs to the beneficiary would be equivalent to costs under Medicaid. The benefit package had to be the same as provided through the Medicaid program, thus it had to cover any services not included in the ESI. States were also required to purchase ESI for non-Medicaid eligible family members if purchasing family coverage was necessary to get coverage for the Medicaid-eligible person and this was still cost-effective. Section 1906 requirements were made optional in 1996.

In 1992, the General Accounting Office (GAO) reported that some 18 states had implemented a HIPP program. (Cited in General Accounting Office 1997) However, in a 1997 study the GAO reported that only three states (Iowa, Pennsylvania and Texas) had achieved programs of any significance. (General Accounting Office 1997). At that time, these states provided the focus for an in-depth study by the GAO. Overall, program enrollment in these three states was not great and constituted only a small proportion of the Medicaid population. Savings were also small.

State Children's Health Insurance Program (SCHIP) (Title XXI). States may use SCHIP funds to subsidize ESI either for children alone or for families with eligible children. No waiver is needed to cover children through ESI but must be obtained if coverage is to be extended to families. Most states interested in coordinating with ESI have also focused on extending

coverage to families and have sought waivers. States have a financial incentive to use SCHIP funds rather than Medicaid to buy into ESI because of the federal higher match. As of March 2001, Maryland, Massachusetts, Mississippi, Wisconsin, New Jersey, Rhode Island, and Virginia had obtained waivers to use SCHIP funds for ESI.

The SCHIP regulations imposed a number of requirements that presented daunting challenges for ESI programs. They included:

- **Coverage must not result in "crowd out"; that is, public coverage must not be substituted for private coverage. The program must not lead employers to drop coverage or reduce their premium contributions or cause currently insured employees to drop coverage for themselves or their dependents.** To deter reductions in employer support, the interim regulations required the employer to contribute 60 percent of the premium, unless the state demonstrated that the average employer's contribution was less. This presented a particular problem since employer often did not contribute anything to dependent coverage. The 60 percent requirement was dropped in the final regulations.

  To be eligible a child had to have been without group health insurance for at least 6 months. This meant that families struggling to make insurance payments were not eligible but others at the same income level who acted less responsibly were.

- **The ESI must not cost the state and federal government more than a stand-alone program—the "cost effectiveness" test.** As for a HIPP program, a methodology for determining cost-effectiveness was needed, and benefit information had to be obtained from the employer. Here, the cost effectiveness test was more stringent since the program could only cover the entire family if the cost to the state was less than it would be to cover the eligible child(ren) in the regular program.

- **Coverage must be at the same level as the SCHIP or benchmark benefit package .** Because most employer plans do not conform to the generous benchmark coverages and offer lesser levels of benefits including higher co-payments, states have to work out a way to provide the additional benefits through "wrap-around" coverages or not allow the eligible to enroll in the ESI. In addition, SCHIP completely prohibits cost sharing for preventive and well baby/child care. This means creating a mechanism so that the provider does not expect to collect a copayment from enrollees.

- **Cost sharing for children's expenses must not exceed 5 percent of family income.** This requires tracking family income and expenditures.

One analyst reviewing the situation in 2000 concluded:

> ***Given the considerable hurdles that states must overcome, it seems unlikely that they will be able to cover a significant number of uninsured children through programs accessing SCHIP funds to subsidize job-based health coverage. (Polzer 2000, p. 9)***

Even the federal government had cautioned states that the administrative costs involved may not be worth it. (Cited by Polzer 2000).

Health Insurance Flexibility and Accountability (HIFA) Initiative. The HIFA initiative introduced in 2001 encourages states to utilize Medicaid and SCHIP resources to increase the levels of health insurance in their states with an emphasis on coordination with the private sector. HIFA permits greater flexibility in benefit design than previously allowed for SCHIP and Medicaid funding. Overall, the States that have received waivers to date have *not* made coordination with the ESI the cornerstone of their initiatives.

Major Issues in Program Design. Implementing an ESI buy-in involves policy issues and operational challenges. Some of the issues arise from the requirements imposed for federal funding and are eliminated when only state funding is used. Others are inherent to the endeavor.

"Crowd out." Mechanisms to avoid crowd out are important to assure that public dollars do not take the place of private dollars. These generally include minimum employer contributions and "look backs". Fear of crowd out is greatest when a firm has many low-income workers.

Employer Contribution Levels. States using federal funds must set minimum contribution levels for employers—usually about 40-60 percent. This is intended to prevent employers from reducing their contributions in effect causing "crowd out". The interim regulations for the SCHIP program required a 60 percent contribution from employers, unless the state could demonstrate that the average employer contribution in the state was less. The final regulations eased this requirement. An employer contribution requirement presents a significant problem when employers contribute $0 to dependent coverage. Analysts have pointed out that a contribution of say 50 percent is just not "realistic" given the firm's overall investment in the employee and have suggested lessening the contribution requirement in the case of low income workers. (Rosenbaum et al. 2001)

"Look backs". These are used to minimize "crowd out". For example, only uninsured persons or persons who have not had insurance in a certain period might be eligible for premium subsidies. Such policies raise equity concerns, however, since they reward those who have not pulled their own weight and punish those at the same income level who have. Medicaid does not have a look back requirement. Anyone eligible for benefits and already participating in ESI can be subsidized. SCHIP funds, on the other hand, can only be used for children who are currently uninsured and for ESI there is a 6-month look back period.

***Cost Effectiveness Determination*.** Regardless of whether federal funds are used or not, it is important for the program to determine whether there will be cost savings in an ESI buy-in program.

For SCHIP funding, cost-effectiveness means that the entire family can be covered in the ESI for less than it would cost to enroll the child in the regular SCHIP program. Cost-effectiveness for Medicaid means that it costs the public less to insure the entire family in ESI than it would cost to insure them in regular Medicaid. Making the cost effectiveness determination presents a

serious operational challenge. It is difficult, resource-intensive, and requires detailed information on the ESI, which may be difficult to obtain. Even when the review is automated, it requires much manual intervention.

Benefit Equivalency. For the ESI to qualify for Medicaid or SCHIP funding, states must see to it that the ESI benefits are equivalent to those available in the regular public programs. This involves collecting information on the benefit plans, which is not always forthcoming and having staff resources for the tedious comparisons.

Wraparound Coverage. Since federal funding has required that the person receiving ESI coverage get the Medicaid, SCHIP or benchmark benefit package, the program has had to supplement the benefits provided by the ESI through "wraparounds". These can be particularly cumbersome to administer in a fragmented group market with many carriers and many benefits plans.

Federal Cost-sharing Requirements. Both Medicaid and SCHIP limit employee cost-sharing. Medicaid funded programs cannot charge certain enrollees for any portion of the premium and copayments cannot exceed those in the state Medicaid program. SCHIP requires that families not spend more than 5 percent of their income on children's health care expenditures, including copayment. To comply with these requirements programs have had to devise mechanisms to track income and spending and make sure that enrollees are not billed inappropriately.

Identification of Eligibles. Programs typically use application workers to screen for the availability of ESI. Applicants are not always forthcoming—for example, they may not want their employers to know they are getting help. Staff must also be kept mindful of their responsibilities with respect to the program.

Employer Cooperation. To enforce contribution requirements, if any, and assess cost effectiveness and benefit equivalency, programs must obtain premium and benefit information from the employers. In the absence of supporting legislation, states do not have the clout to demand this information. Even if state legislation were enacted, without corresponding ERISA amendments, the program still would not be able to command the cooperation of self-insured employers. The need for employer cooperation increases if the state wishes to make the employer the recipient of the subsidy payment.

There are several reasons why employers may be less than supportive of a buy-in program .

- If low-income employees who previously declined coverage begin taking it, the employer's premium expenses will increase.
- If the newly insured employees are higher risk, the employer's premiums might go up.
- If there is a "look back", the employer may perceive the program to be unfair to workers who have been paying for insurance.
- They may simply not want the bother of additional administrative tasks.

Given these obstacles, cultivating relationships with employers becomes a critical for program development.

Subsidy Payments. An ESI program has to decide who will be the recipient of the subsidy payment—the employer, the employee or some third party. Several issues arise when the payment is made to the employer:

- Employees' shares of premiums are typically taken as payroll deductions. Direct payment to the employer on behalf of some employees can interfere with this process and require new administrative systems.

- The employer becomes privy to information on the employee 's family income and Medicaid eligibility, information that should be confidential.

- Employers who are involved in administering the subsidies might be more tempted to reduce their contribution levels, thus leading to "crowd out".

Given these considerations, a consensus seems to have developed in favor of paying the worker directly. When one ESI program gave employers a choice on this issue, 90 percent opted to have the payment made to the employee. (Sexton 2000) When this approach is used, the worker simply selects the employer's plan, and the employer makes the necessary payroll deduction as he or she would for any other participating employee. The program arranges for the subsidy to be paid to the worker, usually on a prospective basis. The program then has the responsibility of monitoring that the coverage is actually in effect. This can be done by the intermediary if one is used, through the employer's carrier or by verifying the ESI deduction on the worker's paycheck.

Open Enrollment Limits. Employees have only a small window of opportunity to enroll in employer plans. These open enrollment periods do not necessarily coincide with the eligibility determination, a factor contributing to low enrollment.

Instability in the Low-Income Labor Market. The inherent instability in the low income labor market with frequent job changes adversely affects enrollment levels and compounds the administrative challenge. No sooner might a family be deemed eligible for the program and their subsidies and wraparound coverage be worked out, than the parent might leave that employer. Variations in employee earnings from week to week may also add to the complexity of administering an income-based subsidy.

General Effectiveness of Programs

> ***Because the ESI buy-in programs are new and still quite small, it is too early to know if they have saved money (compared to providing benefits directly) or what changes in employer and employee behavior they may have induced. (Merlis 2001, p. 14)***

The Iowa HIPP is reported to save $3.30 on Medicaid benefits for every $1 paid for ESI. (Ryan 2001) The data provided by the GAO on the three HIPP programs show some small savings (General Accounting Office 1997), and anecdotal information is also available that suggests that for some "high cost" individuals the savings can be great. As a program representative reflects:

> ***We find that's very cost effective, and we're able to cost avoid a lot of really expensive care by keeping people in their employer-sponsored programs. (IHPS and NGA 2001C,, p. 95)***

To date, the premium assistance programs have not been successful in enrolling large numbers of persons. This is due to a number of factors.

- Too few low-income persons who qualify for public programs have access to employer-sponsored insurance.

- Those employers who do provide coverage do not meet the minimum premium contribution, usually set at 60 percent. In particular, this level of contribution is not met for dependent coverage.

- It has been very difficult for plans to secure the information they need to assess benefit equivalency and cost effectiveness, as required for federal funding.

Even when all the issues can be dealt with successfully, there still limitations on what premium assistance programs for ESI can contribute to improving the levels of health insurance coverage in a state. Several pre-conditions must be met for this approach to work:

- The employer must offer coverage (including dependent coverage).
- The employee must be eligible.
- The employer must be willing to cooperate with the government program at least at some level.

In addition, as in any other program, the potential participant must know about program and apply for the subsidy. That is, the program must have an effective marketing component.
Since large firms are more likely to offer insurance than small firms are, a fruitful target population for an ESI program might be the low-income employees who are not taking up insurance offered by their large employers.

Because a large proportion of small firms do not offer insurance at all, a premium support program directed at low income workers might need to be coupled with subsidies directed at the employer. This is precisely the program that is in force in Massachusetts.

Selected Programs

Iowa: Health Insurance Premium Program

Iowa, which has one of the nation's most developed HIPP programs, pays for employer-related as well as other private health insurance for Medicaid-eligible persons. Ninety percent of participants receive subsidies for group coverage. The program also investigates the cost-

effectiveness of COBRA coverage for laid off workers. The state saves an estimated $3.30 in Medicaid benefits for every $1.00 it spends on premium assistance.

As of May 2001, the Iowa program was serving 9,645 people including 3,143 non-Medicaid eligible family members. The Medicaid eligibles in HIPP constitute about 3 percent of the total Medicaid population.

Iowa considers all Medicaid applicants with access to ESI for the HIPP program; it does not limit screening to those who are expected to be high cost. ESI is considered cost effective if the state's share of the ESI premium saves at least $5 per month compared to what would be the state's cost to provide the services covered by ESI under traditional Medicaid. Several situations are deemed to be automatically cost-effective: if the employee's share of premium for individual coverage is $50 or less, if the share for coverage for two persons or a family is $100 or less or if a pregnant woman will be covered by the ESI.

Medicaid-eligibles for whom this test is met are required to enroll in the ESI. They are also issued a Medicaid card that is used to obtain services not covered by the ESI. Employers are given a choice as to whether they are reimbursed for the premium or if the payment is made to the employee. Ninety percent opt to have the payment made to the employee.

The State has compiled an extensive library of employer benefit plans so that they do not have to continually request information, and access to this data is now automated. Nonetheless, the program remains "very labor-intensive". (IHPS and NGA 2001C, p. 94) The staff for the program has grown from 2 in 1991 to 17 in 2001.

While they are not targeted, the program has found it very cost-effective to pay for ESI for high cost individuals. Speaking at a conference, a plan representative discussing one individual provided some figures:

> ***Over the next year, we paid $1,200 in premiums for his individual coverage , and the health plan paid $360,000 in claims. So it was very cost effective for the state to maintain coverage for that individual. This is just one example of where we saved significant money in the Medicaid program with a very small investment. (IHPS and NGA 2001C, p. 93)***

Sources for the Iowa HIPP: General Accounting Office 1997, IHPS and NGA 2001C, Ryan 2001, Sexton 2000, Silow-Carroll et al. 2001,and Silow-Carroll et al. 2000.,

Pennsylvania: Health Insurance Premium Program

As of January 1997, the plan had 4,700 enrollees representing .3 percent of the Medicaid population in the state. The Pennsylvania program gives priority to enrolling persons with special conditions because of the potential for enhanced savings to the state. About 22 percent

of the enrollees as of January 1997 had such "special conditions". The program does not require any minimum monthly savings for the plan to be considered cost-effective. (General Accounting Office 1997)

Texas: Health Insurance Premium Program

As of August 1996, the plan had 5,507 enrollees representing .2 percent of the Medicaid enrollment in the State. The State was confident the program would grow even with the emergence of Medicaid managed care because it was less costly for the State to support a family in an ESI with family coverage than to pay a managed care plan per person premiums. The program does not require any minimum monthly savings for the plan to be considered cost-effective. (General Accounting Office 1997)

MassHealth Family Assistance Program

Massachusetts is the one state that has developed a substantial premium assistance program that has also integrated SCHIP funding to any significant extent. Massachusetts is further distinguished by having a two pronged program of premium assistance –one component that subsidizes workers (Premium Assistance –PA) and another that encourages small groups to offer insurance. (Insurance Partnership—IP) The entire program is known as MassHealth's Family Assistance Program. (FAP).

Federal funding for the Family Assistance Program is through both Section 1115 and SCHIP waivers. SCHIP funding, with 75 percent federal match, is used when:

- The SCHIP look back requirement is met; that its, the enrollee is a member of a family with children that were previously uninsured.
- Family income is between 150 percent and 200 percent FPL.
- The ESI meets the benchmark benefits.
- The employer contribution is at least 50 percent . (Massachusetts demonstrated that the majority of employers in the state contribute at this level than at the 60 percent level required by HCFA).
- It is cost-effective to subsidize ESI premiums in lieu of enrolling the eligible persons in the regular SCHIP program

Medicaid funds, with a 50 percent federal match are used for all of the other enrollees who are primarily:

- Families that already have insurance and have incomes from 150 percent to 200 percent FPL
- Families with incomes up to 150 percent FPL.

The source of funds is invisible to the applicant, and there is a single point of entry to all components of the MassHealth program.

The State pays the employee's share of the employer-sponsored insurance premium minus a small employee contribution. The program also buys into COBRA coverage when it is cost-effective. For families with incomes under 133 percent FPL, the State subsides the entire ESI premium and provides wraparound coverage to bring the benefits to the Medicaid level. Workers with incomes between 133 percent FPL and 200 percent FPL pay a part of the employee's share of premium.

As of June 2001, the Premium Assistance Program covered 12,146 lives. About 60 percent were in large groups with 40 percent in small firms or self-employed. These figures include the family members as well as the Medicaid or SCHIP eligible individuals, who comprise about half of the total. A program representative expressed the significance to the State:

> ***By covering the entire family instead of just the eligible child we have been able to significantly increase our eligible members, while at the same time we decrease the overall amount of uninsurance by the coverage for our MassHealth members as well as their families that are able to benefit from our assistance. (IHPS and NGA 2001C, p. 96)***

While no financial data were presented, the program representative also noted:

> ***We find that's very cost effective, and we're able to cost avoid a lot of expensive care by keeping people in their employer-sponsored plans. (IHPS and NGA 2001C, p. 95)***

Most participants are supported by Medicaid funds owing to the multiple requirements for using SCHIP dollars. In January 2001, only 62 children in ESI were supported through SCHIP while some 4,749 were receiving premium assistance through the Section 1115 waiver. Enrollment through SCHIP is very low since most ESI does not meet the benchmark test, which must be met benefit by benefit.

Program Highlights/Unique Features

- Under both the Medicaid waiver and the SCHIP initiative, Massachusetts may subsidize ESI in situations where the employer's contribution to premiums is only 50 percent instead of the 60 percent that has been usually required for SCHIP and 1115 waivers.

- There is no look back period. The 1115 waiver allows Massachusetts to use Medicaid funds for people who are already insured. The State's philosophy was described by a program representative:

- > ***. . . a lot of families were covering their kids at below 200 percent of the federal poverty level, but they were really struggling to do that. And we didn't want to have a program***

where we just had people who hadn't been using their money in that way getting the benefit of not doing it, and the people who really had been struggling to do the right thing and cover their kids not get to benefits from this program. (IHPS and NGA 2001C, p. 98)

- The Massachusetts ESI program is invisible to the employer as the subsidy is paid to the participant or to the "billing and enrollment intermediary" (BEI) that is used to administer the program. When the subsidy is paid to the worker, the BEI verifies that the ESI is actually in effect.

- State law was changed to make MassHealth eligibility a qualifying event for enrollment in ESI.

- Massachusetts is not constrained to meet the stringent SCHIP requirements but can cover working families through the 1115 waiver. Enrollment has been further facilitated by leniency permitted by that waiver; namely, a 50 percent employer contribution and no "look back".

Sources for MassHealth FAP: CMS, MassHealth Annual Report, CMS MA Fact Sheet, Conwell and Short 2001, Curtis 1999, Hearne and Tollen 1999, Holahan and Haslanger 2000, IHPS and NGA 2001C, Polzer 2000, Silow-Carroll et al. 2001, Silow-Carroll et al. 2000, and State Coverage Initiatives March 2001.

Mississippi: SCHIP Waiver Premium Assistance Program

Mississippi's SCHIP waiver program was approved February 1999. The program was put on hold when the state identified a number of administrative issues, which seemed to sound the death knell for the program.

- While the Mississippi waiver allows the employer's premium contribution to be as low as 50 percent , it was estimated that only 10-15 percent of the employer plans would be eligible for subsidies because most do not contribute to family coverage.

- Most health benefit plans have enrollee cost-sharing requirements that greatly exceed the SCHIP limits.

- Mississippi has many small employers and many non-standard plans. The general cost of meeting SCHIP requirements, the cost of creating and administering wrap-around benefit packages, and the cost of actually providing the wraparound benefits were expected to be so high that the program would not meet the cost effectiveness test.

In addition, employers were very non-receptive to the program and expressed many concerns, indicating that they did not want to receive subsidy payments.

Despite these obstacles, the premium assistance program was finally scheduled to begin January 2001. To address employer concerns, the program planned to make the subsidy payments directly to the families. The program also planned to use a single supplemental carrier to provide the wraparound coverage.

Sources for Mississippi: IHPS and NGA 1999, Polzer 2000, State Coverage Initiatives March 2001, and Tollen and Curtis 1999.

Wisconsin: BadgerCare

Wisconsin's BadgerCare uses two funding streams to subsidize ESI--Title XIX and Title XXI. The SCHIP waiver was received September 2000. Children and their families up to 185 percent FPL are eligible and once enrolled, may remain until their income exceeds 200 percent FPL. Families with incomes over 150 percent FPL contribute not more than 3 percent of income. There is a 6-month look back period.

BadgerCare itself began July 1999 and, after one year of "phenomenal" growth, enrolled 60,000 people (25,000 cases). The ESI component, which began October 1999, has not been as successful enrolling only a handful of families. The majority of families (90 percent) eligible for BadgerCare have incomes under 150 percent FPL and do not have access to ESI. Only 6 percent of BadgerCare applicants (907 cases) in a one-year period had access to ESI. Of these only, 5 families were ultimately enrolled in the premium assistance program.

People do not qualify for the ESI program for the following reasons:

- Employer's contribution to premium is either too low (less than 60 percent) or too high (80 percent or more.) (Main reason for disqualification)

- The coverage offered is too limited to qualify for the subsidy program (Second most frequent reason for disqualification).

- Employer does not respond to the questionnaire used to determine eligibility (only 65 percent send back information and this is often "bulky, misleading, or outdated").

- The worker has already left the employer who is surveyed (30 percent of responding employers).

- There is no access to family coverage through the ESI (40 percent of responding employers).

Enrollment data for the premium assistance program are abysmally low. As of May 2001, 32 families representing about 90 persons were enrolled. An additional 27 families were awaiting enrollment due to open enrollment restrictions.

Despite the low enrollment Wisconsin has persevered in developing the infrastructure to support the premium assistance program so that it will be poised to take advantage of any relaxed CMS regulations in the future. The program anticipates even further administrative complications as more employers move to defined contribution plans.

Program Highlights/Unique Features

- Wisconsin uses a single point of entry for all of its public programs, and the ESI program uses the existing BadgerCare infrastructure as much as possible.

- The entire BadgerCare program is not an entitlement program but operates with an enrollment threshold.

- Once a person is deemed income eligible for BadgerCare, the program sets out to determine whether the person is eligible for the employer subsidy program. The program has invested heavily in computer technology to make the eligibility determination. An Employer Verification of Insurance form is sent to the employer whenever a member of an family eligible for BadgerCare has employment and there is a possibility of ESI. The process of collecting information and checking requirements can take two months or more. According to a BadgerCare representative: ***"The verification process is very time consuming and very labor intensive"***. (Alberga 2001, p. 4)

- To determine cost-effectiveness, the program compares the family portion of premium, wrap-around costs, and an administrative fee to the capitation rate for a Medicaid HMO.

- Once eligibility is determined, the employer and employee decide how the worker's share of premium will be submitted. The most popular option is to elect to have the premium paid through payroll deduction. The subsidy is then mailed directly to the worker by the state. The program then verifies coverage in ESI with the employer once a year. Paystubs are also checked to verify enrollment in coverage.

- The employer must pay from 60 percent to 80 percent of the monthly premium. The maximum contribution is imposed by state legislation.

- Although very few employers participate owing to the low enrollment, the program reports that it has not had problems securing employer cooperation since the program pays the subsidy to the worker and is invisible to the employer.

- Wisconsin was preparing a state plan amendment in 2001 that would drop the minimum employer contribution to 50 percent. It was estimated that this would double the number of cases that could reviewed for cost-effectiveness.

- Wisconsin has explored the changing state law to allow the SCHIP buy-in program to supersede open enrollment periods. .

Sources for BadgerCare: Alberga 2001, Holahan and Haslanger 2000, IHPS and NGA 2001C, Merlis 2001, Polzer 2000, Silow-Carroll et al. 2000 and State Coverage Initiatives March 2001.

New Jersey Family Care Premium Support Program

New Jersey began enrollment in its Premium Support Program (PSP) for ESI July 2001 as part of New Jersey Family Care, which operates under Section 1115 and SCHIP waivers.

Enrollment growth has been slow with only 150 individuals enrolled and 108 ending enrollment as of December 2001, after 6 months of operation. NJ Family Care program is unlikely to reach its target revenue from the ESI component. (31) Two factors deter enrollment: the 50 percent employer contribution and the difficulty of demonstrating cost-effectiveness. Representatives from industry have raised concerns about the level of the employer contribution.

Program Highlights/Unique Features

- The assessment of cost effectiveness is simplified since earlier market reforms resulted in standardized benefits in the small group market. As one official observed:

  Without standardization in the small-group market, the wraparound would have been impossible. (Silow-Carroll et al. 2002B, p.68)

- For large groups, the program does a benefit by benefit comparison. If the ESI falls below the benchmark, the applicant must go into the public program.

- The program pays the subsidy directly to the worker. This was in response to focus group findings which revealed employer concerns about the administrative burden.

Sources for NJ Family Care: Conwell and Short 2001, Silow-Carroll et al. 2002A, Silow-Carroll et al. 2002B, and IHPS and NGA 2001C.

Oregon: Family Health Insurance Assistance Program (FHIAP)

The Family Health Insurance Assistance Program (FHIAP) is a state-funded program that provides access to private insurance either through employer plans or in the individual market.

Premium assistance is provided on a sliding scale for persons up to 170 percent FPL. As a state-funded program there have been no constraints from federal requirements and subsidies are provided for any ESI.

Despite the lack of complex requirements, the enrollees in the FHIAP have overwhelmingly been persons not using ESI. Of the 3,795 enrollees as of March 2002, 598 were in employer-sponsored coverage. (*Note: There is a cap on overall enrollment in the FHIAP program and waiting lists have tended to be long.)* About 200 employers are involved in the program.

Program Highlights/Unique Features

- State-only funding
- No employer contribution requirement
- No specific benefit requirements; all ESI qualifies.
- "Look back" period of six months
- The subsidy payment is made to the employee prospectively to avoid cash flow problems with payroll deductions. The process is invisible to the employer, who does not know which of the firm's employees are receiving subsidies. The employee must send paystubs to the state monthly to confirm enrollment.
- The state maintains a database of the benefit plans of the employers involved in the program.

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Going Forward. Oregon was not successful in negotiating a SCHIP waiver. Several of the conditions would have been particularly onerous for the existing program. The benefit package and cost-sharing requirements would have required a wraparound or a new product . There was concern that the coverage for the subsidized employees would be richer than what the employer's give their non-subsidized employees thus introducing inequities into the workplace. The SCHIP requirement that applicants be screened for Medicaid eligibility would have introduced a new component to the application process that was deemed undesirable. In January 2002, Oregon applied for a HIFA waiver that would apply to the FHIAP program.

Sources for Oregon FHIAP: Sexton 1998, Silow-Carroll et al. 2002A, Silow-Carroll et al. 2000, and State Coverage Initiatives March 2001.

Washington Basic Health Plan

The Washington Basic Health Plan is a state-funded premium assistance program providing subsidies on a sliding scale to persons with family incomes less than 200 percent FPL. The

subsidy may be made directly to the individual or to through employers who contribute to the cost of coverage. Coverage is purchased from any of 9 participating health plans.

As of June 2000, 1,176 people were enrolled through employer groups, representing less than 1 percent of the enrollment. Relatively small numbers participate in the group coverage component since the program incentives are biased toward individual coverage.

Employers enrolling eligible persons in Basis Health group coverage may pay all or part of their employees' monthly premium. However, they must pay at least $45 per month for each full-time employee and $25 per month for each part-time employee. These employer premium contributions for group coverage were designed in anticipation of an employer mandate that did not come to fruition. Since a worker obtaining coverage through the individual market may pay as little as $10 per month, without a mandate to provide coverage, employers have an incentive to encourage their workers to enrolls as individuals.

Program Highlights/Unique Features

- Uses only state funding.

- Although most participants are enrolled on an individual basis rather than through a group, the minimum employer contribution requirement of $45 per month per individual falls below the usual 50 percent to 60 percent requirement.

- Does not effectively involve groups in contributing to coverage for their workers, thus does not leverage significant private dollars for health insurance coverage.

Sources for Washington Basic Health Plan: Andrulis and Gusmano 2000 and Silow-Carroll et al. 2000.

Rhode Island*: *RIte Share

RIte Share is a premium subsidy program for low-income workers with access to ESI and is mandatory for RIteCare applicants with this access. The program began May 2001 and operates under a Section 1115 and a SCHIP waiver. The program pays all or part of the employee's share of premium. Insights into the implementation process and the collaboration involved are provided in IHPS and NGA 2001B. Since there are a small number of health plans in the market, the program did not find providing wraparound coverage a huge obstacle. The program has faced administrative difficulties and employer resistance. RIteShare enrolled 2,148 persons as of August 2002.

Sources for RIteShare: IHPS and NGA 2001B, Silow-Carroll et al. 2002A and Silow-Carroll et al. 2002B.

Illinois: KidCare Parent Coverage Demonstration

Using state funding, Illinois has been providing premium assistance to families whose children have access to ESI through its KidCare rebate program. As of November 2001, this program covered 5,779 children. The rebate is currently set at a maximum of $75 per month per eligible family member.

Under a HIFA waiver, the basic features will remain unchanged. It will be offered to all parents and children in the KidCare income range, including the expansion populations.

Program Highlights/Unique Features

- The rebate program does not have a "look back" requirement; income eligible children qualify for the rebate regardless of whether they are uninsured or not. This provision is viewed as deterring crowd out by helping currently insured families who might otherwise drop coverage to quality for KidCare.

- There are no minimum employer contribution requirements.

- To quality for a subsidy, the benefit package must be "comprehensive"; that is, it must cover outpatient physician services and inpatient care. However, Illinois is using neither the Title XIX cost-sharing limits nor the Title XXI benchmark standards.

- The State does not believe it is effective to police benefits packages or employer contributions, and it believes the combined choices of employers and employees will assure adequate benefits to the low-income population.

Sources for Illinois KidCare: CMS November 2002, CMS June 2002, and CMS Illinois HIFA Letter.

New Mexico: State Coverage Initiative

Through New Mexico's HIFA waiver, uninsured workers will be covered through a commercial product similar to the typical employer-sponsored benefit package. Employers, employees, and the State will share the cost of the coverage. Employers will contribute $75 (about 35 percent) and employees, $20 or $35 depending on their income level. The state and federal government will pay the balance of an estimated monthly coverage cost of $210, or approximately 48-55 percent of the total.

Program Highlights/Unique Features

- A standard benefit package will be available to groups through managed care organizations, thus in effect creating a quasi-purchasing pool.

- Copayments will exceed the nominal copayments of Medicaid and SCHIP.
- Crowd out will be minimized by limiting eligibility to uninsured employees.
- The employer's of premium ($75 per month) comes to about a 35 percent contribution.

Sources for New Mexico State Coverage Initiative: CMS October 2002 and Engquist and Burns 2002.

Maine: Private Health Insurance Premium Program

Maine has been administering a Private Health Insurance Premium program that pays employer-based insurance premiums for certain MaineCare members subject to a cost-effectiveness test. Under its HIFA waiver, Maine will cover the expansion population through ESI to the extent possible. (CMS November 2002)

Arizona: Feasibility Study

Arizona conducted a feasibility study relative to an ESI pilot program to examine issues of concern. (To have been completed May 1, 2002). (CMS July 2002)

California: Feasibility Study

California is conducting a feasibility study relative to an ESI pilot program to examine relevant issues. It is scheduled to be completed October 31, 2003. (CMS May 2002)

Indirect Subsidies: State Tax Incentives

Discussion

As of 1991,seven states had income tax credits for small employers offering health insurance. They included California, Kansas, Kentucky and Oklahoma. (General Accounting Office 1992) While some description of these incentives is available in the literature, they have not received wide attention.

It appears as if the prognosis for their effectiveness is guarded for several reasons:

- They usually do not cover a significant portion of the premium.

- While they may attract some firms, they do not work for companies without reportable income unless the credits are refundable.

- They are usually temporary and thus employers may be wary.

- Employers also said to dislike the administrative work involved.

In authorizing a tax credit, a state must deal with eligibility issues including firm size and prior coverage status. The state may also decide to mandate a employer percentage contribution and require certification of the health plan. These factors will all affect the how many employers utilize the credit..

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Kansas: Small Employer Health Insurance Contribution Credit

This state-funded program provides a refundable tax credit to employers for the first 5 years during which they provide health insurance to their workers. The credit is available only to firms that have not contributed to health insurance premiums for employees in the two-year period prior to application. As of May 2000, 62 firms had been issued certificates to receive the credit (but not all may not have purchased coverage and claimed the credit.)

The credit is reduced over the five-year period as shown below:

	Credit per eligible worker
Year 1	Lesser of $35 month or 50 percent of total paid during tax year
Year 2	Lesser of $35 month or 50 percent of total paid during tax year
Year 3	Lesser of $26.25 month or 50 percent of total paid during tax year
Year 4	Lesser of $17.50 month or 50 percent of total paid during tax year
Year 5	Lesser of $8.75 month or 50 percent of the total paid during tax year
Year 6 and after	No credit

Since the tax credit is only temporary and also represents less than 20 percent of the typical employer premium, employers may be guarded about taking advantage it. One of the recommendations of a recent state planning grant (SPG) project was to revamp the tax credit to provide a greater incentive for employers not offering coverage and to reward small businesses when their low-income workers enroll in ESI.

Sources for Kansas Tax Credit: General Accounting Office 2001, Health Services and Resource Administration 2001, Kansas Department of Insurance, and Silow-Carroll et al.2000.

Massachusetts

A GAO report in 2001 referred to the Massachusetts tax credits to "small businesses" and to "low income employers". Further details were not provided except to note that the policy was too new to assess its effect on coverage. (General Accounting Office 2001)

Georgia

Georgia did not proceed with a health insurance tax credit for small employers after an independent study showed this would not have a great impact on health coverage relative to its cost. The employer tax credit was an initiative proposed in the "Business Plan for Health", a collaborative effort of the public and private sectors. The tax was to provide tiered benefits favoring employers in rural areas and those not previously offering coverage. (Silow-Carroll et al. 2002A, 2002B)

Indirect Subsidies: Affordable Products

Healthy New York (Stop Loss Insurance)

Healthy New York is a state-run program authorized by the Health Care Reform Act of 2000 and directed at increasing the level of health insurance coverage in the State.

The state provides an indirect subsidy to small groups of 50 or fewer workers by providing reinsurance to the insurers. Under the stop loss provision, health plans are reimbursed for 90 percent of enrollee claims between $30-$100K. In addition, the products used in the program are exempt from some benefit mandates. Premiums are 15-30 percent less than in the small group market.

To be eligible for participation, a small group must have not have provided health insurance in the last 12 months. In addition, at least 30 percent of its workers must earn less than $31K. Fifty percent of all eligible employees must enroll and at least one of them must earn less than $31K

annually. The employer's contribution to the employee's premium must be at least 50 percent . There is no employer contribution requirement for family coverage.

Program enrollment began January 2001 and as of August 2001, Healthy New York covered more than 1,000 lives. In addition to workers in small groups, this figure includes low/modest income sole proprietors and low/modest income uninsured workers who are also eligible.

Healthy NY has an allocation of $219M for the 30-month period from January 2001 through June 2003. All HMOs licensed in the state are required to participate. Plans are required to use community rating and to rate each enrollment tier (single, husband/wife, etc.) based on the combined experience of the three participant categories (small groups, sole proprietors, and individuals). The benefit package, while comprehensive, has been exempt from some mandated benefits including mental health care, home health care, chiropractic services, and outpatient treatment for alcoholism and substance abuse.

Sources for Healthy New York: Conwell and Short 2001, New York State Department of Health, Silow-Carroll et al.2000, and Swartz 2001.

Health Care Group of Arizona (Stop Loss Insurance)

The Health Care Group of Arizona offers coverage to small groups of 50 or fewer workers and the self-employed through several participating HMOs. The program was established by the legislature in 1982 to provide coverage to small groups, particularly those with 5 or fewer workers that were unable to obtain coverage elsewhere. The program was not implemented until 1988 when start-up funds became available through a private foundation.

The program did not receive any state funding during the first ten years of its operation. When plans threatened withdrawal in 1998 owing to high losses in what had essentially become a high-risk pool, the state stepped in.

The Health Care Group of Arizona now reinsures participating health plans against high losses with the state providing $8M annually for this reinsurance. The state self insures for claims between $20K and $100K and buys reinsurance for catastrophic claims of $100K and over. .

As of 2001, this program was enrolling about 12,000 people in about 3,600 small businesses of 1-50 employees. This was about half of the enrollment of its heyday in 1997 before the fiscal crisis. Micro-groups of fewer than 5 workers are the HCGA's main customers with the average group size, including dependents, at 3.2 persons.

Program Highlights

- There is no premium subsidy; employer and/or employees pay in full.

- There is no minimum employer contribution
- The products are more stripped down than usual commercial products.
- There are participation requirements depending on group size: 100 percent participation is required for groups of 1 to 5 workers and 80 percent participation is required for groups over 5.
- There is no look back.
- There is no medical underwriting but there are waiting periods for pre-existing conditions.

Sources for Health Care Group of Arizona: Silow-Carroll et al. 2001, Silow-Carroll et al 2000, and State Coverage Initiatives July 2001.

Small Business Health Insurance (SBHI), New York (Product Design)

The Small Business Health Insurance project provided low-cost comprehensive health insurance to small businesses (2 to 50 employees) in selected zip codes in New York City. The project was jointly sponsored by an insurance carrier (Group Health Insurance "GHI") and NYC through its public hospital system.

Premium costs were kept extremely low through deep discounts from the participating providers (the NYC Health and Hospital Corporation members). Premium costs were less than half of those available in the commercial market and were just under $100 for individual coverage and $235 for full family coverage.

The program began January 1999 as a two-year demonstration project with approximately 15,000-17,000 small businesses comprising its target market. Program capacity was projected at 3,000 enrolled individuals. There was no requirement that groups be uninsured.

The program failed to reach a significant portion of its target population, and after two years, only 53 small businesses had enrolled in the program. While the enrollment was very low, 80 percent of the participating firms had not provided coverage previously and 64 percent of the individuals who enrolled did not have coverage.

A premium 50 percent below market rated should have resulted in more participation, and after the demonstration concluded an evaluator reported:

> ***Poor implementation and marketing, plus flaws in product design, were found to be largely responsible for the program's failure to catch on among the city's small businesses.*** ("Briefing Note" for Rosenberg 2002)

The main flaw in product design was viewed to be a geographically restricted network that did not meet the needs of the business owners who did not live near their place of business.

Sources for SBHI: Andrulis and Gusmano 2000, Rosenberg 2002 and Silow-Carroll et al. 2000.

Premium Stabilization

While analysts have discussed this approach (Rosenbaum et al. 2001), no instance was described in the literature. This would involve the state absorbing cost increases over a certain amount so that premium increases could be guaranteed.

Other Strategies: Health Care Purchasing Pools (Cooperatives)

Discussion

Overview. Purchasing cooperatives are directed at improving the buying power of small groups through pooled purchasing. By acting together, it is hoped that small groups will gain market clout and access to more affordable products. This will in turn improve the availability of insurance to workers in small firms.

The expected benefits of purchasing pools include:

- Clout for premium negotiation through sheer numbers of participants.
- Better access and choice through a single point of entry to multiple carriers and benefit packages.
- Standardized products that facilitate comparisons and decision-making.
- Fewer carrier-imposed administrative hurdles.

Thus cooperatives are expected to improve the small group market in two ways—by affecting cost and coverage availability.

As of 2000, more than 20 states have passed laws allowing the establishment of small employer purchasing pools or cooperatives. Cooperatives have been set up under the sponsorship of state or local governments or through voluntary efforts usually led by business coalitions. They have

been created in a diversity of environments and have taken on different forms. Usually, a completely new organization is set up to bring small companies into the health insurance buying pool. Examples of this structure are Health Pass (NY), PacAdvantage (CA), the Alliance in Denver, CO and the Alliance in Madison, WI. In a more modified version of the concept, business coalitions have simply shared their network access and provider discounts with small groups.

Results in Brief. The consensus seems to be that pools have not succeeded in lowering the price of insurance to small groups**.**

> ***With very few exceptions, premiums for employers buying through co-ops have not been lower than those available to small employers elsewhere. (Wicks 2002, p. 4)***

However, as discussed below, lower than market premiums create an environment conducive to adverse selection. So paradoxically, when coops did achieve the goal of lower premiums, it usually had serious consequences for the continued operation of the cooperative.

They have, however, improved product availability for pool participants and have simplified purchasing by making it easier for a small group to evaluate available products. Enhanced choice appears to be a major benefit:

> ***Employers in each of the five cooperatives we reviewed offered their employees a greater choice of health plans than did small employers outside of the cooperative. (General Accounting Office 2000, p.15)***

> ***. . . firms purchasing their coverage through a cooperative are more likely than other firms to offer a choice of health plans to their employees. They also have access to better information about those plans, such as the benefits offered and the quality of care provided. (Congressional Budget Office 2000, p. 9)***

Cost Savings and Purchasing Pools. Viewed from the vantage point of hindsight, it is clear that some of the assumptions that fueled interest in purchasing pools have not held up.

Administrative Savings. Insurers were expected to save on administrative expenses since they would deal with the cooperative rather individual groups. Insurers have contended, however, that their administrative costs have not gone down. They still need to service the groups that enroll, and there are inherent diseconomies in serving many small groups in lieu of one large group. In fact, marketing costs have increased since they need to compete against the other insurers serving the pool. In some cases, the insurers have had to make system modifications to accommodate the cooperative. Even when the cooperative takes over some of the insurers' functions (marketing, collecting and submitting premiums etc.,) the insurer stills needs to maintain the administrative infrastructure to serve its non-pool customers. Even in cases where administrative costs are reduced, insurers may not be able to lower premiums if it is not permitted under state laws. In addition, the pooling organization itself incurs administrative costs, which add to the total and usually require member fees.

Savings from Broker Commissions. Some pool sponsors thought that costs could be kept down by eliminating broker commissions. However, it became clear that small groups relied on brokers for their insurance purchases and without broker involvement, the pools did not grow their membership. The current consensus is that a pool will be successful in attracting participants only if brokers and agents are involved in the promotion and sales effort.

*Specifying Rating Rules***.** In many cases, cooperatives have no rating flexibility because of state insurance laws. Where there is flexibility, cooperatives can run into problems. If rates are kept under market for certain groups through lenient underwriting, this will lead to adverse selection if the groups are subject to more stringent underwriting outside the pool. In general, if premiums are not close to the market, the pool attracts worse risks.

Other Routes to Lower Costs. While some of the expected sources of savings have not materialized, cooperatives can hold down premium costs in other ways.

> Benefit Design**.** For example, Health Pass sponsors are working with the participating insurers to develop leaner benefit packages in order to keep costs down. Thus the pool organization serves a platform for the development of products that are more affordable for small businesses.
>
> Provider Discounts. Cooperatives may be able to benefit from provider discounts already negotiated by large employers. For example, several cooperatives are designed around such sharing, where coalitions have simply opened up their network access and provider discounts to small groups. Examples include the Health Care Network of Wisconsin in Milwaukee and Buyers Health Care Action Group in Minneapolis, MN.
>
> Selective Contracting**.** If allowed by state law, a cooperative can limit its contracting to insurers at the low end of allowed rates.

Results with Respect to Uninsured Rates. For the most part, there is no evidence that pooled purchasing has had an impact on the level of health insurance coverage in areas where it is available. Market share has generally been low, and there is little evidence that cooperatives are particularly instrumental in enrolling uninsured groups

> ***HPC's (health purchasing cooperative's) market share has generally been 5 percent, except for COSE (Cleveland) and perhaps CBIA (Connecticut). (Wicks et al 2000, p. 1)***
>
> ***Each alliance had a very low share of its state's small group market. Among small employers that offered insurance as a benefit, only 2-6 percent purchased it through an alliance. (Long and Marquis 2001, p. 5)***
>
> ***None of the purchasing cooperatives we reviewed had a large enough market share to create bargaining leverage and therefore had a limited ability to significantly increase the***

percentage of small employers offering coverage in their states. (General Accounting Office 2000, p. 18)

"Have alliances increased coverage? The answer is no—at least, not in the states and time periods we studied, which contain the three largest small group alliances implemented to date". (Long and Marquis 2001, p. 7)

- Cooperatives typically enroll about the same proportion of previously uninsured as the rest of the small- group market. (Wicks et al. 2000)

- Cooperative membership has varied with respect to "previous insurance" status of the participating groups. Less than 10 percent of the groups in the CBIA Health Connections (CT) had not provided insurance in the year prior to joining while 25 percent of the groups in California's Pacific Health Advantage, had not done so. (General Accounting Office 2000) Other cooperatives report as many as 50 percent of the groups are newly insured. (Meyer et al. 2001)

- Since purchasing pools have not succeeded in lowering premiums, they will not be able to attract the firms that need lower cost coverage. Even if they succeed in lowering premiums, they will not have much impact. Research has shown that a 30 percent reduction in premium would be needed to attract 15 percent of small uninsured employers (Wicks 2002) thus cooperatives cannot be expected to have a significant impact on the uninsured rate.

Potential Use for Public Policy. While they have not had much impact on insurance levels when used in isolation, cooperatives might confer advantages when used in tandem with other strategies for increasing the levels of health insurance. They can be used to make coverage and choice of benefit plans available to those purchasing coverage with premium assistance and tax credits. This might include small employers as well as individual purchasers. (Anderson 2000, Trude and Ginsberg 2001) The Kansas Business Health Partnership, which is not yet developed, will have such a dual thrust.

As one analyst expressed it,

Providing new mechanisms to help small firms purchase health insurance, either alone or in conjunction with individual or employer premium assistance could also expand employer-based coverage. (Glied 2001, p. 32)

A cooperative structure would facilitate coordination between the public and private sectors for ESI buy-in programs. For example, making a benefit subsidy available through a purchasing pool would provide the advantage of working with a set of insurance products that can be designed to meet any "benefit" requirements and thus eliminate the administrative burden of analyzing a multiplicity of products for their "equivalency".

With governmental support, a cooperative would grow its memberships and become a force to be reckoned with. There are a number of actions that could be undertaken by state governments to

strengthen cooperatives. Government could, for example, specify them as the source for coverage for employers or individuals that receive subsidies or tax credits. Regulations could also be developed that would help attract small groups to the cooperative. Theoretically, a successful cooperative could eventually replace an ineffective market.

The development of a cooperative can also marshal considerable voluntary contributions at little or not cost to the state.

Major Issues in Program Development. A number of issues are involved in designing and implementing a purchasing cooperative.

Sponsorship. While some purchasing pools began as pure state efforts, others were privately sponsored. The California pool, which began as a state effort, was later privatized. The Health Pass project in NY began as a joint effort of the NYC government and the local business coalition.

The issue of sponsorship is important because it is closely tied to the amount of direct funds available for start-up as well as the indirect or in-kind staff support that will be available from the sponsoring organizations. Considerable expertise is needed to make a pool work and the members of a business coalition may, for example, bring considerable purchasing savvy to the program.

Sponsorship is also closely related to the goals of organization. In some cases, pools have taken on lives of their own regardless of their contribution to the policy goals and have become still another player in the insurance market.

*Start-up Costs***.** Start up costs have varied but have been considerable. For example, New York City put up $2 M in seed money to get Health Pass off the ground. A considerable investment of in-kind costs in the form of staff time was also needed.

Small Group Market in Which Pool Operates. The experience of the purchasing pool is highly determined by the insurance market in which it participates. As yet another player, its experience is closely intertwined with what is happening in the wider market. Pools are also subject to state insurance regulations including rating requirements and benefit mandates. Whether there are any exemptions depends on the particular state. For example, Health Pass (NY) is considered a health insurance trust, but did not have the membership at the time of its incorporation that would allow it to be experience-rated. The insurers who participate in Health Pass are required by state law to use community rating just as they do for the regular small group market. Because of this requirement, Health Pass products have no significant price advantages over the regular market.

*Rating Practices***.** Because of the delicate balance between the cost of insurance and risk, it is not wise for pools to offer insurance products at lower prices than are available in the regular market. When they have done so, pools have encountered problems. If the regular market

underwrites for health status and a pool does not allow or limits medical underwriting, the poorer risks will gravitate to the pool, subjecting the insurers to increased risk and greater expenses.

Insurers as Major Stakeholders. The pool itself does not assume risk but works with insurers who are the risk takers. The situation with respect to attracting insurers is somewhat like the proverbial chicken and the egg. The cooperative needs members to attract insurers and at the same time needs insurers to attract members. Most cooperatives do not have large membership and have been caught in this dilemma. To get the most favorable rates, cooperatives also need to be able to selectively contract with insurers. However, state laws do not always allow this.

There is a constant undercurrent of belief among insurers that purchasing pools are going to attract poor risks. This drives their willingness to offer products to a pool. Pools that used more favorable rating practices than the regular market did attract poorer risks and justify the insurers' skittishness. Insurers are also wary that certain products are more prone to anti-selection than others. For example, products with out of network options are viewed as attracting poorer risks.

Insurers may also fear the potential clout purchasing cooperatives give small groups. They dislike the individual choice feature that allows each employee to pick a different plan and then switch at every open enrollment. They also believe they can penetrate more of a group for enrollment in the regular market.

Negotiating and getting health plans on board is a critical and time-consuming component of cooperative development. Not all cooperatives have been successful in attracting and keeping insurers who are willing to work within the cooperative structure.

Pools can use a number of strategies to limit risk for participating insurers. These include requiring each participating insurer to offer that same product types, using standardized benefits packages that similar to or leaner than those in the regular market, redistributing revenues among insurers depending on risk profile of enrollees, and reinsuring for high individual claims. For example, PacAdvantage controls risk by making retroactive adjustments to the insurers who experience high utilization.

Brokers and Agents. Although it was initially thought that cooperatives could hold down costs by not paying commissions, the consensus is now that the cooperation of agents and brokers is essential for membership to grow. However, since brokers may refer high risks to the program in order to preserve their relationship with the carriers, a cooperative needs to be wary of broker referral patterns.

Membership Fees. These are assessed and are used to support the administrative functions of the pool.

Size of Eligible Group. Most cooperatives are limited to small groups of 2 to 50 workers. Some also include the self-employed (groups of one).

*Number of Insurers and Number of Coverage Options***.** Cooperatives usually work with multiple insurers and have a number of coverage options available.

Benefits. The benefit packages offered by the insurers are usually standardized. This facilitates shopping for coverage and minimizes adverse selection among the insurers. Employees can select any of the packages offered by their employer.

Premiums. If the cooperative is using rating practices that are similar to the rest of the market, premiums will more or less be in step with the rest of the market.

Enrollment Rules. Employers are usually required to pay a minimum share of premium. A certain minimum enrollment of eligible employees is required to help reduce adverse selection.

Marketing. In addition to involving brokers and agents in the marketing effort, most cooperatives find it is necessary to promote the program actively to the target groups.

Ingredients for Success. The success of a purchasing pool depends on the confluence of a multiplicity of factors. The pool must be large enough to negotiate rates and must be free to contract selectively with insurers. It must be able to attract a large number of employers not just the smallest groups Benefits and rating practices must be comparable to the regular market. Cooperatives will not work if they are used to pool different risk levels. (Wicks 2002) Other critical ingredients include enabling and supportive governmental action, seed money and other resources, expertise from big business, regulatory reform (including regulations to attract small firms, and help with high-cost claims. (Meyer and Rybowski 2001)

Cooperatives that have failed have had difficulties with membership and/or insurers. The Florida Community Health Purchasing Alliance was ultimately was unable to attract members and also lost health plans. The Texas Insurance Purchasing Alliance had membership problems and also problems retaining health plans, which led to its demise in 1999. Problems with insurers stemmed from its rating practices, which drew high-risk individuals. The North Carolina Purchasing Alliance was unable to attract sufficient members, and the Alliance in Colorado could not retain insurers and closed as a result.

Selected Programs

Health Pass, New York

Overview. Health Pass was started at the initiative of New York City , which brought in the New York Business Group on Health as a founding partner. It has been operating since 1999 and is available in the 5 boroughs of NYC and surrounding counties. .

Impact on Level of Health Insurance Coverage. A large proportion of groups (52 percent) report offering insurance for the first time and 28 percent of employees say they did not have coverage before. At the same time, market penetration remains negligible ---490 groups (as of June 2001) in a geographic area that is home to some 200,000-250,000 groups (including the

self-employed). Familiarity with Health Pass (NY) among small employers is low. A 2001 survey found that only 26 percent of small firms (3-49 workers) were familiar with it.

Some 7,000 persons were covered through the cooperative as of 2002 .

Start-up and Development. The program required $2M is seed money for development plus significant in kind contributions of staff time. Development spanned two years. In addition to recruiting insurers and developing relationships with brokers and agents, the program had to find a membership and billing TPA that was willing to deal with the complications of having employees of one employer in different plans. Although led by the business coalition, large employers did not have heavy formal involvement. Basically, they lent staff but the contribution was the result of the staff's personal interest rather than a structural commitment by the organization.

Insurer Relationships. The largest insurers would not participate. Insurers did not want to participate because they had poor experiences with pools elsewhere, were afraid it would cannibalize existing small group business, and feared adverse selection. Four plans were eventually recruited.

Brokers and Agents. The program works with a select cadre of brokers and agents. The program does not exceed the market commission but provides sales promotion support to the brokers and agents. Program has had to tutor brokers and agents on the program's selling points—the advantage of defined contribution to the employer, the "choice" advantage, etc.

Rating Policies. The cooperative is considered a health insurance trust but did not have the membership to qualify for experience rating. Insurers must use the community rating in effect in the small group market.

Enrollment Requirements. There is no minimum payment requirement for employers, and the employer may also provide commercial coverage. Adverse selection is addressed by a 75 percent participation requirement with at least 2 employees in Health Pass. In addition, the program works closely with insurers to hold down anti-selection by monitoring enrollment for possible fraud.

Attraction to Members. There is no price advantage over the regular market Presumably employers have been attracted by the choice of health plans afforded through the program. The small employer has access to four different insurers with 5 standard products each; employees may chose from all products. Choice for the individual worker is greatly enhanced and shopping by the employer is simplified.

Marketing. Marketing costs have been high. The product is positioned as a defined contribution product that limits the employer's exposure. Employees have to pay the rest, which may not be feasible for low-income employees, although they could select a lower option product.

Other Features. The sponsor has worked with the participating insurers to develop leaner benefit package thus the cooperative provides a platform for addressing cost issues that might not otherwise be possible. However, the benefit packages that can be developed are constrained by mandated benefit requirements.

Sources for Health Pass: Meyer et al. 2002, Meyer and Rybowski 2001, Whitmore et al. 2001, and Wicks 2002.

Pacific Health Advantage (PacAdvantage)

Overview. This program was set up by the legislature in 1992 to make coverage more affordable and accessible to small employers. It was later privatized and turned over to the Pacific Business Group on Health. It has also been known as the Health Insurance Plan of California. (HIPC). It is one of the largest small employer purchasing coops in the country.

Impact on Level of Health Insurance Coverage. As of the end of 2000, some 10,000 small employers (2-50 workers) were participating for a total of 140,000 covered lives. The cooperative's share of the small group market is about 2 percent.

The impact on the uninsured is unclear. While some data show that 20 percent of HIPC enrollees were previously uninsured, it was not clear if this enrollment was due to HPIC, the healthy economy, or small-group reform laws.

Insurer Relationships. The program uses more than a dozen health plans. Insurers may not offer a plan outside of the cooperative at a lower price if it is richer or equivalent to what is offered in the coop.

The program uses standardized benefits; however, the out-of-network plans experience worse selection than HMOs. The program applies a retrospective risk-adjustment formula to redistribute funds to insurers that enroll a sicker, higher cost population

.
Insurers have not experienced administrative savings.

Brokers and Agents. Initially, the cooperative had terrible broker relations since they were excluded from the program.

Enrollment Requirements. Employer contribution must be at least half of the lower-cost, single-coverage age-based premium for the plans that its employees are eligible to join. Seventy percent of eligible employees must participate.

Premiums. Premiums have fluctuated both above and below the market.

Attraction to Members. The main attraction is health plan choice. PacAdvantage works with 12-18 insurers, offers HMO, POS and PPO plans and 3 standard benefit packages.

Sources for PacAdvantage: Brandel and Pfannerstill 2001, General Accounting Office 2001, Long and Marquis 2001, Meyer et al. 2001, Meyer and Rybowski 2001, Wicks 2002 and Wicks et al. 2000.

Council of Smaller Enterprises (COSE), Cleveland, Ohio

COSE has been in existence for 25+ years and dominates the small group market in Cleveland. It is sponsored by the business community and has had neither special legislation nor public funding. COSE enrolls about 200,000 people. As of 1992, 20 percent of the small businesses purchasing insurance through COSE had not been offering coverage.

COSE appears to have lower premiums than are available in the regular market, and it maintains a separate pool for higher risks. It differs from other cooperatives in that only two insurers participate and one has almost the entire enrollment. COSE is the largest customer of that carrier.

Sources for COSE: Brandel and Pfannerstill 2001, General Accounting Office 1992, Wicks 2002 and Wicks et al 2000.

Connecticut Business and Industry Association (CBIA) Health Connections.

One of the largest small group cooperatives in the country, CBIA was insuring 3,500 groups for a total of 55,000 lives as of 1999. (1) Privately established, CBIA targets groups of 3 to 50 workers and covers about 5-8 percent of the small group market in Connecticut. (1)

CBIA works with 4 insurers, offers HMO and POS options, and uses 2 standardized benefit packages. (1) While the insurers have experienced reduced administrative costs, under Connecticut community rating, administrative savings cannot be passed on to CBIA. (1)

Source for CBIA: General Accounting Office 2000

Kansas Business Health Partnership

The Kansas Business Health Partnership Act was passed in 2000. This unique program combines the advantages of a purchasing pool with premium assistance. It allows the Alliance Employee Health Access to combine private funds and state subsidies to purchase health insurance. This

nonprofit partnership will offer small businesses at least two low cost health plans exempt from mandated benefits. The program will also subsidize premiums for low/modest income workers. To qualify, workers will have incomes under 200 percent FPL and will work for a small firm that never offered insurance or with a majority of employees earning less than 200 percent FPL. At least 70 percent of the workers in a firm will need to participate in coverage.

As of 2002, the program was not operational. Its implementation was a recommendation of the recently completely SPG planning project.

Sources for Kansas: Brandel and Pfannerstill 2001 and Sacks et al. 2002

New Mexico Health Insurance Alliance

The New Mexico Health Insurance Alliance makes health coverage accessible to small businesses, self-employed individuals and persons who lose group coverage through guaranteed issue and modified community rating. Through the program, health plans are available through as many as 12-13 different insurance companies, most of which are mandated by state law to participate. The program does not provide any premium assistance. The program was established by the state legislature in 1994 and was scheduled to end June 2002.

On the group side, the program is open to small firms of 2 to 50 eligible workers. At least, 50 percent of eligible workers must enroll in an Alliance plan, and the business must offer the Alliance plans exclusively. Self-employed individuals are also eligible as long as they are purchasing coverage for themselves and at least one dependent.

As of November 2000 approximately 8,500 people were covered through 1,800 small business accounts and 600 individual policies. The Alliance has insured some 12,000 to 14,000 people since the program began in 1995. While the program has attracted a wide variety of businesses with workers at many different income levels, the majority is reported to earn less than $30K per year. Since the program simply makes coverage available, it does not address the problem faced by low-income workers who cannot afford insurance. While the majority of employers make some contribution, there is no requirement in this regard and the contributions are often less than the commercial market requirement of 50 percent . Analysts report that many employees do not sign up because of the lack of employer contribution; others do not enroll even when there is a contribution because they cannot afford it. Nonetheless, a very high 91 percent of enrollees report they would have been uninsured without access to Alliance coverage. Estimates show that the program has saved the state approximately $10-15M each year by covering previously uninsured residents and thereby reducing the cost of uncompensated care.

Because of its rating policies, the program has been constantly challenged by adverse selection. The insurers have not been content with their experience and also view the program as

competing with their commercial business. The Alliance uses a reinsurance pool to spread risk among the participating carriers.

Sources for New Mexico Health Insurance Alliance: Silow-Carroll et al. 2001 and Silow-Carroll et al. 2000.

Coverage Availability: Buy-ins to Public Programs

Discussion

The literature on buy-ins to public programs is focused largely on the individual market, which will be covered in a separate literature review.

Health policy experts have, however, sketched out some possibilities for employer buy-in programs. One suggestion is for a buy-in to the Federal Employees Health Benefit Program (FEHBP) which would allow a specified number of uninsured small businesses access to health plans in their local areas at the same rates as federal workers. (Lambrew and Garson 2003; Fuchs 2000) The major issue is whether a separate risk pool would be needed. Other experts envision letting small employer groups or their employees buy into Medicaid and SCHIP. (Rosenbaum et al. 2001)

Georgia

Georgia opened its state employee benefits program to allow medical staff in critical access hospitals to purchase affordable coverage. (Silow-Carroll et al. 2002A) Further details are not available in the literature.

Rhode Island

Rhode Island has considered letting businesses buy into the state public program, RIteCare. The advantage would be more stable and perhaps slightly lower premiums. The proposal has been opposed by one of the state's health plans, which sees it as competitive with its commercial business. (Silow-Carroll et al. 2002B)

Postscript: Activities on the Drawing Board

While they have not yet implemented in most cases, state planning grant (SPG) projects have identified many activities to bolster employer-sponsored insurance in their states. (Sacks et al. 2002. They are listed below:

Kind of Intervention	Specific Activity	State
Affordable Product	Create a low-cost product for employers not currently providing coverage, using state subsidy through a reinsurance mechanism that pays for high cost cases.	Iowa
Affordable Product	Sell catastrophic policies with high deductible in the group and individual markets in combination with MSA's.	Massachusetts
Affordable Product	Create a low-cost product for employers not currently providing coverage, using state subsidy through a reinsurance mechanism that pays for high cost cases.	South Dakota
Buy-ins to Public Programs	Create employer-state health insurance partnership: Extend the safety-nets benefits package through voluntary participation of employers unable to obtain insurance in the private market. Employers would buy into Medicaid paying based on the income level of the employees.	Arkansas
Buy-Ins to Public Programs	Create a Medicaid buy-in for small employers and low-income people.	South Dakota
Buy-Ins to Public Programs	Give employers the option of purchasing cover for employees and dependent through the public program (VHAP) (premiums would be less than private market)	Vermont
Employer Mandate	Expand current public programs and create a pay or play requirement for employers. Employers would pay a premium for any employee not covered by ESI and employees would contribute a percentage of wages.	California
Employer Mandate	Require all organizations receiving the majority of their revenues from the state to offer their employees affordable coverage.	Massachusetts

Kind of Intervention	Specific Activity	State
Employer Tax Credit	Maximize use of current tax credit for small businesses.	Kansas
Employer Tax Credit	Use a refundable tax credit to encourage coverage. Limit to firms that have not provided insurance in last 12 months and with average payroll below the state average for small firms.	Vermont
ESI Buy-in	Provide subsidies to low-income workers to purchase employer-sponsored coverage.	Connecticut
ESI Buy-in	Subsidize SCHIP eligible children and their families in ESI.	Delaware
ESI Buy-in	Utilize the 1906 authority to buy into ESI for Medicaid eligibles.	Kansas
ESI Buy-in	Obtain federal funds for the FHIAP to subsidize private health insurance.	Oregon
ESI Buy-in	Utilize public-private buy-ins; continue to support enrollment in the BadgerCare HIPP employer buy-in program.	Wisconsin
Market reform	Develop small group reinsurance strategies: require insurance companies to reinsure high-risk individuals in the small group market.	Arkansas
Market reform	Revise rating requirements for small-business employer health plans.	Texas
Market reform	Relief from benefit mandates, small-group market regulations, high-risk pool expansion, universal catastrophic coverage.	Washington
Premium Assistance	Offer coverage to employers who have not offered coverage for the last year through the One-Third Share Plan.	Delaware
Premium Assistance	Incentives to small employers: State is working to develop incentive programs by partnering with CAP grant recipients.	Illinois

Kind of Intervention	Specific Activity	State
Premium Assistance	Provide subsidies directly to employers to help them purchase coverage for their workers; target small employers with low-wage workers.	Iowa
Premium Assistance	Follow the one-third option, which would divide cost evenly among employers, employees and the public.	New Hampshire
Premium Assistance	Directly subsidize small employers by offering vouchers.	South Dakota
Premium Assistance	Subsidize employee contributions to ESI.	Washington
Purchasing Pools	Establish community-based purchasing pools/cooperatives: Communities should organize, develop, and deploy community-based purchasing pools and cooperatives with support from the Arkansas Department of Insurance and insurance companies operating in the state.	Arkansas
Purchasing Pools	Establish a subsidized purchasing pool for employees of small employers and people with incomes 100-200 percent FPL. The state would establish an entity to act as a purchaser of health coverage.	Delaware
Purchasing Pools	Develop the Kansas Business Health Partnership to offer at least two plans to small businesses.	Kansas
Purchasing Pools	Create a statewide small employer purchasing alliance.	Texas
Purchasing Pools	Employer-based purchasing pools, individual/small market purchasing pools, etc.	Washington

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