

Health Insurance Coverage for Small Employers

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OVERVIEW — *For workers of small employers, access to affordable health insurance coverage is a growing concern. This paper examines the problems these firms and their employees face in obtaining health insurance coverage they can afford. The degree to which these challenges become obstacles varies greatly, depending on, for instance, the size of the employer and the characteristics of its employees. Reviewed here are these challenges to access, as well as some of the efforts made through state and federal reforms to address them, including rules regarding guaranteed issue and guaranteed renewability. This paper also explores some of the more recent initiatives designed to help small employers, including group purchasing arrangements (such as association health plans) and health savings accounts.*

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Health Insurance Coverage for Small Employers

The rising number of uninsured in the United States—44.7 million in 2003—remains one of the most critical concerns facing policymakers today. As the cost of health care rises yearly, it has become increasingly necessary for Americans to obtain health insurance coverage, which enables individuals to protect themselves against the potential risk of costly health expenses. By spreading the risk, the cost of care becomes more predictable and affordable for the individuals involved.¹

The primary vehicle for health insurance coverage in the United States is through the workplace. In 2003, 60.4 percent of Americans received coverage through their employer.² This number, however, has taken a downturn since 2000 when the figure was 63.6 percent. A decrease in employer-sponsored coverage, coupled with a rise in the number of uninsured, has led to reforms targeted at ensuring the continued availability of coverage for small employers and their workers.

Nearly all businesses that employ 200 or more workers offer health insurance coverage. Smaller firms, in contrast, have lower offer rates. The smaller a firm is, the less likely it is to offer coverage to its employees.³ Smaller groups have fewer persons to spread risk among, making their “risk profile” less predictable and more vulnerable to high-cost claims. Such claims greatly increase the cost to the insurer, which in turn raises premiums.

Workers employed by small firms, and their families, are more likely to be uninsured compared to those in households with an employee of a large firm (Table 1).⁴ More than three-quarters of businesses in the United States are considered small, and they employ nearly one-third of the private sector workforce.⁵ This portion of the workforce is left particularly vulnerable to being uninsured. In 2003, for example, half of the uninsured either worked in firms of fewer than 26 workers or were self-employed.⁶

The problems of the uninsured are well documented. They often forgo needed care, experience less continuity and poorer quality of care, and suffer financial stress (including “medical bankruptcies”) as a result of costly medical bills.

In order for this current employer-based system to survive, affordable health insurance coverage must be made more accessible to small employers. A number of federal and state efforts to expand coverage and stabilize this market have met with limited success. Newer initiatives continue to be debated and show varying degrees of promise.

TABLE 1
Percentage of Uninsured,
by Firm Size

No. of Workers	Percent Uninsured
Fewer than 10	35.5%
10 to 24	28.7%
25 to 99	20.7%
100 to 499	15.7%
500 to 999	13.9%
1,000 or more	12.8%

Source: Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey,” Employee Benefit Research Institute, Issue Brief 276, December 2004, 12.

CHARACTERISTICS OF SMALL EMPLOYERS AND THEIR WORKERS

There are many reasons small businesses find it difficult to provide coverage to their employees. Cost remains the most significant one. In the last few years, double-digit increases in premiums have continued to outpace the growth in inflation and employee earnings. A firm's characteristics, including whether a small firm is a component of a larger business, the composition of its workforce, and the industry of which it is a part, are also important factors in assessing an employer's ability to access affordable health coverage for its employees.

Workforce Changes

To best examine any component of health insurance coverage in America, it is helpful to understand some underlying trends in the workforce. Jobs have shifted away from manufacturing in the United States; with a total of 14.3 million jobs, manufacturing employment is at its lowest in more than 50 years.⁷ In the past, manufacturing has been the private sector leader in health insurance coverage for its employees. In 2003, over 69 percent of workers within the manufacturing sector were covered by their own employer's plan, second only to the public sector in which 74 percent were covered.⁸ As manufacturing jobs continue to diminish, the number of workers with employer-sponsored coverage is likely to follow.

The U.S. workforce has also developed a greater reliance on part-time, temporary, and contract workers.⁹ These workers are much less likely than full-time workers to be eligible for coverage. In 2004, 23 percent of firms offered health coverage to their part-time employees; 4 percent offered benefits to temporary employees.¹⁰

Size Matters

Studying this issue of small business and insurance access becomes complicated by the varied use of the term "small" (see text box, next page). Often conflicting, definitions among federal and state laws, as well as the organizations that conduct research on small businesses, can make discussion of insurance and small business quite confusing.

The U.S. Small Business Administration (SBA) uses different "size standards" that vary from industry to industry (that is, manufacturing, retail trade, transportation, health care) to determine eligibility for SBA programs. These standards use criteria based either on a firm's average annual receipts or on the average number of workers employed by a firm (500 employees, or 100, depending on the industry).¹¹ The Health Insurance Portability and Accountability Act (HIPAA) of 1996 set the threshold much lower, defining a small employer as one that employs between 2 and 50 people. Most states use the definition set by HIPAA, although some states include groups of 1 in their definition.¹² Studies

DEFINING "SMALL BUSINESS"

The threshold for what constitutes a small business is determined in a variety of ways.

HIPAA — This federal law defines a small employer as having between 2 and 50 employees.

State-Level Reform — States apply their small group reform laws to groups of either 1 to 50 or 2 to 50, with the exception of Missouri, which defines a small group as 3 to 25.*

SBA — The SBA definition varies from industry to industry and is based on a set of "size standards," which are almost always stated in terms of number of employees or average annual receipts. The SBA has established two widely used size cutoffs for what they consider small: 500 employees for most manufacturing and mining industries and \$6 million in average annual receipts for most nonmanufacturing industries. However, many exceptions exist.**

Kaiser Family Foundation–Health Research and Educational Trust — In their jointly published *Employer Health Benefits Annual Survey*, the term "all small firms" includes those employers with 3 to 199 workers. Some findings are broken down to reflect subsets of small employers.

Employee Benefit Research Institute — Their "Small Employers and Health Benefits" survey defines a small employer as having between 2 and 50 employees.

* *The Henry J. Kaiser Family Foundation, <http://statehealthfacts.org>.*

** *For more information on the Small Business Administration's size standards, see the SBA's "Guide to Size Standards," available at www.sba.gov/businessop/standards/guide.html.*

compiled from independent and scholarly research regarding small employer benefits do not use a standard definition of a small business, making direct comparison of such studies difficult.

Small firms are different from their larger counterparts in a number of ways. Most have been in existence for a shorter period of time and are more likely to be located in rural areas.¹³ A greater percentage of a small business' workforce focuses on goods and services rather than on administrative functions, such as management and sales.¹⁴ Even among small firms, those that do offer health coverage to their employees often have very different profiles than those that do not. This is discussed further in the next section.

Just as small firms are different from large ones, so too are their employees notably distinct. Employees of small firms tend to have lower wages than employees of large firms, which might make them more vulnerable to high health care costs. Small firms employ a greater proportion of part-time workers than larger employers. They also employ a greater number of female workers, twice as many Hispanic workers, more workers under the age of 25, and twice the number of workers older than 65.¹⁵ A greater proportion of workers in small businesses have a high school diploma or less.¹⁶ Employees of small business are also more likely to be receiving public assistance.¹⁷

OBTAINING HEALTH INSURANCE FROM AN EMPLOYER

Studies have shown that the smaller the firm, the less likely it is to offer health insurance,¹⁸ leaving employees of small businesses more susceptible to being uninsured. Is coverage simply unavailable to these employees? Are they not able to afford the coverage offered?

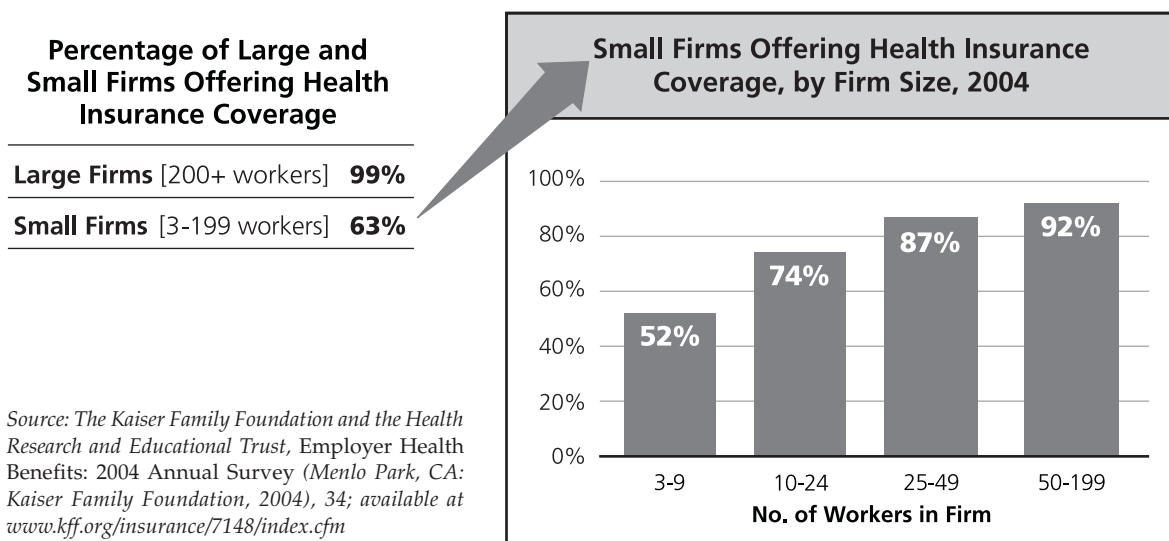
In all cases, employees seeking employment-sponsored coverage must meet three requirements: (a) the employer must offer health insurance coverage, (b) the employee must be eligible for the coverage, and (c) the employee must accept the employer's offer and be able to make any financial contribution required by the employer.

Coverage Offer Rates

Offer rates are important measures of insurance availability because most employees who are offered coverage choose to participate.¹⁹ A smaller percentage of employees of small firms are offered health insurance coverage than their counterparts in larger firms (Figure 1). Firms with 3 to 9 employees have a 52 percent offer rate, whereas firms with 25 to 49 employees have an offer rate of 87 percent. Nearly all employers with 50 or more employees offer health coverage.²⁰

Characteristics other than firm size have also been shown to affect offer rates, such as the level of income of the employees, the percentage of full-time workers employed, and the extent to which employees are unionized. Firms that employ higher income workers, a greater proportion of

FIGURE 1
Coverage Offer Rates for Small and Large Firms, 2004



full-time workers, and a greater number of unionized employees are more likely to offer coverage.²¹ More than two-thirds of small firms employing low-wage workers do not offer coverage.²² Moreover, firms whose worker profile includes a greater proportion of employees who are female, who are under age 30, and who are minorities tend to have lower offer rates.²³

Eligibility

Even if an employer offers health insurance coverage, eligibility requirements may exclude certain employees. For example, most small firms do not extend health coverage to part-time or temporary employees, and many impose waiting periods for newly hired personnel.²⁴

Employee Participation

The financial contribution required of employees appears to be the most significant reason given by uninsured workers for not accepting their employer's offer of health insurance coverage. Among employees who are eligible for their employer's coverage but decline, more than 52 percent cite cost as the reason for not participating in their employer's health plan.²⁵

Many employers require a financial contribution by their employees to help offset the expense of insurance premiums. In an effort to encourage more prudent use of services among those who do enroll, most employers also design their insurance coverage in a way that requires additional contributions in the form of deductibles, copayments, or coinsurance.

Cost is an even greater concern when an employee wishes to obtain family coverage. The percentage of employees who accept their employer's offer of dependent coverage is lower than the acceptance rate for employee coverage alone.²⁶ Small employers report that 35 percent of their employees decline dependent coverage due to concerns about cost.²⁷ The Kaiser Family Foundation reports that 42 percent of small employers (defined as 3 to 199 employees) absorb the full cost of the premium for single coverage, but these employers contribute less, on average, to family coverage. Workers in small firms contribute an average of \$43 per month for single coverage and \$282 per month for family coverage. Employees in large firms, in comparison, contribute \$48 for single coverage and \$195 for family coverage.²⁸ (In 2004 the average monthly cost among all small and large firms for single coverage was \$308; for family coverage, it was \$829.²⁹)

A COMPLEX DECISION FOR EMPLOYERS

Whether to offer health insurance coverage can be a complicated decision. Employers must look at the compensation given to their workers relative to what they produce. Employers make decisions about offering health insurance coverage in the context of the overall employee

compensation package that may include other benefits, wages, and/or bonuses. Wages are compromised to cover the cost of health coverage, known as “noncash compensation.” The degree of competitiveness of the labor market in which the firm is operating and whether competing employers are offering coverage to workers with similar skills may also influence an employer’s decision. Employers must also make decisions about offering health coverage and other benefits versus using their resources for other business-related expenses, such as equipment.

All employers must assess the true costs and benefits associated with the provision of health insurance and must determine whether offering it is in their best interest and in that of their employees. This is particularly challenging for small employers, who often lack dedicated benefits staff with expertise in these issues.

Despite the high cost of premiums and the cost of administering the benefit, small employers cite many important business reasons for offering health insurance coverage to their employees. A majority say they provide such benefits because it helps with employee recruitment, increases employee loyalty, and decreases turnover.³⁰ Many also note that these benefits positively affect employee attitude, performance, and health.³¹ The most important reason for offering health insurance coverage, small employers say, is that “it is the right thing to do.”³² Those who do not offer coverage also cite a number of different reasons, including a belief that their employees have coverage elsewhere.³³ The most significant reason for an employer’s decision to not offer health benefits, however, is cost.

Higher Cost, Lower Value

Cost is the most significant reason employers give for not offering health insurance coverage. Almost 80 percent of employers who did not offer health insurance have chosen not to do so because of financial concerns.³⁴ For small and large firms, average annual premiums are similar: \$3,695 for single coverage and \$9,950 for family coverage.³⁵ Though these were the average premiums among those employers who offered coverage, employers who chose not to offer coverage may have faced even higher premiums. And, as with all averages, they fail to shed light on outlying figures.

Furthermore, the cost of health insurance has been rising. Since 2001, the cost of employer-based coverage has increased by 59 percent.³⁶ Between 2003 and 2004, premiums increased an average of 11.2 percent, significantly faster than other economic indicators: inflation rose 2.3 percent and wages rose 2.2 percent.³⁷ Increases in premiums were comparable for small and large firms overall, but firms with 3 to 24 employees did experience slightly higher increases of 13.6 percent.³⁸

Cost is the most significant reason employers give for not offering health insurance coverage.

Although average annual premiums are comparable between small and large firms, the value of the coverage purchased by small employers may be less. A number of studies, including one conducted by the U.S. General Accounting Office (GAO, now known as the Government Accountability Office), found that the coverage purchased by small employers, though similarly priced, often required higher cost sharing from employees.³⁹ For one type of plan, average annual deductibles for firms with 3 to 199 employees were nearly \$200 higher than those for firms that employed more workers.⁴⁰ Plans purchased by small employers often excluded certain benefits, such as mental health or chiropractic care. Overall, small employers received less comprehensive coverage than their larger counterparts for the same cost.

Why do small employers receive less value for their health insurance premium dollar? One factor is that administrative costs associated with providing coverage for these groups are higher. Larger firms typically hire internal human resources staff and/or hire consultants to manage their employee benefits programs. In contrast, many smaller employers rely on insurance brokers to perform many of the functions related to benefits administration, including everything from securing price information from insurers to educating employees about different benefit options and assisting employees if their claims have been denied.⁴¹ It is estimated that at least half of all employers with fewer than 50 employees work with brokers.⁴² The functions performed by brokers, however, do come at a price. Brokers typically receive commissions from insurers, ranging from 2 to 8 percent according to one study, in exchange for selling their products.⁴³ Unlike the cost of services performed by staff or consultants, broker commissions are usually built into the premiums that insurers charge small employers—even for small employers who do not use a broker's services.⁴⁴

Because small businesses have fewer workers, administrative expenses incurred by the insurer, such as billing and enrollment, represent a greater share of the premium for each worker. Also, when dealing with many small employers, the insurer must perform the same administrative functions multiple times and in different locations. Brokers add these administrative expenses to premiums through a charge known as a "loading factor."⁴⁵

Despite these costs, small employers have little choice but to rely on commercial insurers. Their larger counterparts often self-insure, that is, they directly fund the costs of their employees' covered health care and assume the risk of potentially costly care.⁴⁶ The size of small employers makes self-insurance too risky; even a limited number of high-cost claims could affect the financial solvency of a small employer. Small employers typically offer fully insured plans—plans that are purchased from a commercial insurer or a managed care organization that bears the risk of the cost of care—and are left with limited power to negotiate with insurers to secure favorable premiums or more attractive benefit packages.

Small Groups and Risk Profiles

The risk profile for small employer groups is more variable than that for larger groups because the average cost of care for a small group is less predictable; an individual with high-cost claims will have a greater effect on the average costs for a small group than a large one. Smaller groups also raise insurer concerns about “adverse selection,” which occurs when a disproportionate share of individuals in poor health enrolls in a plan.⁴⁷ As the proportion of individuals with high costs rises in a group, so do the average costs and premiums. This coverage becomes less valuable to employees with low health care costs, and these higher premiums may prompt them to leave the group. This creates a vicious cycle in which only the sickest individuals remain and the pool experiences what is known as a “death spiral.”⁴⁸

To reduce the risk of adverse selection, health insurers commonly require small employers to contribute some portion (sometimes 50 percent) of the health insurance premiums for their employees and may also require that a certain percentage of eligible employees participate in the plan. Very small employers are often required by the insurer to pay 100 percent of employee (but not dependent) premiums.

To further reduce the potential risk associated with small groups, insurers may opt to go through a medical underwriting process before offering a plan. This involves reviewing the health status and claims history of the individuals in the group and setting the premiums and terms of coverage accordingly. This process of medical underwriting is costly; because it is usually not done for large groups, underwriting is another factor that contributes to the increased administrative cost of covering small groups.⁴⁹ Certain state and federal laws, however, limit insurers’ ability to deny coverage to certain groups or to charge one group significantly higher premiums than another group. State guaranteed issue laws require insurers to provide coverage to all small employer groups that apply, and almost all states limit the extent to which premiums may vary from group to group on the basis of the health status and other characteristics of the group. (These laws are discussed in greater detail in the “Small-Group Market Reforms” section below.)

Another mechanism used by insurers and self-insured employers to protect themselves from very high-cost cases is the purchase of reinsurance (insurance purchased by an insurer that provides some level of protection from a portion of the risk that it has assumed), also known as stop-loss coverage.⁵⁰ Reinsurance can be purchased on an aggregate or individual basis. Aggregate reinsurance protects against the total amount of claims over a certain threshold, whereas individual reinsurance protects against individual claims that reach a defined level.⁵¹

Smaller groups raise insurer concerns about “adverse selection.”

Tax Benefits and Employer Awareness

There is a lack of awareness on the part of small employers, and in some cases their brokers, regarding tax benefits and other market protections designed to make coverage more accessible and affordable. A survey of small employers in 2002, for example, found that 57 percent of employers surveyed did not know that health insurance premiums were fully deductible as a business expense.⁵² Many were also unaware of other state and federal laws that aimed to improve the accessibility and affordability of coverage, including rate regulations and guaranteed issue requirements. This survey found that, of those questioned, “60 percent did not know that, under federal law, insurers may not deny health insurance coverage to small employers even when the health status of their workers is poor.”⁵³ A similar survey of employers in California found that many had a limited understanding of their rights or the options available to them in the small-group market.⁵⁴

These misperceptions about the availability and cost of coverage could be affecting decisions about whether to offer insurance coverage. Raising awareness of market protections among small employers, therefore, could increase the number of employers that offer health insurance coverage.

Other Factors

Concerns not related to cost may also surface for small employers as they contemplate offering health coverage. Small employers often cite the uncertainty of revenue as a deterrent to providing such benefits. Others maintain that most of their employees have alternative coverage or are unable to afford it. Still others cite their high employee turnover or high number of seasonal or part-time workers as a reason to not offer coverage.⁵⁵ Whether their competitors offer health benefits may also play a role in a small employer’s decision. In a particular labor market, employers may not need to offer such benefits to attract and retain workers and thus may not see the value in doing so.

HEALTH INSURANCE REGULATION

States have primary responsibility for the regulation of health insurance. States issue licenses to organizations that provide health insurance coverage and review the financial viability and business practices of insurers. States may review insurers to ensure that they guarantee the issue and renewability of insurance plans. They may also mandate the coverage of certain benefits. Regulating premiums is another key function performed at the state level. The extent of this regulation differs from state to state, but these regulations are intended to increase access by controlling the cost of coverage.

Although the states are the primary regulators of health insurance, federal laws also apply, often leading to a complex and confusing overlay of

state and federal regulation. The two federal laws with the most significant impact on health insurance regulation are the Employee Retirement Income Security Act (ERISA) and HIPAA. ERISA was enacted in 1974 to provide oversight of employee benefit programs, including pensions and health insurance coverage. Enforced by the Department of Labor (DOL), ERISA includes a series of reporting and disclosure requirements, fiduciary requirements, and procedures by which beneficiaries file claims.⁵⁶ Most notable among its provisions, however, is the “preemption provision,” which, in essence, acknowledges states’ rights to regulate the business of insurance while exempting self-funded (also known as “self-insured”) employer health plans from such regulation.

HIPAA was enacted in 1996 in an effort to increase the availability of insurance coverage, particularly for workers who change or lose their jobs. HIPAA provided new rights and protections for workers of small businesses with 2 to 50 employees by establishing rules related to portability, preexisting condition exclusions, nondiscrimination, guaranteed renewability, and guaranteed issue. Because HIPAA sets a floor, rather than a ceiling, for standards related to the availability of coverage, many states offer greater protections than those required by HIPAA.

In addition to the above requirements, federal law also requires the coverage of a small number of benefits, including pregnancy and related conditions⁵⁷ and minimum lengths of stay for mothers and newborns after childbirth. These mandated benefits apply to both fully insured plans and self-insured plans.

SMALL-GROUP MARKET REFORMS

To respond to the challenges faced by small employers, states have enacted small-group health insurance market reforms to enhance the health insurance options available to small employers. These include HIPAA-style protections, as well as a variety of initiatives, such as group purchasing cooperatives and exemptions from state mandates. In some cases, these reforms have met with limited success. Brief explanations follow of proposed or enacted reforms and some of the concerns they raise.

Availability of Coverage

Prior to the passage of HIPAA, many states had laws relating to the availability of coverage within the small-group market. HIPAA established a basic level of access to coverage across all states, but preserved states’ ability to enforce their own laws that may exceed the federal protections.

Guaranteed issue — Guaranteed issue laws require insurers participating in the small-group market to offer coverage to any small employer that applies, regardless of the health status or prior claims experience of the members of the group. In turn, all premiums must be paid and other

In some cases, small-group market reforms have met with limited success.

applicable requirements fulfilled.⁵⁸ These laws ensure access to coverage but do not address premiums, though nearly all states combine their guaranteed issue laws with rate regulation in the small-group market.

Guaranteed renewability — Guaranteed renewal laws require insurers to continue an employer's coverage at the employer's option. Exceptions to this rule occur if required premiums are not paid or if the insurer withdraws from a particular geographic area.⁵⁹ These laws are intended to prevent an insurer from canceling coverage for a group that has experienced high-cost claims. In addition, most states govern the extent to which premiums may be adjusted upon renewal.

Nondiscrimination — The HIPAA nondiscrimination clause prohibits an insurer from applying different eligibility rules, offering different benefits, or charging a higher premium to any individual within a group on the basis of certain "health factors." These include, among others, health status, claims experience, medical history, and genetic information.

Limits on preexisting condition exclusions — Some plans limit coverage for conditions that predate a member's enrollment in their plan. Under this "preexisting condition exclusion," an insurer will not pay for treatment or services related to a condition that existed before an individual enrolled in the plan. In response to concern about these exclusions, states began to limit the amount of time after enrollment that an insurer can deny coverage for such conditions.

Through its small-group market reform provisions, HIPAA defined a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period before an individual's enrollment date. HIPAA prohibits insurers from excluding coverage for these conditions for more than 12 months (18 months for late enrollees) after a member's enrollment. In addition, an individual's exclusion period must be reduced (or eliminated) by the length of time that he or she has maintained continuous insurance coverage (that is, without a 63-day break) before enrollment.⁶⁰ A small number of states have opted to apply shorter time frames to their preexisting condition exclusion rules to provide greater protection to covered individuals.

Portability — Portability requirements protect workers and their families from losing their health insurance coverage when workers change or lose their jobs. These requirements prohibit insurers from subjecting individuals to preexisting condition exclusions when they move from one job to another, or when they move to the individual market from the group market, provided they have maintained continuous coverage.

Affordability of Coverage

Although HIPAA was enacted to increase the availability of health insurance coverage in the small-group market, it does not address the cost of that coverage. Almost all states, however, have some form of rate

regulation that dictates the factors on which premium determinations may rest, as well as the amount by which premiums may vary from group to group. States have addressed affordability in other ways as well: some allow small employers to band together to purchase health insurance as a group and some permit small employers to offer products that are exempt from state mandates. These efforts, and others, are discussed below.

Rate restrictions — Although almost all states regulate the way in which premiums can be set, there is great variability in the restrictiveness of these limits. As previously noted, federal law prohibits insurers from charging individuals within the same group different premium amounts on the basis of health-related factors. Different premiums are only permissible among employees who are not similarly situated; for example, they may be in the same group but located in a different geographic area, or they may be employed part time rather than full time.⁶¹

Most rate regulation centers on the permissible range of premiums that can be charged to different small employer groups for the same product and the factors (such as health status, age, or gender) on which differences may be based. State premium regulation typically falls into one of three categories: (a) pure community rating, (b) modified community rating, and (c) rating bands. These three approaches vary in the degree to which they allow insurers to consider certain risk factors in setting their premiums.⁶²

■ **Pure community rating.** This represents the strictest and least common form of rate regulation. It requires that an insurer charge all employer groups of the same size the same rate for the same coverage. Consideration of health status or other characteristics is prohibited altogether. Rates may only differ on the basis of where an individual lives, the size of a covered family, and the benefit package.⁶³

■ **Modified community rating.** This type of regulation prohibits rate variation based on individual health status but allows consideration of other factors, such as age and gender.⁶⁴

■ **Rating bands.** Used by a majority of states, this form of regulation permits insurers to adjust a group's premiums on the basis of the health status of the members of the group, as well as a number of other factors. These bands, however, limit the difference between an insurer's highest and lowest premium rates charged to all small groups. Wider rating bands give insurers greater flexibility in the rates they can charge, whereas narrower bands are more restrictive. Certain states use rating bands to limit premium variation for all groups, taking into account all rating factors, including health status and other demographic factors. In contrast, many states use rating bands to control the variation in premiums based on particular factors. A state may permit rates to differ on the basis of health status, for example, with the groups in the poorest health paying two times that being paid by the healthiest groups.

Almost all states regulate the way in which premiums can be set.

Some states combine elements of these different approaches into their small-group premium regulation. For example, a state may require each insurer to set a community rate and allow premiums to vary among small employers from this rate for certain factors, such as age and occupation.⁶⁵

In addition to regulating the rates that may be charged for new coverage, most states also limit premium increases that may be applied when coverage is renewed.⁶⁶ Only a small number of states limit the frequency of rate increases for policyholders. Many states have requirements, based on the National Association of Insurance Commissioners’ model regulation, that (a) permit rates to increase by the same percentage as the increase in rates for new business; (b) limit premium adjustments to 15 percent for claims experience, health status, and duration of coverage of a particular employer; and (c) allow certain adjustments for changes in coverage or individual characteristics, other than those listed above.⁶⁷

Exemptions from state-mandated benefit laws — One fundamental difference between most small and large employers is the way in which they provide coverage to their workers. For the most part, small employers are fully insured, whereas large employers often choose to self-insure. This distinction is important because it determines whether certain state laws are applicable to the coverage involved. Whereas all coverage is subject to certain federal laws, including HIPAA and federally mandated benefits, self-insured plans are exempt from certain state regulatory requirements by virtue of ERISA.

Generally included among preempted laws are state-mandated benefit laws. In order to sell health insurance in a state, under these laws, insurers must provide coverage for certain diseases, services, or providers, such as mental illness, mammograms, or chiropractors. Such laws became a prevalent form of regulation in the 1990s for states looking to ensure consumer access to certain coverage through their insurance (Table 2). The extent of these laws, the markets to which they apply (that is, small-group versus individual market), and the coverage they require varies from state to state. In 2002, some states had as few as 5 small-group benefit mandates, whereas others had as many as 32.⁶⁸

Concerns about the rising cost of health insurance have recently placed these laws under increased scrutiny. State lawmakers find themselves weighing the benefits of such mandates against their cost. In their quest to make health insurance coverage more affordable and accessible for small employers, states have responded to concerns about state mandates in a variety of ways.

A number of states have enacted, and other states are considering, mandated benefit review laws that require

TABLE 2
Number of States with Most Frequently Mandated Benefits for Specific Services or Conditions, 2002

Service or Condition	No. of States
Mammography screening	46
Diabetic supplies/education	43
Off-label drug use	33
Mental health parity	30
Formula for PKU infants*	27
Well-child care	27
Alcoholism treatment	26
Prostate cancer screening	26
Cervical cancer screening	24

* Infants with phenylketonuria.

Source: GAO, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*, September 2003, 13.

an evaluation of the costs and benefits of mandates before they can be imposed. The goal of these efforts is to ensure that the proposed mandates do not adversely affect the cost or availability of health insurance coverage. Taking a different approach, other states have enacted legislation that (a) allows health plans to offer less costly policies that do not provide coverage for state-mandated benefits or (b) permits small employers to offer products exempt from mandated benefits and certain premium taxes. Still other states allow plans to offer high-deductible products that cover only catastrophic illnesses and injuries.

Due to ERISA exemptions for self-insured employers, opponents argue that state mandates fail to protect all consumers and drive up the cost of premiums, particularly for small employers, and ultimately lead to higher uninsured rates. The true cost of these mandates is difficult to quantify and varies significantly from state to state because it is based on the number and scope of the mandates imposed. Because many plans voluntarily offer benefits that are (or become) mandated, it is difficult to assess the increased cost that results from a particular mandate.⁶⁹

As states move forward in their review of state-mandated benefit laws, tough questions will need to be addressed about the benefits and costs to all involved. Do such mandates actually increase access to care for the insured population? Do they drive up premiums for certain groups? If so, states will need to determine whether increased access to services is worth the additional cost. What are the long-term costs of failing to ensure access to certain services, such as preventive care? Is more limited coverage better than no coverage? Policymakers will need to evaluate the intended and unintended consequences of these mandates as they attempt to reach the competing goals of increased access to certain health care services and affordability of coverage.

Group purchasing cooperatives — Given the increased risk and cost of insuring small employers, proposals have emerged that enable small firms to join together to experience the advantages known by larger businesses. In 2000, 20 states had laws that permitted employers to form purchasing cooperatives for the purpose of securing health insurance for their employees.⁷⁰ The design of these group purchasing arrangements varies greatly among states. Some are governed and managed by the state, others are managed privately; some offer employees a choice of all plans in a given area that participate in the cooperative, others allow employers to select plans.⁷¹ Insurance purchased through state group purchasing cooperatives is bound by all applicable state laws, such as rate regulations and solvency requirements.

Small employers that band together as one large group would, in theory, be able to negotiate better premiums with insurers, reduce certain administrative costs, and improve their risk profile. This, in turn, would lead to more favorable health insurance premiums and an expanded choice of plans from which to choose.⁷²

As noted earlier, administrative costs for insurers and employers are much higher for smaller groups. By pooling many smaller groups into one, certain administrative functions such as marketing and billing could be done collectively (reducing duplication), and the cost of such functions could be spread across more people.⁷³ For small employers, benefit resources are often limited and administrative costs are shared by a more limited number of individuals. Cooperatives may perform a number of functions, including collecting and disseminating plan information, overseeing enrollment, and managing the flow of money from employers to plans.⁷⁴

Reducing the potential risk and adverse selection often associated with smaller groups is also a main goal of purchasing cooperatives. As stated before, larger groups have more predictable levels of risk for insurers, keeping their premiums lower. Bringing together many smaller groups into one, therefore, is intended to reduce the risk associated with any one group.

Group purchasing cooperatives regulated at the state level, however, have failed to have much impact on the small-group market. Although they have been successful in expanding choice for participating small employers, they have not been able to lower costs. Studies of states with purchasing cooperatives have actually shown that premium rates within the cooperative and those in the general small-group market are comparable.⁷⁵

Many attribute this lack of success to the cooperatives' inability to achieve significant enrollment and market penetration. Most cooperatives account for less than 5 percent of each state's small-group enrollment, making significantly reduced premium rates and administrative costs unattainable.⁷⁶ Some also argue that many smaller groups with healthier (and therefore lower risk) workers may forgo cooperative opportunities and purchase coverage directly from an insurer, where their lower risk would result in lower premiums. The "death spiral" concept applies here as well: if only risky groups participate, costs would be driven up and ultimately destroy the cooperative.⁷⁷

Some researchers have suggested that voluntary group purchasing arrangements without additional regulatory assistance would be incapable of increasing access to coverage for small employers. Additional regulatory remedies that may increase enrollment or reduce concerns about adverse selection could include mandated participation of small employers or subsidization of coverage purchased through a cooperative.⁷⁸

Multiple employer welfare arrangements — Similar to purchasing cooperatives, the goal of a multiple employer welfare arrangement (MEWA) is to allow groups of employers to collectively provide health insurance benefits to their employees. MEWAs provide health and welfare benefits to employees of two or more unrelated employers who are not part of collective bargaining agreements.⁷⁹ MEWAs have struggled with a checkered past and their regulation has created significant confusion. Faced with a number of insolvencies and inadequate state and federal oversight, policymakers amended ERISA in 1983 to clarify the states' role in regulating MEWAs.⁸⁰

Although purchasing cooperatives have been successful in expanding choice, they have not been able to lower costs.

Despite the amendment, however, poorly regulated MEWAs led to many instances of insolvency and fraud.⁸¹ A 1992 GAO report found that in a period of three years MEWAs left individuals with over \$123 million in unpaid claims and more than 600 MEWAs failed to comply with state laws.⁸² MEWAs continue to face financial difficulties, and some believe they should be subjected to more stringent solvency requirements. As a provision of HIPAA, the DOL now requires MEWAs to file registration forms; for fiscal year 2002, the DOL received approximately 900 such filings, which covered approximately 3 million participants (exclusive of dependents). The DOL has expended substantial resources for investigations involving fraudulent MEWAs. As of October 2002, the Department had initiated 522 civil and 90 criminal investigations against MEWAs, involving more than 1.8 million individuals and over 121 million dollars.⁸³

Tax advantages for small employers and employees — By providing tax advantages to employers, states are able to promote employer-sponsored coverage, which is usually more affordable and comprehensive than that available in the individual market. Under federal tax law, contributions made by an employer for employee health insurance coverage are entirely tax deductible for the employer as a business expense. The cost of such benefits is also excluded from an employee's taxable income.⁸⁴ Additional tax advantages for employer-sponsored coverage continue to be proposed as a means of encouraging small employers to provide coverage to their workers.⁸⁵ Tax subsidies are attractive to policymakers because they are flexible: they can be targeted to different types of coverage and to different populations, and they may vary with income or be allocated in flat dollar amounts. The way in which they are constructed may determine how successful they are in achieving their goal.

The issue that arises most frequently with these subsidies is their size. How large must a subsidy be in order to entice small employers to offer such an expensive benefit? Research on the effect of such subsidies has shown that unless a subsidy is significant relative to actual premiums, it is likely to have little impact on coverage. In an era of federal and state deficits, sufficiently substantial subsidies may be unattainable. Additionally, subsidies offered by states may be less meaningful to employers than federal subsidies, regardless of their size, because state taxes represent a smaller portion of their overall tax burden.

Another difficulty in setting up effective subsidies is identifying the appropriate population to target. Tax subsidies can be designed to be made available only to certain small employers (for example, those in designated industries with higher rates of uninsurance), or they may be provided directly to employees or groups of employees, such as low-wage workers. Some argue that employers of lower-wage workers (who are least likely to offer coverage) should be targeted to receive assistance, because it is their workers who are more vulnerable to uninsurance.

From an employer's perspective, subsidies can be viewed as too uncertain: some express concern about whether a subsidy will exist from year to year. If a subsidy program is viewed only as a short-term reform effort, many employers may be wary of relying on assistance that may not exist in the near future. Offering employee benefits only to have to eliminate them is, for many employers, a losing proposition.⁸⁶

Much of the debate around health insurance subsidies centers on whether they should be available for employer-sponsored coverage, for the purchase of coverage in the individual market, or both. Even if effective, the tax subsidies described here that are targeted toward small employers and their workers would not help those who are currently unemployed or are ineligible for coverage through their employer (that is, working part-time or in a waiting period).

Federal Initiatives

Federal efforts to expand coverage are as varied as those at the state level. Some strive to bring small employers together to improve their purchasing power and achieve economies of scale. Others create new vehicles for individuals to save for future medical expenses, and still others focus on providing tax benefits for the provision of coverage. Similar to state efforts, federal initiatives have experienced limited success.

Federal group purchasing arrangements — Proposals to create new forms of group purchasing arrangements have been surfacing for many years. Small employers have been able to purchase health insurance coverage through different types of associations and, more recently, through state purchasing arrangements. As mentioned in an earlier section, state purchasing arrangements have led to an increased choice of plans for small employers, but most have failed to achieve lower premiums.

New initiatives have emerged that would enable the creation of new arrangements, including association health plans (AHPs) and HealthMarts.⁸⁷ AHPs would enable small businesses to band together across state lines to purchase health insurance, which in some cases would provide a shield from state regulation. HealthMarts are private organizations that serve as clearinghouses where employers and employees within a geographic area may go to purchase health insurance.

Like state-sanctioned purchasing cooperatives, these federal proposals strive to create arrangements that would bestow on small employers the advantages experienced by large employers. Unlike state cooperatives, AHPs and HealthMarts would be subject to fewer restrictions on how they may be organized and operated and they would be exempt from all state mandated benefits.⁸⁸

AHPs are of particular concern to many as they would be permitted to offer self-insured products, which would shield them from many state small-group reform laws and rating rules.⁸⁹ Proponents of AHPs argue

Federal efforts to expand coverage are as varied as those at the state level.

that large employers already have the ability to shield themselves from state mandates under ERISA through self-insurance.⁹⁰ They also contend that these new arrangements would enable small employers to pool their resources to achieve administrative efficiency and to negotiate with insurers for health coverage that is both more comprehensive and affordable.

Those opposed to AHPs argue that they would do little to help the uninsured and could actually harm employees and small employers. Exempting AHPs from both state-mandated benefits and state rating rules could lead to greater problems of adverse selection within the small-group market. AHP sponsors would be free to offer less extensive benefit packages, which would appeal to groups that are healthier, and charge significantly higher rates to groups that are less healthy. Adverse selection could result, leading to a destabilization of the overall market.

The potential for fraudulent group purchasing arrangements has also raised concern among state and federal regulators, who contend that many employers—frequently small employers—and their workers are being deceived when they purchase health insurance coverage through some associations.⁹¹

Much of the impact of AHPs, and other group purchasing arrangements, will be determined by the competing federal and state regulatory environments in which they operate. Because oversight has traditionally been left to states, questions have surfaced about the federal government's ability to oversee these new health insurance entities. If federal oversight of these entities is too weak, traditional insurance plans under strict state control would be forced to compete against less-regulated cooperatives, and the result would likely be an uneven playing field. Such an imbalance could negatively affect the small-group market as a whole.

Health savings accounts — Health savings accounts (HSAs), combined with high-deductible catastrophic health insurance plans, have become synonymous with a move toward more consumer-directed health care. The idea behind HSAs, and consumer-directed plans in general, is to allow the individual consumer to manage his or her own health care dollars and provide incentives for the individual to use health care services appropriately. In the face of increased costs, HSAs have become an attractive alternative for small employers who are looking for new ways to provide health insurance. Enabled by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, HSAs are designed to allow individuals under the age of 65 to save for future health care expenses on a tax-free basis.

According to a survey by the National Small Business Association, 73 percent of small businesses are interested in HSAs.⁹² Because the premiums for high-deductible plans are significantly lower than for traditional coverage, small employers may view HSAs with high-deductible plans as a means of providing more affordable health insurance coverage to their employees. Employers also find these accounts attractive because their employees are able to contribute their own money.

Some HSA opponents have expressed concern that HSAs will only be attractive to younger, healthier, and wealthier individuals. Those who are healthier and younger will be more willing to give up comprehensive coverage, leading to adverse selection and further driving premiums up. Opponents also argue that wealthier individuals are more likely to gain from a reduction in their taxable income and may be less concerned about the financial consequences of unexpected medical costs. Although HSAs do provide an exemption from deductibles for preventive care, there is concern that such preventive care as defined will not include treatment of an existing condition or disease management and will, therefore, fail to meet the needs of the chronically ill.

Proponents argue that HSAs will reduce the number of uninsured by offering a low-cost, tax-exempt alternative to traditional policies. They believe HSAs will fulfill their goal of allowing individuals to have greater control over their own health care dollars and enabling them to benefit financially from being prudent consumers of medical care. Proponents also argue that HSAs enhance the doctor-patient relationship by limiting the role of insurers and other third parties in health care transactions.

CONCLUSION

Despite years of state and federal efforts aimed at making affordable health insurance coverage more accessible, premiums continue to rise, keeping such coverage beyond the reach of many. Teasing apart the causes and effects of what can and cannot stabilize the small-group market has proven quite difficult. Assuming a continued reliance on an employer-based system to provide health care coverage to a majority of Americans, significant changes are still needed in the small-group market to help small employers provide and maintain affordable coverage.

The direction such change will follow is difficult to predict; reforms to date have met with limited success and have left policymakers with more questions than answers. As policymakers attempt to answer these questions, they may choose to rework current reforms, such as pooling of purchasers, subsidies, or tax credits, or they may need to devise entirely new reforms.

Whichever mechanisms are used, state and federal policymakers will need to carefully monitor these reform efforts to ensure that their goals are being achieved. Care must be taken to ensure that unintended consequences, including adverse selection, destabilization of the small-group market, and a reduction in preventive care, do not undermine these goals.

Significant changes are still needed in the small-group market to help small employers provide and maintain affordable coverage.

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