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5.2

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Need for Small Employer Health Insurance Pools

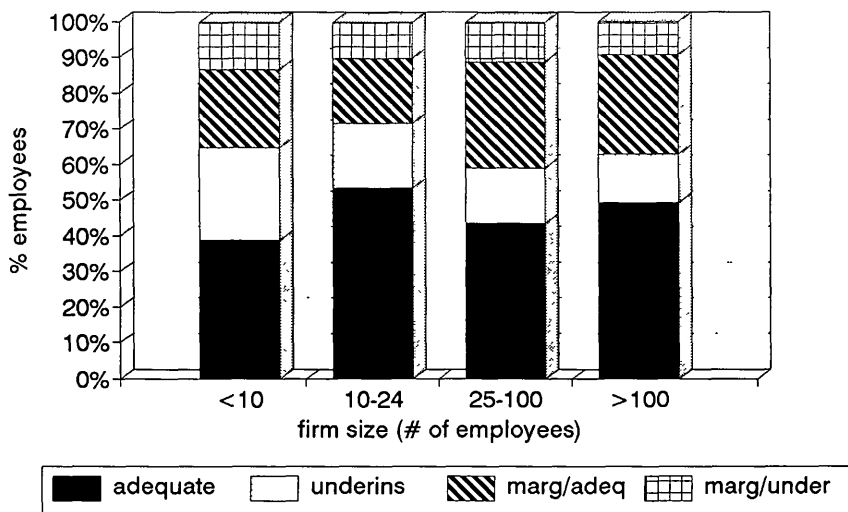
Characteristics of Uninsured and Underinsured Employees

Almost 60 percent of nonelderly adults without health insurance are employed (Swartz 1989). Almost half of these employed uninsured adults live in families with less than 200 percent of poverty income, and nearly two-thirds of them are employed by small firms, generally earning low wages (Moyer 1989).

The Health Insurance Survey of Michigan (Figure 1) indicates that less than half of all employees of small firms (fewer than 100 employees) have adequate health insurance coverage. About 20 percent are underinsured, in that physician's office visits are not covered or as evidenced by problems with inadequate coverage in the past year. Another 25 percent have adequate insurance but are only marginally insured, in that they have either nongroup coverage purchased with after-tax income or their employers make no contribution toward their premium. Ten percent of employees of small firms have coverage that is both marginal and inadequate.

Employed persons with nongroup coverage are likely to relinquish that coverage when small employer pool group coverage is offered. Firms offering poor health benefit coverage may replace it with coverage offered by the pool. Further, many employees in small firms, who are currently covered under a spouse's health plan, may decide to switch to coverage in their own name through their employer from the pool.

Figure 1
Adequacy of Health Insurance Coverage
by Firm Size



Source: Health Insurance Survey of Michigan

Key

adequate: good coverage with significant employer contribution

underins: underinsured, physician office visits not covered, or problems encountered during last year.

marg/adeq: good coverage, with no employer contribution or nongroup coverage

marg/under: underinsured, with no employer contribution or nongroup coverage.

Characteristics of Small Employer Health Insurance Market

A recent survey of Michigan insurance carriers revealed that small employers (< 100 FTEs) may pay premiums from 10 percent to 40 percent higher than the 500+ FTE firm for equivalent coverage (Health Management Associates 1989). Interestingly, the employees of small firms tend to be younger (and perhaps healthier) than their medium- and large-firm counterparts (Hogan 1989), which could make small employer health insurance premiums even more actuarially unfair than the simple premium differential might indicate.

As health insurance premiums have become increasingly less affordable, both small firms and insurance carriers have developed strategies to avoid the risk of paying for adverse selection. In the small firm, one significant illness can lead to a very adverse loss ratio for the carrier. Carriers will attempt to avoid this risk prospectively by various underwriting approaches: exclusion of pre-existing conditions, exclusion of employees with pre-existing conditions or even termination of the policy once serious conditions are identified.

Carriers not adopting these strategies would soon find themselves inundated by demand from excluded firms. The resulting adverse selection will quickly cause unfavorable loss ratios, leading to rising premiums. If the premiums are community-rated, then there will be a flight of small firms without significant risks to those carriers offering lower premiums with restrictive underwriting practices.

Over the years these strategies have led to an enormous churning in the small employer health insurance market. Small employers change carriers readily, and carriers selling to small employers offer limited products which are heavily underwritten and whose premiums often escalate quickly after a year or two. Many large carriers have abandoned the small employer market altogether. Larger employers have also abandoned the health insurance market to avoid sharing the risk of adverse selection and are now almost always under some kind of experience-rated or self-funded arrangement (Gabel et al. 1989). In summary, the employment-based health insurance market has come to rest primarily on small and medium employers purchasing from small and medium

carriers, all of whom have as a major strategy the management of adverse selection. In some states, such as Michigan, Blue Cross-Blue Shield plans are required to act as insurers of last resort and to insure a significant number of small firms.

The high level of carrier-client churning has contributed to the high administrative costs in the small employer health insurance market. As turbulent as the small employer health insurance market is, it is not surprising that small employers have not organized themselves well to deal with one of the major forces in the health care financing in the 1980s: cost-shifting. In the early 1980s, federal and state governments began enacting legislation and administrative rules to limit their liability for health care cost inflation; this came after a decade of unsuccessful attempts to contain health care costs. The Medicare and Medicaid programs changed their reimbursement policies from cost-plus to fixed fees. After years of budgetary restraint, these fees are now significantly below those paid by private insurers (Thorpe, Siegel, Dailey 1989). Whether these fees have fallen below the cost of care is a matter of some dispute. However, once the separation was made between costs and payments for two large payers, other payers began to follow suit. Large employers have been able to leverage their size either with carriers and third-party administrators or through group purchasing arrangements to gain preferential treatment. The result has been that large employer premiums have been increasing at one-half the rate of small employer premiums (Kramon 1989). Small employers have been unable to defend their interests in this process of cost-shifting.

Rationale for Small Employer Health Insurance Pool

The pool attempts to give small employers some of the advantages that large employers enjoy in the health insurance market: elimination of underwriting and exclusions, an organized response to cost-shifting and premium differentials, and an improved benefit design. By joining together, small employers can create a self-funded multiple employer welfare trust that should, over time, bring their health benefit expenses in line with actual costs. Such a self-funded plan can resist cost-shifting and will provide a reasonably stable source of insurance coverage for small employers.

The major challenge for such a pool is the large number of “high-risk” individuals purchasing group or nongroup coverage who will rush into the pool if premiums are set at a level to entice “good risk” small employers not currently offering benefits to join. Adverse selection problems could be severe, and the small employer program could easily become a “high-risk” pool. In addition to adverse selection, the small employer pool will need to contend with the high level of employee turnover and financial instability of small firms (Health Management Associates 1989; Brown 1989). For these reasons, some public subsidy will be required to offset the costs of the high-risk individuals who will join the pool in disproportionate numbers.

Given the large number of small firms currently offering benefits who are either paying a high percent of payroll for the benefit or who are purchasing an inferior benefit, a small employer pool is likely, upon offering a reasonably priced plan, to be inundated by small employers who currently offer benefits and who qualify for subsidies. Such a program could spend substantial subsidies and not appreciably affect the number of uninsured individuals. A major policy consideration is the suggestion that the small employer pool be open only to employers who do not currently offer health benefits. In the long run, excluding employers who currently offer health benefits from participation in the program is probably unfair, but the approach may be workable as a transitional measure.¹

An additional policy issue is whether an employee must work some minimum number of hours per week to qualify for health insurance. Other things being equal, participation of part-time workers increases premium costs more than it increases payroll, resulting in more subsidy payments if premiums are to be affordable.

Administration of Small Employer Health Insurance Programs

One approach is the creation of a small business health insurance pool open to all businesses with less than 25 employees, new businesses (< 1 year) with less than 100 employees, and the self-employed. The state insurance bureau could annually determine actuarially fair premiums plus administrative loadings for the small business pool. Premiums

should not be experience-rated to encourage coverage for high-risk employees, if subsidies can be obtained.

To make the purchase of health insurance more attractive to the small employer, premiums can be subsidized as a percent of total payroll. Eligible employers would pay full premiums as long as the total health benefit expense is less than, for example, 4 percent of payroll. Employers would pay 50 percent of the total premiums in excess of 4 percent but less than 8 percent of payroll, and they would pay 10 percent of total premiums in excess of 8 percent of payroll. To reduce free-riding, at least 75 percent of a firm's uninsured workers would have to be covered for a firm to receive such a subsidy. Employers providing evidence of financial distress could be allowed to delay or reduce premium payments up to one year. Employers may require employees to share in the payment of premiums, as long as the employee earns at least 125 percent of the federal minimum wage.² Employer premium contributions must at least equal employee premium contributions for the firm to receive a premium subsidy.

An alternative subsidy mechanism is to make subsidy payments directly to employees and to base the amount of the subsidy on the economic status of the employee and his or her dependents. Employees with household incomes less than 200 percent of poverty would receive premium subsidies to supplement their own or their employer's premium contributions. Eligible employers could pay full premiums for all employees whose family income exceeds 200 percent of poverty income. For those between 100 and 200 percent of poverty:

$$\text{Premium share} = \frac{\text{Adjusted family income}}{\text{Poverty rate income}} - 1.$$

A somewhat more modest alternative approach is to extend the Health Care Access Project (HCAP) being undertaken in Genesee and Marquette Counties in the State of Michigan (Smith 1989). The HCAP program is one of 15 Robert Wood Johnson access demonstration projects. The program is open to employers who do not now offer health benefits and it uses existing insurance mechanisms (usually the local Chamber of Commerce area-rated group plans offered by Blue Cross-Blue Shield of Michigan). HCAP subsidizes up to one-third of the total premium

contribution for eligible establishments. HCAP will further subsidize some or all of the employee premium contribution based on family income.

In spite of fairly generous premium subsidies, HCAP and other access demonstration projects have been able to enroll only about 20 percent of eligible employers contacted (Perry 1989). The chief advantages of the HCAP-type approach are their reliance on existing insurance programs and the easily understood one-third subsidy. Subsidies based on health benefit expense as a percent of payroll or on family income better target the subsidy dollar and will probably produce higher participation in the long run, but will be harder to understand and more expensive to administer in the short run.

Benefit Options

Selection of a small employer pool benefit package is, by necessity, market driven. The package must be acceptable to those who buy it, but it must not be so rich that it creates more health care cost inflation by causing the coverage offered by firms currently providing benefits to expand. Thus, the package selected is slightly below that typically offered by small employers.

Two possible benefit packages can be considered: a full benefit plan and a plan covering only outpatient services. Either policy offered by the insurance pool should cover employees and dependents. The full health insurance policy offered by the pool would cover inpatient hospital room and board, surgical care, diagnostic x-ray and laboratory, and emergency room care. Both plans will cover outpatient diagnostic and preventive services, laboratory and x-ray, physician office visits, prescription drugs and home health care. The plans should have modest deductibles and copayments for most services to maintain utilization within the financial means of low-income employees.

NOTES

1. Under the Robert Wood Johnson-financed Health Care Access project (HCAP) demonstration in the Michigan counties of Genesee and Marquette, there is no incentive for an employer to drop current coverage in order to qualify for participation in the program because of the limited time frame of the demonstration and the uncertainties about the future. With a permanent program, an employer could more reasonably choose to drop health insurance in the short run to receive the long-term subsidies offered by the program
2. Employee premium contributions are not an effective cost-containment measure when there is only one plan to choose and should be used sparingly with poverty groups. Copayments and deductibles are more effective in limiting excessive health care utilization, but again the low-income levels of many of the uninsured make reliance on these cost-containment mechanisms onerous

Appendix to Chapter 5.2

Small Employer Pool Percent of Payroll Subsidy

Figure A.1 illustrates how the premium subsidy mechanism will work. Suppose a small employer has one employee earning \$1,000 per month in total compensation, \$100 of which is used to pay for health insurance. The first 4 percent of gross payroll (\$40) is paid by the workplace (employer and employee may share this expense). The next 4 percent of payroll (from 4 percent to 8 percent) is divided evenly between the workplace and the subsidy, \$20 each. The last 2 percent of payroll (8 percent to 10 percent) is paid 90 percent by the subsidy (\$18) and 10 percent by the workplace (\$2). The workplace expense is then $\$40 + \$20 + \$2 = \62 . The subsidy expense is $\$0 + \$20 + \$18 = \38 . If the worker were to earn only \$500, the subsidy would grow to $\$0 + \$10 + \$54 = \64 . If the worker earns \$2,000/month, the subsidy would fall to $\$0 + \$10 + \$0 = \10 .

Small Employer Pool Family Income Subsidy

All employees of small employers participating in the pool can apply for premium subsidies. For employees with incomes less than 200 percent of poverty, subsidies will be provided, as is illustrated in Figure A.2.

Figure A1
Employer/Employee Premium Contributions
(Small Employer Pool)

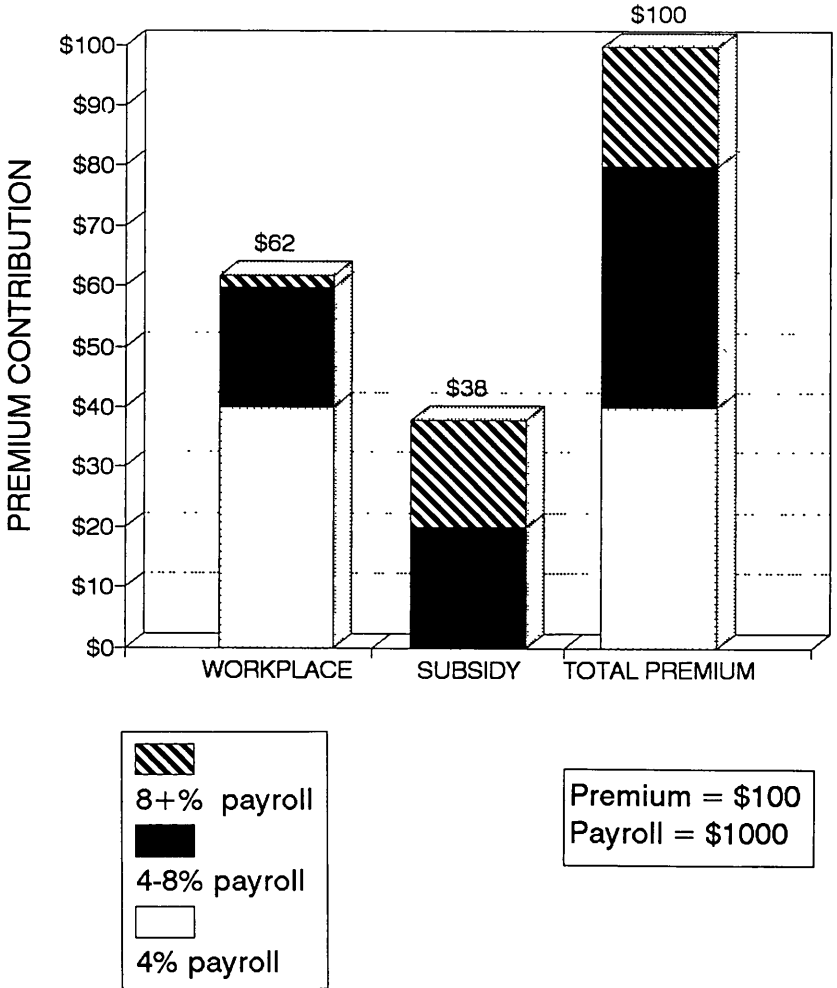
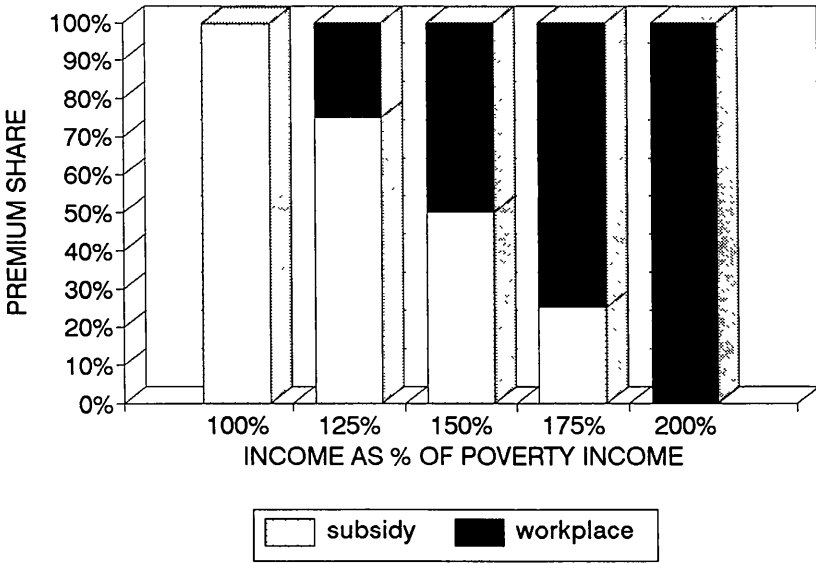


Figure A2
Premium Shares: Small Employer Pool
by Income Category



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