

**Recommendations for Expanding Health Insurance Coverage for
Individual and Families in the Small Employer Market**

Prepared by

The Nebraska Health Insurance Policy Coalition

March 2007

Table of Contents

| | Page |
|--------------------------------------|-------------|
| Forward | 7 |
| Purpose of the Study | 11 |
| Study Approach | 11 |
| Key Survey Findings..... | 12 |
| Options for Expanding Coverage | 18 |
| Recommendations | 26 |
| Next Steps | 26 |

List of Figures

- Figure 1: Percentage of Small Businesses by Offer Status
- Figure 2: Employer Knowledge about Health Insurance Terminology and Cost, and about Current Plans Available to Small Businesses
- Figure 3: Likelihood Business will Discontinue to Offer Health Insurance in the Next Year
- Figure 4: Coverage Status for Employees Not Offered Health Insurance
- Figure 5: Maximum Monthly Premium Non-Offering Employers and their Employees Able to Afford
- Figure 6: Current Contribution for Employee-Only Coverage – Employer and Employee

Forward

In the fall of 2003, the Nebraska Health and Human Services System was awarded a State Planning Grant from the U.S. Department of Health and Human Services. The purpose of the grant was to measure the number of uninsured in the State, identify the characteristics of those without insurance coverage, and develop coverage options to reduce the number of uninsured and strengthen the health care safety net.

The coverage options were developed by the Nebraska Health Insurance Policy Coalition and published in a report entitled *State Options for Expanding Health Insurance Coverage and Strengthening the Health Care Safety Net* (www.hhss.ne.gov/puh/oph/grant.htm). One of the major target groups for expanding insurance coverage was employees and family members who work for small employers.

One of the major conclusions of the study was small employers (i.e., less than ten employees) are considerably less likely than large employers (i.e., more than 100 employees) to offer health insurance coverage. For example, the percentage of small employers offering coverage was 65 percent as compared to 98 percent for large employers. For small employers that have between one and three employees the percentage dropped to 49 percent. As a result, the report included several recommendations for expanding health insurance coverage in the small employer market.

In order to have a better understanding of the small employer market and to develop more targeted policy options, the Nebraska Health and Human Services System applied for and received a second State Planning Grant in the fall of 2005. The purpose of this grant was to focus on the small employer market to determine the types of insurance policies that would be acceptable to both small employers and the employees who work for small employers and the amount they were willing to pay for these policies. The Nebraska Health Insurance Policy Coalition was reconvened to provide advice and recommendations for reducing the number of uninsured for individuals and family members in the small employer market. To receive more immediate input and feedback, the Coalition was expanded to include five additional small employer representatives. A complete list of Coalition members is shown below.

Disclaimer

It should be noted that the recommendations included in the report do not necessarily reflect those of the businesses and organizations that are represented by the individual members of the Coalition.

Nebraska Health Insurance Policy Coalition

Chair

Andrea Skolkin, Chief Executive Officer
OneWorld Community Health Centers
4920 South 30th Street/Suite 103
Omaha, NE 68107
(402) 502-8845
askolkin@oneworldomaha.org

Vicki Gilpin, Executive Director
Lexington Area Chamber of Commerce
Box 97
Lexington, NE 68850
(308) 324-5504
(308) 324-5505 (fax)
vgilpin@atcjet.net

Coalition Members

Lynne Anderson
6626 Cuming Street
Omaha, NE 68132
(402) 556-3786
lsanders6626@cox.net

Judy Halstead
Resource & Program Dev Coordinator
Lincoln-Lancaster County Health Dept
3140 "N" Street
Lincoln, NE 68510
(402) 441-4603
(402) 441-6229 (fax)
jhalstead@lincoln.ne.gov

David Burd, Director of Finance
Nebraska Hospital Association
3255 Salt Creek Circle/Suite 100
Lincoln, NE 68504
(402) 742-8144
(402) 742-8173 (fax)
dburd@nhanet.org

Jeremy Hosein, Policy Advisor
Governor's Policy Research Office
Box 94601
Lincoln, NE 68509-4601
(402) 471-2417
(402) 471-2528 (fax)
jhosein@pro.state.ne.us

Keith Bushardt, Executive Vice President
Blue Cross Blue Shield of Nebraska
7261 Mercy Road
Omaha, NE 68124
(402) 392-4292
(402) 548-4658 (fax)
keith.bushardt@bcbsne.com

Scott Hunzeker, Research Analyst
Nebraska Department of Labor
550 South 16th Street/Box 94600
Lincoln, NE 68509
(402) 471-1025
(402) 471-9867 (fax)
shunzeker@dol.state.ne.us

Jennifer Carter, Staff Attorney
Nebraska Appleseed Center
941 "O" Street/Suite 105
Lincoln, NE 68508-3626
(402) 438-8853
(402) 438-0263 (fax)
jcarter@neappleseed.org

Sandy Johnson, Exec Vice President
Nebraska Medical Association
233 South 13th Street/Suite 1512
Lincoln, NE 68508
(402) 474-4472
(402) 474-2198 (fax)
sandyj@nebmed.org

Gayle-ann Douglas, Vice President
Douglas Manufacturing Corp
Box 187
Crete, NE 68333
(402) 826-5164
(402) 826-5013 (fax)
dougmgcrp@aol.com

John Klosterman
1197 34th Road
David City, NE 68632
(402) 367-3209
jcklos@gmail.com

Patti Knobbe, Executive Director
West Point Chamber of Commerce
Box 125
West Point, NE 68788
(402) 372-2981
(402) 372-1105 (fax)
exec@westpointchamber.com

Pat Lopez
Public Health Assn of Nebraska
4521 Hill Drive
Lincoln, NE 68510
(402) 489-5090
jpnic75@aol.com

Kathy Bigsby Moore, Executive Director
Voices for Children in Nebraska
7521 Main Street #103
Omaha, NE 68127
(402) 597-3100
(402) 597-2705 (fax)
kmoore@voicesforchildren.com

Keith Mueller, Director
Nebraska Center for Rural Health Research
University of Nebraska Medical Center
984350 Nebraska Medical Center
Omaha, NE 68198-4350
(402) 559-4318
(402) 559-7259 (fax)
kmueller@unmc.edu

Donald Peterson, Director Pricing
UnitedHealthcare
2717 North 118th Circle/Suite 300
NE020 370
Omaha, NE 68164
(402) 445-5754
(402) 445-5572 (fax)
donald_peterson@uhc.com

Rick Poore
DesignWear/Velocitee
2630 North 27th Street
Lincoln, NE 68521
(402) 441-5555
rick@shirts101.com

Mary Beth Rathe, Executive Director
Community Action of Nebraska, Inc.
1120 "K" Street/Suite 100
Lincoln, NE 68508
(402) 471-3714
(402) 471-3481 (fax)
marybethrathe@canhelp.org

Becky Rayman, Executive Director
Iowa/Nebraska Primary Care Association
2282 East 32nd Avenue
Columbus, NE 68601
(402) 563-9224 x210
(402) 564-0611 (fax)
rrayman@ecdhd.com

Fred Salzinger, Associate Vice President
Creighton University Medical Center
Criss III 149
2500 California Plaza
Omaha, NE 68178
(402) 280-1821
(402) 280-4027 (fax)
salzin@creighton.edu

Jack Schreiner, President
Bruckman Rubber Company
Box 608
Hastings, NE 68901
(402) 463-3129
(402) 463-3406 (fax)
jschreiner@bruckmanrubber.com

Cory Shaw, Exec Vice President & CEO
University Medical Associates
University of Nebraska Medical Center
984220 Nebraska Medical Center
Omaha, NE 68198-4220
(402) 559-7274
(402) 559-5008 (fax)
cdshaw@unmc.edu

Brad Sher, VP Managed Care/Public Policy
BryanLGH Health System
1600 South 48th Street
Lincoln, NE 68506
(402) 481-5050
(402) 481-8306 (fax)
bsher@bryanlgh.org

Mary Steiner, Administrator
Nebraska Health & Human Services
Medicaid Program
Box 95026
Lincoln, NE 68509
(402) 471-9567
(402) 471-9092 (fax)
mary.steiner@hhss.ne.gov

Galen Ullstrom, Sr VP - State Gov't Relations
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175
(402) 351-5235
(402) 351-5710 (fax)
galen.ullstrom@mutualofomaha.com

Tim Wagner, Director
Nebraska Department of Insurance
Terminal Building
941 "O" Street/Suite 400
Lincoln, NE 68508
(402) 471-4631
(402) 471-2990 (fax)
twagner@doi.state.ne.us

Staff to the Coalition

Patti DeLancey
Nebraska Health and Human Services
Office of Public Health
Box 95007
Lincoln, NE 68509
(402) 471-2353
(402) 471-8259 (fax)
patti.delancey@hhss.ne.gov

Meridel Funk
Nebraska Health and Human Services
Research & Performance Measurement
Box 95026
Lincoln, NE 68509
(402) 471-0198
(402) 471-7783 (fax)
meridel.funk@hhss.ne.gov

Dave Palm, Administrator
Nebraska Health and Human Services
Office of Public Health
Box 95007
Lincoln, NE 68509
(402) 471-0146
(402) 471-8259 (fax)
david.palm@hhss.ne.gov

Colleen Svoboda
Nebraska Health and Human Services
Office of Public Health
Box 95007
Lincoln, NE 68509
(402) 471-7779
(402) 471-8259 (fax)
colleen.svoboda@hhss.ne.gov

Background

The results of national and state surveys have clearly indicated that over 60 percent of the uninsured in Nebraska were either self-employed or work for a small employer. These survey findings also revealed that small employers were considerably less likely to offer health insurance coverage to their employees. Even if small employers make insurance coverage available to their employees, many employees decided not to purchase coverage. The major reason for the low percentage of small employers that offer coverage and the low participation rates by employees was the high cost of insurance policies. Since 2000, health insurance costs for all employers have increased by an average of 87 percent. For many small employers, the cost of insurance plans exceeds the national average and in many cases the benefit package is less comprehensive.

Purpose of the Study

Since the majority of the uninsured population in Nebraska is employed in a small business, the purpose of this study is to better understand the factors that influence small employers to offer coverage and employees to purchase coverage if it is offered. The study will also examine the types of policies that are offered by small employers and amount of money both employers and employees are willing to pay for health insurance coverage. Finally, the study will assess whether a gap exists between the cost that small employers and their employees are able to afford for health benefits and the cost of insurance products that are currently available in the market. Once the gap is identified, policy options will be developed to help close the affordability gap for small employers and their employees.

Study Approach

In the fall of 2005, the Office of Public Health in the Health and Human Services System contracted with the Nebraska Center for Rural Health Research at the University of Nebraska Medical Center to conduct surveys of both small employers and employees who primarily work for small employers. The small employer mail survey was returned by 158 small employers with 50 or fewer employees who were located in Lancaster, Adams, Buffalo, Hall, and Scotts Bluff Counties. The majority (i.e., 61 percent) of the small employers did not offer health insurance coverage.

In the second survey, telephone interviews were conducted with 373 employees who work for employers in the same geographic areas. Although the employer survey focused on businesses with 50 or fewer employees, the employee interviews included those who work for businesses that have between 3 and 500 employees. The wider span was needed to assure an adequate response rate. It was also assumed that employees working for businesses within this size range are likely to have similar levels of information about selecting insurance plans and use a similar process for making

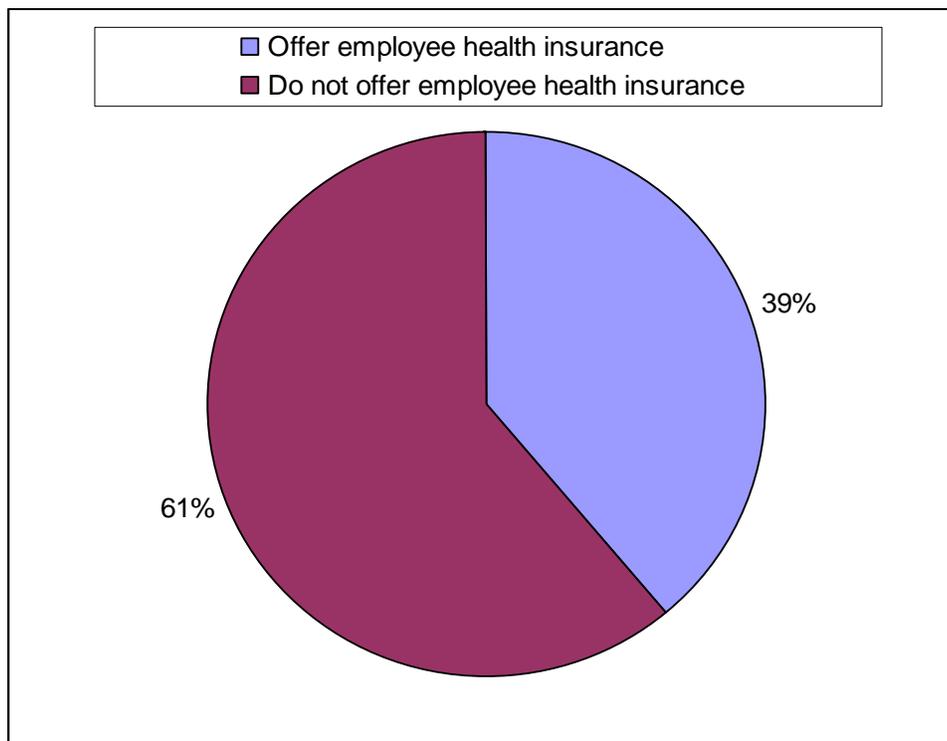
decisions about insurance plans. A more complete description of the methods used in both surveys is included in the following report: *Results from the 2006 Small Employer Survey: Nebraska State Planning Grant, Year 3*, Michelle Mason, et al., (www.hhss.ne.gov/puh/oph/grant.htm).

Key Survey Findings

Some of the key findings from the employer and employee surveys are described below. A complete description of the survey results is available in the report by Michelle Mason, et al. cited above.

- Of the 158 responding small businesses, 61 (39 percent) reported offering health insurance to their employees. Ninety-seven small businesses (61 percent) reported that they do not offer health insurance to their employees (Figure 1).

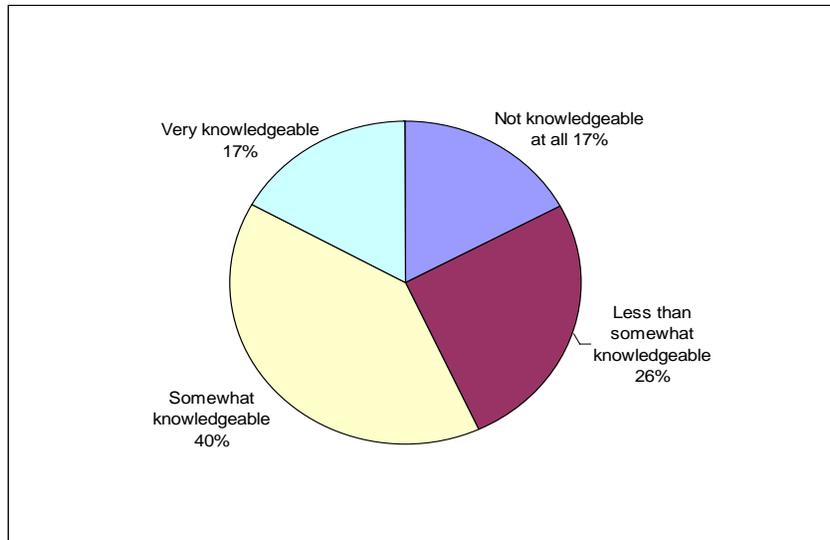
Figure 1: Percentage of Small Businesses by Offer Status (n=158)



- Small businesses located in the Lancaster County metropolitan area are more likely to offer employer-sponsored insurance than their counterparts located in a non-metropolitan areas. Non-offering businesses were more likely to have fewer employees, have a lower percentage of full-time employees, have younger and lower-income employees, and have a higher employee turnover rate, as compared with businesses that offer insurance coverage.

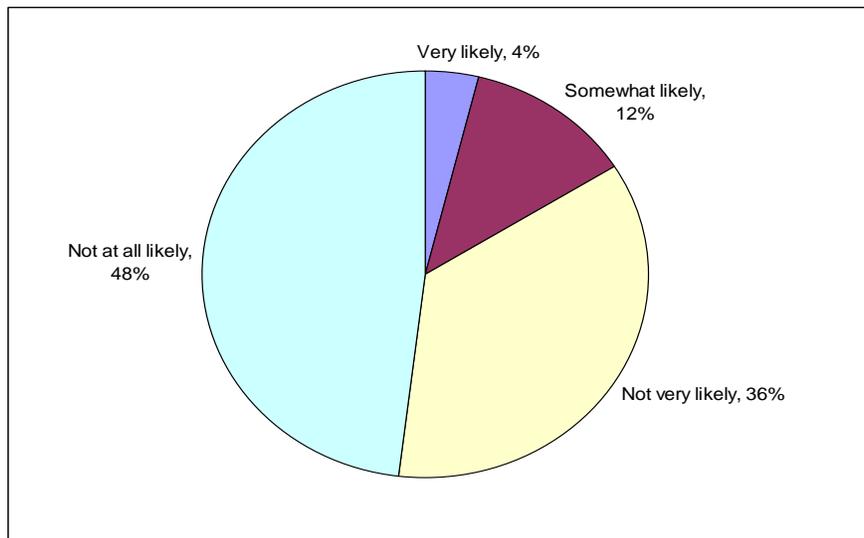
- Forty-three percent of the non-offering employers reported that they have little or no knowledge about health insurance terminology and costs and about current plans that are available for small businesses to offer their employees (Figure 2).

Figure 2: Employer Knowledge about Health Insurance Terminology and Cost, and about Current Plans Available to Small Businesses (n=93)



- The majority (84 percent) of offering employers reported that they are likely to continue offering health insurance coverage for their employees in the next year (Figure 3).

Figure 3: Likelihood Business will Discontinue to Offer Health Insurance in the Next Year (n=58)



What we heard from some offering employers

"We are trying to find a better plan, but have found most to be too expensive."

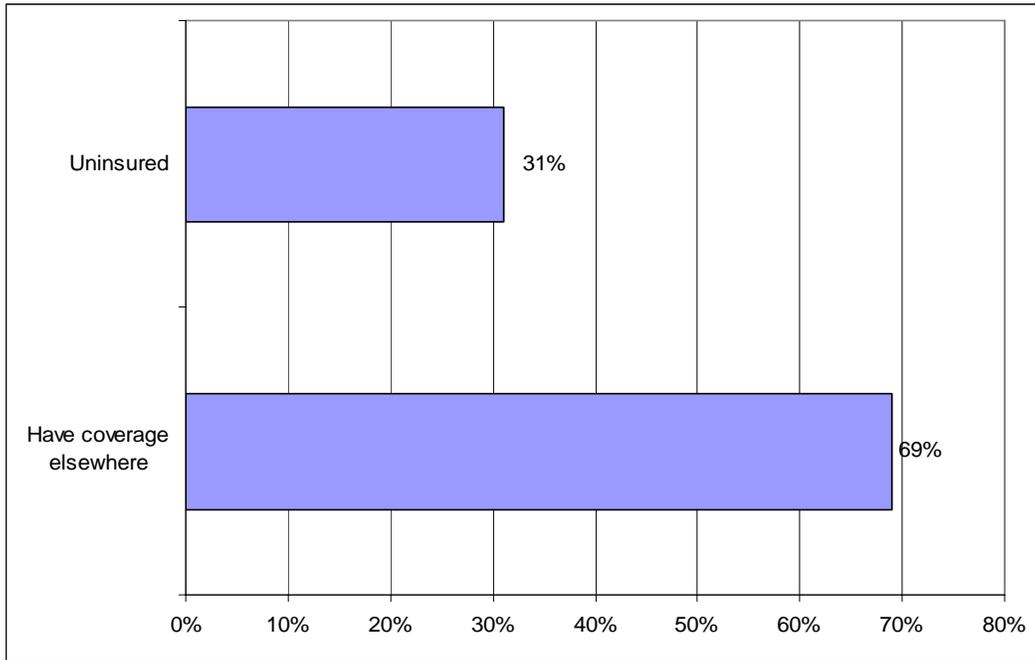
"Currently, employees that are eligible for main medical have coverage through their spouse; therefore, we offer coverage, but it is not used."

"At some point I can no longer afford to offer health insurance coverage. The increasing costs will become too high."

"It would be nice if you don't have any claims on your policy that the premium would go down accordingly, also if you did have claims then the rate would be raised accordingly."

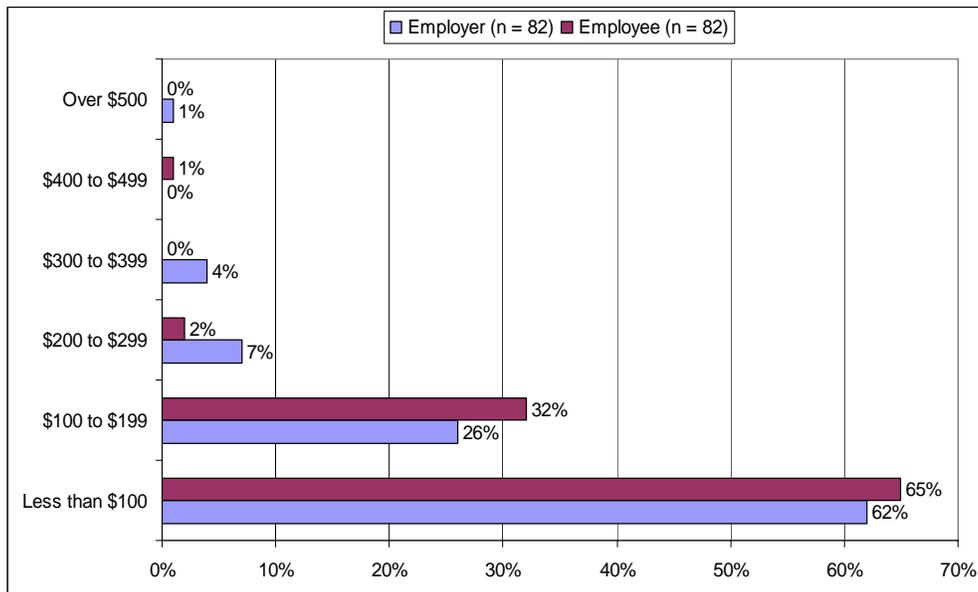
- Thirty-one percent of the employees not offered health insurance by their employer reported that they are uninsured (Figure 4). Seventy-eight percent of these employees work for a business with fewer than 50 employees.
- Sixty-nine percent of employees not offered health insurance reported having coverage elsewhere (Figure 4). Ninety-five percent of these employees work for a business with fewer than 50 employees.

Figure 4: Coverage Status for Employees Not Offered Health Insurance (n=59)



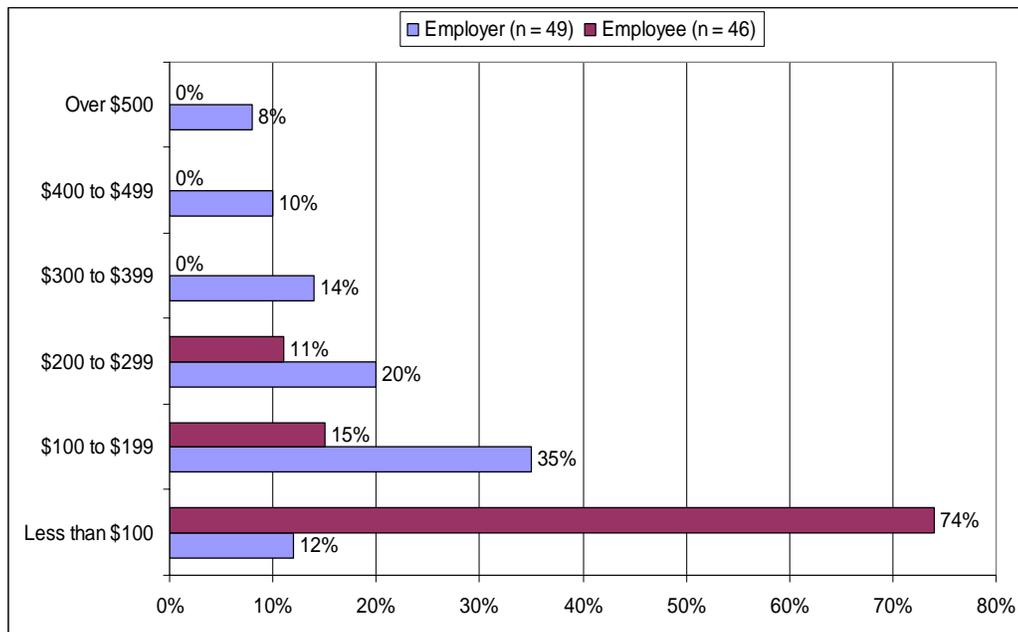
- The majority of the small employers who do not offer health insurance and their employees could afford a monthly premium of less than \$100 each for health insurance coverage (Figure 5).

Figure 5: Maximum Monthly Premium Non-Offering Employers and their Employees Able to Afford



- For employers who offer coverage, 74 percent pay a monthly contribution of less than \$100 a month, but 88 percent of employees who work for small employers who offer coverage reported that their employees pay more than \$100 a month and over half paid more than \$200 a month for coverage (see Figure 6).

Figure 6: Current Contribution for Employee-Only Coverage – Employer and Employee



- The magnitude of the premium gap between self-reported affordability and coverage options currently available for small employers and their employees would be \$50 to \$100 employer-only coverage and at least \$500 for family coverage, assuming that the small business has a close-to-average age distribution of employees. This finding is based on the survey results and an expert panel of insurance company representatives. The survey results indicate that almost two-thirds of non-offering small employers and their employees reported that they could only afford premiums of \$100 each per month per employee. On the other hand, a panel of insurance company representatives indicated that the minimum monthly premium price for a health insurance product with a reasonable benefit design is somewhere between \$200 and \$300 and likely to exceed \$250.
- It is very unlikely that employees who work for small employers who do not offer coverage will purchase any type of a family policy. The cost of a family insurance plan is at least \$500 per month.
- In making the decision to offer or enroll in an insurance plan, the most important factor, and in some cases the only factor for small employers and their

employees, is the premium price. Employers that do not offer health insurance are 3.38 times more likely to offer health insurance coverage if the total monthly premium is \$300 as compared to \$500. Although premium price is by far the most important factor to employees working for small employers when considering whether to enroll in a health insurance plan offered by their employers, they are also responsive to changes in the deductible, co-payment, and coinsurance provisions.

Options for Expanding Coverage

After carefully reviewing the results of the survey, the Nebraska Health Insurance Policy Coalition began examining policy options for expanding insurance coverage. The first step was for the Coalition and a panel of representatives from insurance companies who are major sellers in the small employer market to assess the feasibility of developing new insurance products that better meet the needs and affordability of small employers and their employees. All of the insurers that were members of the panel felt that a wide range of insurance products that included various benefit packages, cost sharing arrangements, and premium costs were already available on the market. They agreed that with the exception of insurance policies with a very limited benefit package (i.e., bare bones), none of the products seemed to have the benefits that would be acceptable to most small employers and their employees and still meet the \$200 per month per employee cost criterion for an insurance plan. After reviewing a sampling of the policies and prices available in the small group market, the Coalition decided that other policy options should be considered to close the \$50 to \$100 gap that appears to exist between what small employers and their employees are willing to pay monthly for an "acceptable" insurance plan.

In order to close the gap, the Coalition reviewed the expansion options that were approved in the initial State Planning Grant. These options were included in a 2005 report entitled *State Options for Expanding Health Insurance Coverage and Strengthening the Health Care Safety Net*.

The Coalition also reviewed policy options and key strategies that were under consideration or being implemented in other states. A report was prepared that summarized some of the major developments underway. For example, the comprehensive efforts in Massachusetts and Vermont were reviewed as well as single focus initiatives (e.g., children) in Illinois and Pennsylvania. The report also identified the strategies that targeted small employers and individuals with low-incomes such as in Tennessee, Rhode Island, and West Virginia. The final section examined some of the major changes in state Medicaid programs. These changes included premium assistance programs (e.g., Oklahoma), defined contributions (e.g., Florida), tiered benefits (e.g., Kentucky), and limited benefits (e.g., Arkansas).

A total of eight policy options were considered by the Coalition. Under each option, there is a description and rationale, a list of advantages and disadvantages, and a discussion of the potential costs. For all of these options, the target population is small employers (i.e., less than 50 employees) and low-wage workers and their families who work for small employers.

Option 1: Create public-private partnerships between small employers and Medicaid.

Description and Rationale: Some states have expanded coverage by creating premium assistance programs. In these public-private partnership programs the state, the employer, and usually the employee share the cost of the premium. In a proposed Oklahoma plan, for example, the employer would pay 25 percent of the premium, the employee would pay 15 percent, and Medicaid would pay the remainder of the premium. The program is limited to employees and their spouses who have a household income at or below 185 percent of the FPL and work in firms with 25 or fewer workers. Unemployed workers who are seeking work are also eligible.

Of course, there are many variations depending on the state. For example, the share paid by the employer, the employee, or the Medicaid program can be higher or lower. Also, in some states, the program includes employers with 50 or fewer employees and the income levels may be higher or lower.

Advantages: Several states have been successful in expanding coverage with premium assistance programs. Second, in comparison with a direct Medicaid or SCHIP expansion, the state's share of the costs is lower under a premium assistance program because the employer and employees are paying for part of the cost. In addition, these types of programs have less stigma than programs that are totally subsidized by the government. Finally, these programs reduce "crowd out" (i.e., replacing private health insurance coverage with a public program).

Disadvantages: These programs have high administrative costs for both state government and employers. In addition to higher administrative costs, new state funds are needed for Medicaid expansion. Finally, a waiver is needed from the federal government, and federal outlays must be budget neutral so the state must absorb all of the additional costs.

Cost: Although the costs are shared among employers, employees, and state government, some new state funds are needed. Also, the administrative capacity of the Medicaid program would need to be expanded.

Option 2: Expand SCHIP eligibility above the current income level of 185 percent of the Federal Poverty Level (FPL).

Description and Rationale: Based on the survey results, most employees who work for small employers and do not have insurance coverage are willing to contribute only about \$100 per month for insurance coverage. Given that the premiums for a family health insurance policy are at least \$500 per month, the vast majority of these employees are not likely to purchase a family policy. Therefore, even if insurance coverage is expanded to workers in a small business setting, their children will still not

be covered unless their family income is below 185 percent of the Federal Poverty Level.

One of the most direct ways of expanding coverage for children who live in low-income households is to expand income eligibility levels for Kids Connection (the State Children's Health Insurance Program). Currently, the maximum income eligibility level for the Kids Connection is 185 percent of the FPL. By expanding the income eligibility level to 200 percent or 250 percent of the FPL, it would be possible to cover more children of low-wage workers who work for small employers.

Several states have taken advantage of flexibility in the federal law to implement new coverage options. In order to expand coverage to more low-income populations, states may change the benefit packages and perhaps require cost sharing for "higher" income populations. In most cases, however, a federal waiver is required. In exchange for greater flexibility in the Medicaid program, the waiver application must demonstrate that more people can be covered without increasing the federal share of expenditures. When the waiver requests are budget neutral, the financial burden falls on the state. However, there are other cases where income eligibility levels increase (e.g., expanding income eligibility levels for Kids Connection from 185 percent to 250 percent of the FPL) where a waiver is not needed and the federal government would pay its normal share of the cost.

Advantages: Expanding income eligibility for Kids Connection is an effective strategy for providing insurance coverage for children who live in low-income families. A second advantage is that the administrative structure is already in place. Finally, there are several expansion options where the federal government will pay at least 60 percent of the cost.

Disadvantages: A major expansion would require an increase in state funds and it does not appear that there is sufficient interest nor support from policymakers to expand Medicaid or the Kids Connection program. In December of 2005, the Nebraska Medicaid Reform Plan was published. The recommendations included in this plan focused mainly on strategies that will moderate the growth of spending to ensure long-term financial stability.

Cost: At this time, no estimates are available about how many children would be covered if the income eligibility levels were expanded to 200 percent or 250 percent of the FPL. Also, depending on whether a waiver is needed, the state must pay up to 40 percent of the expansion costs. If a waiver is required, the amount of federal support does not increase, but there is greater flexibility in the eligibility requirements, covered benefits, and cost sharing options.

Option 3: Conduct a study to determine the feasibility of implementing a publicly funded reinsurance program.

Description and Rationale: A reinsurance program attempts to make insurance premiums more affordable for small employers and self-employed individuals. In such a program, public funds would be used to subsidize the purchase of a reinsurance policy that would cover claims above a certain threshold (e.g., \$25,000) for small employers of a certain size (e.g., under 25 employees). Because the state picks up a portion of the insurer's high cost claims, the premiums are likely to be lower and more stable from year to year. The availability of state-funded reinsurance should be linked to state approved plans that are targeted at low-income, uninsured individuals, and small employers.

Advantages: Reinsurance programs can leverage employer contributions to cover more people with public funds. These programs have been effective in a few states, and they have reduced insurer costs because they can be less aggressive in underwriting and marketing. Also, because of less risk of paying high-cost claims, insurers are likely to hold less surplus funds, which should reduce the premium costs.

Disadvantages: Publicly funded reinsurance programs require state subsidies and substantial marketing efforts are needed to advertise the program. Finally, a complex study is needed to determine which employer groups should be eligible, what the threshold levels should be, what policies are needed to limit the problems of adverse selection, how "crowd out" can be eliminated, and how the program will be financed.

Cost: A comprehensive study must be undertaken before the actual costs can be calculated. Based on the experience of other states, the cost of reinsurance programs varies depending on the scope of the program. For example, changing the threshold level from \$25,000 to \$40,000 would result in a lower cost. Also, a narrow definition of the target employer groups could significantly change the cost. However, it appears that substantial subsidies may be needed as an incentive for employers to participate in the program.

Option 4: Provide tax subsidies to encourage small employers to offer health insurance coverage and/or low-wage workers to purchase insurance policies.

Description and Rationale: Tax subsidies can provide an incentive for both small employers and low-wage workers who work for small employers to purchase health insurance coverage. If the tax subsidy is perceived as adequate, it can overcome the high cost of insurance premiums. The major issue is the amount of the subsidy that will be needed to enroll eligible employers in the program. Based on the results of the 2006 employer and employee surveys, it appears that a tax subsidy of about \$100 per month per individual is needed as an incentive to purchase health insurance. Other issues that must be addressed include the size of the employer (e.g., less than 10 workers) and

income levels (e.g., below 200 percent of the federal poverty level). Some states such as Utah have placed an enrollment cap (e.g., 5,000 workers) on the number of workers who can receive the subsidies.

Advantages: Depending on the complexity of the program, administrative expenses should be fairly low and could be managed within the existing state infrastructure. Also, if the tax subsidies are considered adequate, it could significantly reduce the number of uninsured.

Disadvantages: The main disadvantage of this approach is the potential cost of the program. Relatively small tax subsidies (e.g., \$50 per month) have not worked in other states. It is also difficult to decide which employers and employees should qualify for the subsidies and to determine whether there should be an enrollment cap.

Cost: The cost of the program will depend on the amount of the subsidy and the number of employers who are eligible. For example, if the subsidy was \$50 per month per employee and the number of employees was capped at 10,000, the total cost is estimated to be \$6 million. Of course, many other configurations are possible which will lower or raise the total amount.

Option 5: Organize health insurance pools for small employers and self-employed individuals.

Description and Rationale: Health insurance pools are relatively large groups of small individual entities (either individuals or employers) whose medical costs (claims) are combined for evaluating financial experience and determining premiums. The size of the pool will vary although current Nebraska laws require a minimum of 25 people in the pool. However, greater benefits are likely to accrue to pools that have several hundred people in them. Larger pools can reduce administrative expenses and the risks can be spread more evenly across the group.

In 1994, the Nebraska Legislature passed the Small Employer Health Insurance Availability Act. Section 51 of the Act revised the group statutes to allow individuals to form Insurance Pooling Groups (IPGs) for the sole purpose of purchasing insurance coverage. In order to establish an Insurance Pooling Group, the legislation requires that an association be formed which has a constitution and bylaws and that they buy a fully-insured health insurance policy. The association must consist solely of Nebraska residents, and must insure at least 25 members. This legislation allows individuals to join together for the sole purpose of buying health insurance and may include self-employed individuals, small businesses, and individuals.

Despite the legal authority to create insurance pools for small employers and individuals, the pools have generally not been successful. Some of the major challenges include organizing employers and individuals into the pool, preserving the continuity of

the pool, and maintaining a sufficient choice of plans. Given these challenges, it appears that some type of technical assistance and marketing initiatives will be needed to make insurance pools a viable option.

Advantages: One advantage is that since insurance pools act on behalf of a large number of individual buyers, administrative costs can be reduced by centralizing tasks (e.g., marketing, enrollment, and premium collection and distribution) that would otherwise be performed separately by several insurance organizations. Second, pools have the potential to eliminate or reduce the adverse effects of risk selection. By pooling together a large number of self-employed individuals and small businesses, the risks can be spread more evenly across the group. Also, as the market share of the pooling groups expands, it should be possible to negotiate lower premiums, and obtain better benefit packages as would be the case for very large employers. Finally, in a very large insurance pool the choice of plans that are offered to employees may increase.

Disadvantages: One of the major disadvantages of insurance pools is that it is difficult to organize small employers and self-employed individuals into a pool. Second, even if the pool is organized, some employers will leave the pool if they can find a lower cost plan. As a result, the premium costs to those still in the pool are likely to increase because the pool will contain more unhealthy individuals. Third, since relatively few insurance companies sell in the small group market, the number of insurers willing to offer plans to pooling groups is likely to be fairly low. If only one insurer offers a plan, it becomes difficult to negotiate lower premiums and offer a choice of plans. Finally, a few states are experimenting with different types of insurance pools, but none of the states have been very successful in using insurance pools to reduce the number of uninsured.

Costs: Unless public funds are used for organizing and marketing insurance pools, the costs are nominal.

Option 6: Offer limited benefit plans that provide comprehensive primary and preventive services.

Description and Rationale: Traditional limited benefit insurance plans have been available for several years. These plans generally provide limited coverage for physician and hospital services, some medications, and emergency care. The plans often exclude maternity benefits, behavioral health services, and any type of long-term care services such as home health. The plans are relatively inexpensive, but very few policies have been sold in Nebraska or across the country. The weak demand for these products reflects very low perceived value from the products.

In order to keep premium costs low, a few states have begun to focus on offering plans that provide comprehensive preventive and primary care services. These plans would include clinical preventive services (e.g., low cost or free immunizations, prenatal care, and cancer screening programs). Some coverage would also be available for behavioral

health, basic dental care, and some medications. Some hospitalization coverage is provided, but it is limited.

A few hospitals across the country have supported this concept by providing free preventive care for chronic disease patients rather than absorb the high cost of repeated emergencies. Hospitals in New York, Denver, and Texas are assigning many uninsured patients to community clinics that charge modest or no fees.

Advantages: The major advantage of a limited benefit plan is that individuals and families can have access to primary care services and receive the necessary clinical preventive services. These low-cost plans are also very affordable for many small employers and many of their employees. With good care coordination, the overall health of the uninsured should also be improved.

Disadvantages: The main disadvantage of these plans is that they provide only limited coverage for specialty and hospital care. Because of the limited coverage on the backend, the demand for these plans has been very weak.

Cost: The amount of state funds that are needed to implement this option is minimal.

Option 7: Create three-share plans at the community level.

Description and Rationale: A three-share model can be developed at the community level. In this model, the employer and the employee pay a share of the premium and the third share can be paid by a government entity, a private foundation, or providers. The benefit packages are more limited and the main target is small businesses (usually with less than 25 employees) that have not offered health insurance coverage for six months to a year. Several of these three share plans are now operating in Michigan and Illinois.

Advantages: Three-share insurance plans are usually developed by key stakeholders in the community. The stakeholders determine the eligibility levels (e.g., employer size), the benefit package (e.g., physician office visits, hospital care, medications, mental health care), and the deductibles, copayments, and coinsurance levels. An insurance plan designed at the community level with input from small employers is more likely to be purchased. Another advantage is that these plans have been reasonably successful in both Illinois and Michigan. Finally, if the cost of insurance is spread among the three shares, the burden of the cost is less for both the employer and employee.

Disadvantages: One of the major disadvantages is finding the “third share”. Most communities do not have private foundations nor are local governmental entities willing to pay the third share. Some providers may be willing to take discounts in return for lower uncompensated care costs, but they may not be willing to pay for the full amount of the third share. Another disadvantage is that the benefits contained in the plan will

be somewhat limited in order to offer a reasonably priced plan. If the benefit package is perceived to be too limited, the demand for the product will be low, regardless of the price. Finally, a community planning committee must be formed and sustained over a period of time. The committee must have excellent leadership and cohesion during a lengthy period of time.

Cost: The amount of state funds will be minimal. At the local level, some funds will be needed to operate the planning committee and design the plan. Of course, the largest expense is to find options for funding the third share.

Option 8: Create an insurance connector program to assist small employers and self-employed individuals in finding an appropriate plan.

Description and Rationale: The results of the focus group interviews with small employers in 2004 and the 2006 survey of small employers indicated that one of the major barriers to purchasing health insurance is the lack of information and knowledge about the various plans that are available. In order to address this issue, an insurance connector program can be established in the Department of Insurance. The role of the insurance connector is to inform and educate small employers about the range of insurance options that are available and where they can find more information about the plans. The connector should have information about all of the major plans sold in the small group market including approximate premium costs, benefits, and cost-sharing provisions. The connector should also have a list of insurance brokers who assist small employers in making their decisions. While the connector attempts to link small employers with possible options, he/she should remain unbiased and not attempt to “sell” a particular insurance product.

Advantages: The major advantage of the insurance connector program is to provide accurate, unbiased information about the insurance options available and how the information can be accessed (e.g., web sites, brokers, other contacts). The connector should be a convenient source of valuable, independent information on the health insurance plans offered in the market.

Disadvantages: Other than some cost and the time to collect the necessary information, there is not a major downside to this option. Obviously, it will be essential to develop a marketing strategy to inform small employers about the services of the connector.

Cost: Some state funds will be needed to establish this program. An individual will need to be assigned to the program and it is essential to communicate the availability of the program through various media outlets. The estimated total budget is about \$100,000.

Recommendations

After considering each of the policy options, the Coalition made the following recommendations. All of these recommendations will require further study to identify the impact and the estimated costs. The Coalition also recognized that policymakers cannot move forward on all of these recommendations immediately and that a reasonable time period would be one to three years. The recommendations approved by the Coalition in February, 2007, are ranked by priority below:

- Creating a premium assistance plan where the employer, the employee, and the state Medicaid program pay a portion of the insurance premium.
- Expand Kids Connection (the State Children's Health Insurance Program) eligibility above the current income level of 185 percent of the Federal Poverty Level.
- Create three-share plans at the community level.
- Create an insurance connector program to assist small employers and self-employed individuals in finding an appropriate insurance plan.
- Provide tax subsidies to encourage small employers to offer health insurance coverage and/or low-wage workers to purchase an insurance plan.

The other three policy options were not selected because of cost, the lack of demonstrated effectiveness, and the limited impact. For example, an expensive study would need to be conducted to determine the feasibility of a reinsurance program. This type of program may also require a considerable investment of state funds to be effective. Purchasing pools have not been effective in Nebraska nor in other states. However, some other states are attempting to implement new models, and the results should be closely monitored to determine if they could be effective in Nebraska. Finally, a limited benefit package was not accepted because this option provides only limited coverage and only marginally improves access to health care services. Also, past demand for these policies has been extremely low because of the limited benefits provided.

Next Steps

This report will be submitted to the Governor and the members of the State Legislature to provide future direction. If a decision is made to further explore one or more of the recommendations, it would be desirable for the Nebraska Health Insurance Policy Coalition or a new coalition with a similar diverse membership to be involved in the implementation process. Another benefit of maintaining the Coalition is to monitor and evaluate new federal and state initiatives that are under consideration or are already in the implementation process. Nebraska is in an ideal position to learn from other states and adopt successful strategies without undergoing a steep learning curve.

NOTES

NOTES