POLICY OPTIONS FOR SMALL EMPLOYER HEALTH INSURANCE

A Report to the
Small Business Administration

January 1991

by

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SBA Requisition Number
3111.1.25.024
Health insurance and related issues have been listed consistently as one of small business owners' most pressing problems. Those small businesses who historically had purchased health coverage for their employees are finding the coverage is difficult to maintain; either due to skyrocketing costs or insurance company practices, for example, cancellation or non-renewal. Those small businesses which do not offer health insurance as a benefit to employees are the principal business segment of the uninsured population; in fact, it is frequently noted that 75 percent of all the uninsured have employment connections, as employees or dependents, mostly in very small businesses.

Simply stated, any public policy which makes health insurance coverage more accessible, affordable, and attractive to small businesses will increase the density of the insured population, and forestall efforts to nationalize insurance coverage, i.e., Canada, or health care, i.e. Britain, which are gaining momentum. A well conceived integrated policy position with respect to small business interests can indeed play a large part in reducing the numbers of the uninsured significantly and lead to more universal-like coverage, within the voluntary system of health insurance that the United States has historically embraced.

This memorandum details a number of policy options recommended to the Administrator of the Small Business Administration (SBA) by the National Advisory Committee (NAC). These recommendations are the result of a number of meetings with small business owners, trade associations, and other related interest groups. These proposals focus on what small business interests view are the barriers to effective health insurance distribution; notably costs, employer/employee participation, and access to insurance coverage. And while the problems of the current system are simple to describe, solutions to these problem are complex to construct, primarily due to the convoluted system of health care financing and delivery which has evolved in the United States.

**PRELUDE**

Health care is a major area of concern not solely for the small business community, indeed the scope of health care reform initiatives is very broad. Any public policy, or private sector dealmaking for that matter, should recognize the interplay between the five major sectors of the health care establishment: providers, purchasers, payers, users, and government. It is worthwhile prior to delineating the policy proposals to be considered, to review the facts and interrelationships among these important groups in the delivery of health care as we know it in the United States.

**PROVIDERS:**

The provider sector is comprised of those health care individuals and institutions who actually deliver health care services. Principal among the provider group are physicians, psychologists, chiropractors, dentists, hospitals, clinics, HMOs, long term care facilities, durable medical equipment and drug companies, labs, and many other health care specialists.

Historically, providers have been free to determine both [1] the levels of care utilized in the treatment of patients and [2] the costs/reimbursement associated with the delivery of
that care. The tremendous increases in costs associated with the health care sector during
the decade of the 1980s has led to limitations in this traditional freedom.

Managed care is a broad term encompassing a variety of efforts, primarily
administered by the payers, to restrict the ability of providers to utilize virtually any
treatment regimen without hesitation or consideration of costs. These efforts include
programs for: pre-admission certification, which develops standards for in-patient treatments
and out-patient incentives; health maintenance organizations, which historically\(^1\) paid
providers on a capitated basis thus reversing the incentives of fee-for-service medicine; second
opinion surgery, which paid for alternative treatment evaluations; utilization review, which
monitors and evaluates the levels and density of particular services for a given population,
and many other programs.

Prospective payment programs, like diagnostic related groups (DRGs), are methods
of restricting and pre-determining the reimbursement levels which providers for providing
particular services. Recently, the Federal government, has pursued a program in Medicare
entitled Resource Based Relative Value Schedules (RBRVS) in which physician
reimbursement levels would be re-adjusted so that diagnosis services are valued, and paid
more highly than in the past, and procedures are paid less. While many of these programs
have begun as government policy, their use in the private sector is increasing as other
purchasers and payers adopt cost controls.

Both managed care and reimbursement modifications have not been well received by
the large proportion of providers. This should not be surprising as freedom to practice and
price is being restricted by non-health care professionals. Providers, however, are the key
to the overall cost question. Providers determine the capacity of the system, the investment
in technology, the price structure, and ultimately the utilization levels and the health status
of the nation. Therefore, providers must be adequately compensated\(^2\), while being encouraged
to provide a level of care which is consistent with standards, but not in excess of them. In
order to achieve this ratcheting-down of the anticipations of the level of care which equates
with high quality care, users of the system will be required to adjust their expectations.
Certainly, providers must be encouraged to continue to develop standards of care and
reasonable methods for reimbursement. Many believe there is room for a reallocation of
health care resources among the variety of health providers which would lead to significant
savings and better health care. Certain providers, e.g., chiropractors, have cemented their
position in the health segment by lobbying for inclusion as a mandated benefit in many
states.

A long-standing "hot-button" for the provider community is the medical liability reform

\(^1\) The trend in HMO payment to providers has gone to a discounted fee-for-service method rather
than capitation methods.

\(^2\) Reimbursement levels in many government programs, particularly Medicaid, are significantly
below market or negotiated, discounted reimbursements. Adequate compensation of providers is critical
in all segments of the purchaser community to prevent cost-shifting to other segments--in particular, the
insured small business segment.
issue, that is, malpractice. Pressure from the liability system does two things: increases the direct cost of care for the costs of liability insurance, and increases in the indirect costs of care through increases in the diagnostic testing and procedures associated with treatment routines. Tort reform is a two-edged sword; since effective provider policing of poor performers is non-existent, the incentives for quality, non-negligent care must be maintained. Certainly, there is room for a more common-sense approach to "bad outcomes" in which little or no negligence is present. Presumably, that is what the courts are called on to accomplish. This issue is not one, however, that is directly germane singularly to the small business interests.

PURCHASERS:

Health care purchases are dominated by three groups: employers, government, and individuals. In terms of dollars spent, individuals spent $123 billion (27.8 percent), private third-party payers spent $144.3 billion (32.6 percent), and government spent $175.3 billion (39.6 percent). These figures combine government's spending in social programs and for employment purposes.

Since the early 1980s, purchasers in all categories have focussed their actions on controlling the amount of resources spent on health care. Purchasers have used a variety of techniques to achieve savings. First, they embraced managed care programs, in particular HMOs which they had historically disdained. Employer coalitions and formation of purchasing groups to get discounts in return for volume also became viable entities. Employers also attempted to force users, employees and dependents, to absorb more of the cost. Incentives through Preferred Provider Organizations (PPOs) to use reduced-cost providers and increases in deductibles and co-payments also were increased. Savings were also achieved through the use of self-insurance plans, through the avoidance of premium taxes of insurance companies, risk charges, and classification subsidies. Self-insurers also could avoid the requirements of complying with mandated benefits, which were increasingly applied by the states, thus further saving money. In general, all of the above approaches to cost savings apply to the largest companies in the nation. Few of these options are available to small businesses of 50 or fewer employees. Indeed, the actions of the larger companies have increased the costs of smaller insureds, since volume for discounted care, avoidance of mandated benefits and other costs were not available to small companies.

Somewhat surprisingly, one effect which has not been generally observed is a reduction in the coverage that employees receive in their benefit plans. Many large employers have actually increased coverage for dental, vision, mental health, and other areas. Further, attempts to pass more costs of health care to employees have been roundly assailed by unions and employee groups, for example, AT&T. Somehow a reduction of existing coverage levels

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3 Liability insurance prices are subject to a very strong cycle, typically 3-4 years up, then 3-4 years down. One must be careful in discussing liability price increases to understand this cycle phenomenon.

to the vast majority of the insured population must occur if the insurance system is expected to accommodate universal coverage, and/or long-term care benefits in one form or another (publicly or privately financed) as suggested by the Pepper Commission and others.

PAYERS:

The health care system in the United States has evolved in a way such that the exchange of money between the buyer and the seller of health care is generally handled by an intermediary. By and large the intermediaries of choice have historically been: Blue Cross and Blue Shield organizations, health insurance companies, and third party administrators. During recent years, self-administered plans (the buyer paying directly) have been used with more frequency.

The payer group has positively affected the health care system through the development of cost controls focussed on the activity of the providers, i.e., managed care and utilization review. Recently, however, the costs of providing payer services have come into question. Certainly, payers do require funds to cover expenses, and in some cases, profit to exist in the private sector. Much has been made of the comparison between the cost of delivering Medicare health coverage (about 3-4 percent) versus private health insurance (between 12-25 percent depending on the carrier). Insurers and the Blues have a number of expenses which the Medicare insurance package does not have to deal with regularly, including: marketing expenses (most private health insurance is a transfer from one carrier to another), actual policy development and issuance (Medicare does not issue paper), multiple coverage options (there is only one Medicare plan), customer service (Medicare assistance is very difficult to obtain), subscriber submitted claims (most Medicare claims are submitted by providers directly) and risk charges (private insurers are required to hold surplus which is at risk of loss from poor claims experience). The fact of the matter is that insurer expenses do increase the cost of coverage, what is at question is whether the services associated with those costs warrant the expenditure. Given the diversity of the US economic environment, the flexibility of the private insurance system does appear to have merit.

For small businesses and individuals, the biggest problems with the payers are their underwriting and contract practices. From the insurer's point-of-view, such practices are necessary to protect the 'net worth' (surplus) of the organization, which is at risk. A few large claims can easily deplete the premiums paid by a large number of health individuals. People seeking insurance want protection for the unknown claim. Even more onerous is the individual who knows a claim (injury or disease) is present, then seeks insurance, that is, others to pay part of the claim. This is the issue surrounding the hotly discussed contract provision called pre-existing conditions clauses. Insurers need to recognize and develop methods to spread the costs associated with pre-existing conditions so that insurance coverage can be competitive among firms, and portable among insureds. Reinsurance coverage routinely provides such a mechanism in many lines of coverage. In sum, insurance companies need to be aware of the societal nature of the health insurance coverage, and work to develop mechanisms, with the other players, to achieve broad health care goals.
USERS:

Individuals—whether insured or uninsured, employee or dependent, active or retired—are the actual users of the health care system. As stated earlier, consumer expectations, for those who have been insured, of the access, convenience, quality, and cost of health care are a major problem in seeking cost controls for the system. Users have historically been insulated, almost totally, from the cost of health care through the insurance mechanism. Further and related to the cost issue, users have grown accustomed to the convenience of highly localized, accessible secondary and tertiary care. One of the most clear comparisons of the Canadian versus United States systems of health delivery is the scope of investment and access to technological innovation and specialty care. In sum, the Canadians spend less, in part because users expect less, and less is available. Whether such an approach is viable in the United States is problematic, unless there is widespread concurrence among the various components of the health care system.

One necessary ingredient is some agreement on a minimum level of health coverage. Recently, the AMA, and others, have attempted to define a basic health insurance package. Martin Feldstein wrote years ago that for the most part US employees have too much health coverage—what has not been discovered is the right amount of health coverage. Thus, it is important to give employees and employers the capability of determining basic packages without the imposition of requirements for care which may not be considered apropos, e.g. in vitro fertilization, chiropractic care, and mammograms.

Regardless of expectations of the convenience of health care, users must be made part of the payment equation or there will be no point-of-service check on the provision of care by the providers. While users resist larger deductibles and co-payments, they are shown to be an effective method of cost control for the system, not just a cost reduction feature for the employer.

GOVERNMENT:

Government acts as employer, and therefore, purchaser. Government also acts as payer in the cases of Medicare and Medicaid, CHAMPUS, and other programs. Government also regulates, or has regulated, many aspects of health care delivery, including price regulation of hospitals, prohibition of advertising of physicians, insurance regulation on the State level, licensing of health care professionals and institutions, and many other areas of interest. Finally, government makes health care policy which impacts not only governmental units, but also ripples through the entire health care system.

Government policy has a fundamental decision to make: retain, but improve, the voluntary, quasi-free-market based, multiple payer system which has evolved, or create a new financing mechanism with universal coverage as a fundamental prerequisite. Assuming that the Administration prefers the retain and improve approach, policies must be developed which actively reverse the trend in the uninsured rate, and work towards achieving more stability and restraint in the growth of the health care sector. Most importantly, policies must be congruent and consistent with each of these goals, and work to involve all of the five sectors: providers, payers, purchasers, users, and government itself.
POLICY RECOMMENDATIONS

There are three categories of recommendations discussed and forwarded by the NAC group. These recommendations relate to the following areas of interest: [1] The Cost of Health Insurance, [2] Employer and Employee Participation, and [3] Health Insurance Availability and Access.

Small businesses that offer health insurance have the problem of the increasing cost trap! First, costs have been going up in big doses. There are two fundamental reasons that costs are going up for small business: [1] small employer's employees costs are increasing, as all health care costs are increasing due to increased utilization, prices, and demographics, and [2] large employers and government have shifted costs to small employers through the 'deal-making' associated with payment plans (capitations, DRGs, PPO discounting, etc) and avoidance of mandates--whose costs are solely carried by small and medium sized fully-insured plans. Small employers are trapped by these increasing costs because of the nature of the insurance markets and administrative processes of insurance companies provide significant barriers when employers attempt to shop for health insurance coverage to bargain down increased costs. Underwriting restrictions, such as diagnosis-based underwriting, and policy restrictions, such as pre-existing conditions limitations, at least partially prevent small companies from freely choosing to move from one insurance carrier to another.

Those small employers who do not offer health coverage are the most significant component of the uninsured problem in this country. That is, employers of 0-10 employees have a high incidence of no coverage, and employees of such firms are a large percentage of the uninsured population. As such a large part of the uninsured problem, these firms are targets for policymakers who want to legislate universal coverage through the existing system of health financing and insurance, for example the Kennedy-Waxman proposal. Mandation of coverage in the small employer community is problematic since many small employers margins are not strong enough to support health coverage, which explains why they do not currently offer health coverage, and mandation simply makes these companies cost structures less competitive.

Twelve individual recommendations are offered, here, for consideration, based on the NAC Recommendations (Tab C). Each is discussed briefly, with some background, and pros-cons analysis.

NAC Committee Recommendations for SBA Evaluation and Policy Development

THE COST OF HEALTH INSURANCE

1. 100% DEDUCTIBILITY OF SELF-EMPLOYED HEALTH INSURANCE EXPENSES (NAC Recommendation #1)

This recommendation goes to leveling the playing field between large employers and small. Large employers have many advantages with respect to volume discounts, ERISA pre-emption of state mandated coverages, and self-
insurance possibilities. Additionally large employers can deduct the full cost of health insurance to all employees, while the self-employed are limited to 25 percent of the cost. Since the tax code subsidizes health insurance costs to large employers, an equal level of subsidy to small employers will reduce the net cost of health insurance to the small business owner, and therefore, will increase the acceptability of offering health insurance to many self-employed individuals, thus increasing the density of health insurance in the population.

Clearly, there is a negative revenue impact of adoption of 100 percent deductibility of health insurance premiums. Analysis of the value of such a proposal must focus on the realistic benefits associated with the costs of the proposal. While it is relatively straightforward to estimate the revenue loss associated with the increase in the tax shield, it is less clear what increasing the tax-favored status of health insurance for self-employed will do to the incidence of health insurance. Will, in fact, the number of small businesses offering health insurance increase, or will it simply improve the cost of health insurance for those now offering coverage?

One way to find the answer to this major question is to investigate the results which were experienced when the tax-deductibility of premiums was raised from 0 percent to 25 percent. Once the costs/benefits of the tax change are known, the acceptance of the proposal can be more easily understood and sold. Until that point, the loss of tax revenue is unattractive. This is particularly true when many (including Secretary Sullivan) are once again suggesting that the full tax-deductibility of health benefits for any business is unhealthy for the health care system. The taxing of health benefits in excess of some minimum or average plan, is very attractive as a means of carte blanche reducing the overall level of benefits in the nation's health care system. Without further data, this NAC Recommendation may be out-of-step with the direction of reform in this regard.

2. AVOIDANCE OF STATE MANDATED BENEFITS
(NAC Recommendation #3)

One reason that small employers are differentially clobbered by health care costs, relative to large employers, is that since virtually all small companies fully-insure their plans, they must comply with all 50 state insurance codes. Automatically, then, small employers are subjected to a 2-3 percent state premium tax, levied by each state on each insurance premium dollar, and all the mandated benefits must be included in their plans. Larger companies can avoid both of these costs through self-insurance and the ERISA pre-emption. Section 514 of ERISA preempts the application of all state laws targeting employee benefit plans. Thus, states retain their authority to regulate only those plans who use traditional insurance programs.

During the recent past, growth in the number and nature (therefore expense) of these mandates has been substantial. A recent study indicates that
in total over 730 mandates have been legislated by the states, up from 343 in 1978\textsuperscript{5}. The Gabel/Jensen study strongly suggests a relationship between mandated benefits and the decision of small firms not to offer health insurance coverage. Further, they suggest that mandates influence the decision of medium and large firms to self-insure.

This recommendation, then, goes to leveling the playing field between the large and small employers further. Small employers would be extended the same cost reduction techniques that large employers are, including offering a basic "no frills" insurance policy that meets the needs of employees, while not crippling the financial ability of the employer to maintain business quality. Administrator Engeleiter has already embraced the development of "no frills" policies for small businesses, therefore, this recommendation is consistent with her position on the matter. The overall policy thrust is again to reduce the scope of coverage for those insured, in order to increase the incidence of available health insurance coverage and to reduce the cost. In fact, this approach is being used to some extent, and with some success in the marketplace currently. Insurers, using trust mechanisms, are reducing scope and cost through the development of 'skinnied-down' policies.

This policy is clear, and sound. Implementation is the tricky part. Federal policy is useful, because a clear and universal direction can be set, however, State regulation of insurance must be preserved. One model which should be examined is the 1980 Baucus Amendment (Public Law 96-265, Voluntary Certification of Medicare Supplemental Health Insurance Policies) with respect to Medicare supplement insurance policies. This approach set Federal standards, with limited penalties, but used the State insurance departments to enforce the regulation. The policy standards used under the Baucus approach were established by the National Association of Insurance Commissioners (NAIC).

3. SUPPORT FOR MANAGED CARE
(NAC Recommendation #5)

Part of the reason that health insurance and health care costs are increasing is that utilization of services has been uncontrolled in any meaningful way. The development of HMOs has shown that some modification of practice standards and patterns can be made which reduce costs and maintain quality. "Managed Care" is a term which embodies the techniques available to payers to monitor, incent, and control the cost of the delivery of health care services. Some of these techniques include: reimbursement modifications, pre-admission certification, second opinion surgery, hospital bill audits, outpatient utilization incentives, and others. Many of these techniques have been applied to large employers accounts and insurance plans, the NAC

encourages the adoption of these plans in the small business community and health insurance marketplace.

This recommendation is a vehicle to increase the incidence of health insurance in the small business sector; in that managed care plans are effective methods for controlling costs, and the health care system is still learning how to use these methods so further gains can be expected. This recommendation is also somewhat moot in that managed care plans are pervasive in most markets and products, and growing fast in others. Buyers of insurance plans will soon have no option regarding some components of managed care, since they will be part-and-parcel of health insurance coverage automatically, as payers aggressively attempt to manage the annual increases in charges to insurance buyers.

Neither providers nor employees have embraced managed care enthusiastically. For providers, managed care has dramatically changed the independence and control that physicians perceive they can exercise in the delivery of their patient's care. Additionally, managed care has frequently forced providers to negotiate discounts and alter long-standing referral and practice patterns. Employees view managed care plans suspiciously. Often provider choices are limited, and the newness of managed care plans has been awkwardly implemented in many cases. Regardless of these difficulties, pervasive managed care appears to be inevitable.

4. EXAMINATION OF COBRA
(NAC Recommendation #6)

The 1985 passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) led to uniform continuation of health insurance coverage for 18 months after employees terminate employment. In 1989 the original provisions were expanded. Since the original bill's enactment, the provisions, their effectiveness, and the cost implications for all business have not been examined at all! The recommendation is for Congress to review COBRA, and its role in the health insurance debate.

Two approaches are possible here: One is a direct request of the appropriate Committee of Congress to hold hearings, and investigate the salient questions regarding COBRA's impact on the barriers to health coverage. Another tactic is to direct a research initiative, from SBA, to examine the COBRA impact on health care insurance/costs in small business, then use the results to direct the Congressional investigation.

Regardless of the approach, some fundamental questions must be asked and answered regarding COBRA continuation coverage. First and foremost, what are the costs and benefits, comprehensively defined, of the COBRA legislation, as amended? How much adverse selection costs are employers bearing do to COBRA continuation coverage, and should these costs be shared
by a bigger base? Are continuation coverage requirements reducing the incidence of health coverage among employers, particularly smaller employers? Many other kinds of questions may also be addressed by an investigation of the law.

5. TORT, PARTICULARLY MEDICAL MALPRACTICE, REFORM
(NAC Recommendation #14)

The direct and indirect costs of the medical malpractice litigation system are substantial in the provision of health care. NAC representatives are sensitive to tort reform for their own liability coverage and costs, and therefore, are easily supportive of any tort reform movement.

As discussed earlier, the tort reform and malpractice reform are thorny questions. Clearly, there are abuses and costs. There are also many benefits of the tort system (safer cars, football helmets, operating rooms, etc) which are hard to measure directly. It may be a more crisp set of recommendations with respect to small business health insurance, if SBA steers clear of the malpractice issue.

EMPLOYER AND EMPLOYEE PARTICIPATION

1. SUPPORT FOR DEDUCTIBLES AND COPAYMENT PROVISIONS
(NAC Recommendation #4)

One reason that health care costs have risen with impunity is that the providers have not been challenged by the receivers of care, the patients, regarding either the level or cost of care. Because most insurance plans provided 'first dollar' coverage, employees never were involved financially in the health care purchase. Unions frequently bargained to maintain this insulation from the cost, and still do. However, a direct financial link between the patient and the provider leads to demonstrated savings in utilization and prices. This recommendation simply suggests that employee cost sharing is beneficial, to the entire health care system, as well as to the employer who will be reducing costs through sharing them with employees. Support among employee sectors for both cost sharing and managed care is relatively low, even though the effectiveness of these approaches is well-demonstrated.

The choice for small employers and their employees is between [1] no coverage, and [2] fair coverage, affordable to the employer who will pay most of the cost generally, and with some controls on the providers so that cost increases are reasonable. These controls must include payments by employees, and the institutional restraints applied by managed care plans. This position will likely be more difficult with the employees of large organizations than those of small businesses. However, this position does mean an effective reduction of current pay, which is never popular. This is why it is so critical to paint a picture of each of the five segments giving up something, so that the system will survive and thrive for all.
2. SUPPORT FOR FLEXIBLE SPENDING ACCOUNTS
(NAC Recommendation #8)

The cost sharing with employees recommended above can be softened through the subsidy offered by the tax code, linking support for increased deductibles and co-payments with support for flexible spending accounts (FSA) which provide tax savings for out-of-pocket health expenses. Employee out-of-pocket costs can be made with pre-tax dollars by using employee spending accounts. Small employers adopting cost sharing with employees should be encouraged to enact a flexible spending account (Section 125 Plan) vehicle to help employees bear the cost using Federal tax subsidies which are already available, and require no modification of the tax code. Of course, any modifications which would simplify the ability of a firm, particularly a small firm, to implement a flexible spending account program would be welcome. The SBA could encourage development of a simplified FSA plan for small businesses, as an example.

A model for simplifying the administration and implementation of FSAs is the Simplified Employee Pension (SEPs) program. Small employers and self-employed persons found the requirements of ERISA very difficult to meet in the formation of a pension plan. As a result, most small businesses either did not establish a plan, or adopted an alternative retirement income program. SEPs were developed as a uniform, standardized pension, meeting all of the ERISA requirements, and leaving administration to a bank, savings and loan, or other financial institution. Thus, SEPs are "off the shelf" pension plans for small businesses, and a similar approach should be examined for FSAs.

In addition to seeking simplification of the adoption of FSAs for small businesses, the SBA may also consider lobbying for special exceptions for small business in the Internal Revenue Code. One of the major concerns of small business in the adoption of an FSA plan is the financial risk the firm must bear in permitting employees to use pre-tax dollars to fund health insurance deductibles, child care, and other benefits. The SBA could seek an exception for firms with less than some specific size, although past experience suggests these kinds of exceptions are difficult to achieve. The tradeoff between adoption of a health insurance plan by small businesses, and the risk associated with unfunded FSAs and the tax revenue loss may be viewed as attractive. SBA should investigate the aspects of FSAs which are problematic for small business, and then explore the viability of seeking IRS modification for small business interests.

3. EDUCATION OF SMALL BUSINESS OWNERS AND EMPLOYEES
(NAC Recommendation #12)

The cost problems associated with health insurance are well-documented. Small business owners and employees, however, need to be educated regarding how they fit into both the cost problem and the solution.
The SBA is encouraged to investigate ways to communicate and educate small businesses in the techniques for dealing with the health insurance cost crisis. This recommendation ranges from tax advice and strategies, insurance information, and cost reduction strategies.

One obvious educational approach is to examine existing SBA books and booklets, usually used by new businesses being formed, to determine the extent to which owners are encouraged to adopt a cost effective health insurance program for employees from the outset. There are many of the SBA publications dealing with insurance, benefits, and development of business plans. Do these publications support the incorporation of a health insurance plan, or do they discourage such a plan?

National Federation of Independent Business (NFIB), the Chamber of Commerce, and other small business trade associations have devoted much time, effort, and money to assess attitudes and problems of small business owners regarding the health insurance issue. SBA can join with these groups to distribute information regarding check lists and suggestions for the purchase and maintenance of health insurance.

INSURANCE AVAILABILITY AND ACCESS

1. SUPPORT FOR NAIC AND HIAA REFORMS
(NAC Recommendations #8 and #9)

Both the National Association of Insurance Commissioners (NAIC) and the Health Insurance Association of America (HIAA) are recommending reforms in the regulation and operation of the health insurance industry. The SBA is encouraged to review and support those portions of these reforms which will lead to long-run cost stability and increased access in the health insurance market, particularly as it relates to the small business insurance market.

The insurance industry is in for a difficult time during the decade of the 1990s. Erosion of broad support for traditional insurance values is nearly complete. As an example, in a recent study completed by the American Council of Life Insurance\(^6\), while nearly 60 percent of the population thought it was fair for life insurance companies to turn down a person with several heart attacks in 1979, in 1990, 60 percent of the population thought it was unfair! Similarly, more people think it is unfair, rather than fair, to classify individuals for insurance purposes. Finally, 43 percent of the population thought 'very or mostly unfavorably' towards the insurance industry, highest of any industry measured including the nuclear power and chemical industries.

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\(^6\) "Monitoring the Attitudes of the Public", American Council on Life Insurance and Health Insurance Association of America, 1990.
These findings suggest two things: there is wide-spread popular support for insurance bashing, and the insurance industry must react, and make a meaningful, positive response to the societal problems with which it relates. The HIAA proposals are probably directed at this end. It is not clear, however, that these proposals are solidly supported by the industry itself.

The HIAA proposals have a recognizable goal: to move to more universal coverage, by increasing the incidence of health insurance in the small employer market and the poor and near-poor populations. HIAA suggests more portability of health insurance as employers change carriers, or employees change employers. Support for this concept by SBA should be solid, since this is a major barrier for small businesses and their employees to remain covered. HIAA also suggests a private reinsurance program for the small employer market; the goal is smooth price differentials across employers. HIAA also proposes tax subsidies, expansion of Medicaid, state risk pools for uninsurable individuals, and exemption from State mandated benefits. In sum, many of the proposals recommended by NAC, individually, are also proposed by HIAA.

The NAIC proposals are more technical and arcane, relating primarily to mollifying potential rate changes over businesses and time. Specifically, this model law, if adopted by the states, would limit: [1] group-specific annual rate increases, [2] the range of price differences within a 'class' of business, and [3] variation among all classes of small business sold by a particular insurance company. Thus the year-to-year price increases to health insureds would be softened through allowable ratemaking techniques. These proposals are attractive to small businesses and the SBA should advocate and monitor the progress of model bill adoption.

2. FEDERAL 'LEVERAGE' FOR HEALTH INSURANCE REFORM
(NAC Recommendation #2)

State by state reform of insurance regulations has proven to be a slow process in the past. This recommendation suggests that Federal leverage, such as that employed in the Baucus Amendment for Medicare Supplement insurance, be evaluated as a catalyst for faster change in health insurance reform.

If there is a place for SBA to take a leadership role in the development of an overall health policy, it would appear that formation of a Federal leverage package is that opportunity. Whether a punitive approach, such as Baucus, or an incentive approach is taken, SBA can lead the small business interests in this way. Presumably, it is then reasonable to seek HIAA, Chamber, NFIB, and other support for the SBA proposal, rather than the reverse!

3. EXPAND/MODIFY MEDICAID FOR LOW INCOME EMPLOYEES
(NAC Recommendation #10)
Some have suggested that one compromise solution to the uninsured problem, short of full national insurance, is to permit low income workers to "buy-in" to Medicaid. This approach bridges the gap between employer sponsored health coverage which has provided 85 percent of the population with coverage and a government sponsored plan, which would yield universal coverage. The concept of the Medicaid "buy-in" is to provide an opportunity for lower income individuals, who do not qualify for fully paid Medicaid benefits, to purchase the set of Medicaid benefits as an individual (or family) insurance policy. Some proposals of "buy-ins" provide a partial subsidy of the purchaser.

This recommendation is to investigate expansion of access to Medicaid benefits at the same time that the Medicaid benefit package is reviewed. In many states, the Medicaid benefits package is well beyond the level either offered or desired (the "no-frills" approach) by small employers. In order to give more access to a basic plan, Medicaid eligibility could be expanded, and possibly subsidized, to cover more of the low-income population---while also reducing benefits to include a common, uniform, no-frills package.

The obvious way to bring Medicaid into the small employer health problem is through the development of a benefits package which can be easily duplicated, at low cost, for a Medicaid buy-in possibility. Providers, however, are very suspect of Medicaid because the reimbursement levels have been inadequate and stagnant. This approach also partially embraces the acceptability of a national health insurance program.

4. STATE RISK POOLS
(NAC Recommendation #12)

Many states have adopted risk-pools designed particularly for those that the private voluntary insurance market does not cover, for examples, disabled and people with serious medical conditions. While these programs have not worked ideally, this recommendation finds merit in continuing to explore the approach, so that an insurance outlet exists for those who are privately 'uninsurable'. Funding for these programs should, however, be on the broadest basis possible, for example, general tax revenue.

Once again supporting an approach for which the agency does not know the effectiveness of the program is troubling. Some studies have been undertaken to examine the productivity of risk pools, but results are not yet known. Clearly, to achieve universal coverage these individuals must be covered. To fund the costs, a broad basis of financial support only makes good sense to reduce the availability of cost shifting potential.

CONSOLIDATING NAC PROPOSALS FOR A COMPREHENSIVE SBA INITIATIVE

The individual recommendations presented here are generally not new in fact they have been discussed by many groups, and in many settings. One at a time they would have
little impact on the cost of health coverage to small business or the incidence of small employer health insurance coverage. Further, as stated earlier, an approach which integrates and requires participation of all the sectors of the health care market is ideal. What follows is the germination of a proposal which combines and packages many of these ideas into a new form, which taken together can be a program identifiable as an SBA plan, and hopefully, can be legislated.

The essence of the proposal is to create a trade-off, and incentive for the provision of small employer health insurance coverage. Costs must be reduced, incidence of coverage must be increased, providers must be controlled for price and utilization stability, state enforcement of insurance must be maintained, and new expectations of users must be formed.

Building on Administrator Engeleiter's articulate support for reduced coverage policies, and to level the playing field between large and small employers, the key provision to promote development of "no-frills" health insurance policies is for the Federal government to offer the ERISA pre-emption of state mandates to 'QUALIFIED HEALTH INSURANCE' plans. Such a proposition would require the amendment of ERISA. In return for a Federal release from state mandates and the subsequent development of "no-frills" coverage, the qualifying insurance coverage would be required to satisfy certain minimum standards. These minimum standards are the opportunity to shape the nature of the insurance coverage, to assure that the incidence of employer purchased health insurance increases.

Thus, this proposal attempts to achieve the following goals:

[1] increase the incidence of employer sponsored health insurance, principally in the small employer segment through the lower cost associated with "no-frills" coverage,

[2] increase the stability of health insurance through the adoption of underwriting, contract, and pricing concessions established in the minimum standards,

[3] involve the employee segment through the requirement of deductibles and copayments in the qualifying plan design,

and

[4] involve the provider segment through the requirement of managed care provisions in the qualifying plan design.

Such an approach has historical precedents. Self-employed business owners were provided special 'qualification' in the Keogh legislation for retirement income benefits. Thus, under Keogh plans self-employed business owners were given tax benefits comparable with large corporations, so that retirement income plans increase in number.

The method of using Federal standards to achieve policy goals has been utilized by the Baucus Amendment, and was also suggested by Senator Durenberger for the small employer
health market. Durenberger's tactic was to use IRS tax penalties, which tend to increase costs and provides no incentive for the 'no-frills' coverage. Durenberger's approach is geared to target the insurance industry, rather than gaining concessions from all health care sectors.

The authorization to write policies without regard to individual state mandated benefits should be a tremendous incentive for the trust and insurance business to develop new coverages. This approach should increase competition for small business health insurance by setting the markets free to seek new business with new products. By incorporating the HIAA and NAIC initiatives as specific provisions of the minimum Federal standards, these new policies would cost less, be available to more entities, be more stable in cost and availability, and would de facto speed up the process for adoption of health insurance reforms. By using those specific proposals, the support of the insurance industry could also be leveraged.

The administration of this proposal need not be determined at this point, although some options remain which can be discussed. First, ERISA has two administrative components: [1] at the Department of Labor which collects and monitors disclosure of employee benefits subject to ERISA, and [2] at the Internal Revenue Service, which in fact, 'qualifies' retirement income plans for tax purposes. One aspect regarding administration of this proposal is strongly recommended: standards should be determined and communicated at the Federal level, while enforcement and compliance should be established at the state level with insurance regulators. That enforcement approach uses the best, most experienced group, and avoids costly duplication in the Federal system.

Since the Department of Labor (DOL) handles other employee benefits disclosures under ERISA, DOL is a likely agency to look to for this program. On the other hand, if DOL is not politically feasible, SBA itself could be used as the Federal agency to qualify plans. Of course, if SBA is involved the program would have to be limited to small businesses.

The definition of a 'Qualified' plan is where the trade-offs are made. First, a minimum benefits plan would be determined. The plan would incorporate deductibles and copayments, dependent coverage, minimum employer contributions, requirements for the portability requirements suggested by HIAA, prohibit certain underwriting practices, and would require certain managed care program components. Thus through the development of the qualification package, all of the sectors of the health care market bring something to the table: government brings ERISA pre-emption, insurers make underwriting and contract concessions, providers are required to abide by stringent managed care provisions, employees pay part of the cost and monitor the providers more aggressively, and employers are encouraged to purchase and maintain health coverage for their employees and dependents.

Most of the NAC proposals could be rolled into this approach. For example, qualified plans could also be offered tax full deductibility. Such a provision would certainly increase the cost of the plan to the Treasury. Yet, the specific provisions of such an approach need more study, development and refinement. What is clear is that the structure outlined here has been used (Keogh and Baucus) and would incorporate a coordinated effort to achieve a decrease in the number of the uninsured, and reduce the problems of small business.