PROGRAMS TO IMPROVE HEALTH INSURANCE ACCESS FOR SMALL BUSINESS – WHAT WORKS AND WHAT DOESN'T

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PROJECT DIRECTOR: ZACHARY DYCKMAN, Ph.D.
PREPARED BY: ZACHARY DYCKMAN, Ph.D.
JOANNA BURNETTE

PREPARED BY:
CENTER FOR HEALTH POLICY STUDIES
9700 PATUXENT WOODS DRIVE
SUITE 100
COLUMBIA, MARYLAND 21046

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EXECUTIVE SUMMARY

Small businesses face substantial cost and other barriers in obtaining health insurance coverage for their employees. An analysis of Current Population Survey data indicates that 28 percent of workers aged 18-64 who are employed by firms with fewer than 25 employees had no health insurance coverage in 1989, compared to 8 percent for firms with 1,000 or more employees.

Over the past several years, programs have been implemented by state governments, community-based organizations, private health insurers and others to improve small businesses' access to health insurance coverage. The primary purpose of this report is to identify and review the characteristics of programs which have been successful or show significant promise of success in expanding health insurance coverage for small businesses. These programs include efforts to improve information available to employers regarding insurance options, elimination of mandated benefits requirements for policies sold to small businesses, use of significant cost sharing, and provider discounts to reduce premium rates, group purchasing arrangements, use of managed care programs, restructuring insurance industry practices relating to underwriting practices and others. A review of these programs' characteristics and performance should help in the design of other program initiatives and the development of appropriate public policy which will be most effective in removing barriers to health insurance coverage for small businesses.

NATURE AND DIMENSIONS OF THE HEALTH INSURANCE ACCESS PROBLEM

Several recent studies have identified the primary reasons why small businesses do not provide insurance coverage for their employees. The most frequently cited reasons are:

- Insurance premium rates are too high.
- Employees do not need insurance; many employees have insurance through another employed family member.
- High employee turnover makes insurance coverage impractical.
- Employees do not want health insurance if its being offered results in lower wages, particularly young workers who do not expect to incur substantial medical costs.
- The firm cannot find an acceptable plan.
- The firm or some of its employees cannot qualify for coverage -- because it is in a "high-risk" industry, because of preexisting medical conditions of employees or dependents, or for other reasons.
The high cost of health insurance has been consistently identified as the most important reason for small firms not providing health insurance for their employees. High health care costs is a significant problem for employers of all sizes. However, a number of factors exist which exacerbate the cost problem for small businesses. These include:

- Higher insurance administrative costs -- approximately 30 percent for firms with 25 or fewer employees compared to less than ten percent for firms with 1,000 or more employees.
- Lack of insurance expertise and bargaining power to negotiate favorable premium rates and benefit program characteristics with carriers.
- Perception by insurance carriers that small firms are poorer risks than large firms.
- Health insurance costs being a larger proportion of total labor costs for small firms than for large firms, because small firms use lower wage employees.
- Benefits of self-insurance generally not being available to small firms (e.g., exemption from state-mandated benefits, exemption from state premium taxes, and improved cash flow).

Additional access problems relate to availability of insurance coverage. Many private health insurers do not sell to small firms in identified "high risk" industries or to firms with one or more employees with preexisting health care problems.

PROGRAMS TO IMPROVE INSURANCE ACCESS FOR SMALL BUSINESSES

A total of 27 programs have been reviewed in this project. These are listed in Exhibit 1. The programs reviewed include those funded by the Robert Wood Johnson (RWJ) Foundation as part of its Health Care for the Uninsured Program, state legislative initiatives, products specifically designed for uninsured small businesses developed by Blue Cross and Blue Shield plans, programs implemented through trade associations, and model legislation to improve access developed by the National Association of Insurance Commissioners (NAIC). These programs are voluntary in that they were not required to be performed as a result of government enacted laws or regulations. However, for a sizeable proportion of these initiatives, state legislation was enacted to remove existing regulatory or legal barriers to their implementation, e.g., the elimination of mandated benefits for small businesses. The primary findings from the review and assessment of the 27 programs are included in the body of the report. Case studies of each program are provided in the Appendix.
EXHIBIT 1

PROGRAMS TO IMPROVE HEALTH INSURANCE ACCESS
FOR SMALL BUSINESSES

-CASE STUDIES-

PROGRAMS SPONSORED BY THE ROBERT WOOD JOHNSON FOUNDATION

1. Arizona Health Care Group
2. Bay Area Health Task Force
3. Washington Basic Health Plan (Health Systems Resources)
4. MedTrust-Tennessee Primary Care Network
5. Michigan One-Third Share Plan
6. Florida Health Access Corporation
7. Shared Cost Option for Private Employers (Denver)
8. MaineCare
9. Alabama BasicCare
10. Utah Community Health Plan
11. Wisconsin Small Employer Health Insurance Maximization Project

PROGRAMS SPONSORED BY STATE GOVERNMENTS

12. Rhode Island
13. Virginia
14. Missouri
15. Florida
16. Kentucky
17. Kansas
18. Illinois
19. Washington

INDUSTRY-SPONSORED PROGRAMS

20. The Construction Industry
21. The Retail Trade Industry

OTHER PROGRAMS

22. Blue Cross and Blue Shield of Oregon-Oregon Option
23. Blue Cross and Blue Shield of Oklahoma-Basic
24. National Association of Insurance Commissioners Model Act
25. Community Health Plan-New York State
26. Health Insurance Plan-New York State
27. Council of Smaller Enterprises (COSE)
OVERVIEW OF LESSONS LEARNED IN THE PROJECT

1) High cost of coverage is the major barrier for most small businesses currently without health insurance coverage. Insurance premiums for small businesses are higher than for large firms, because of substantially higher marketing and administrative costs. Even where these additional costs have been eliminated (as some programs reviewed in this study have done), most small businesses without health insurance coverage have not purchased coverage. Based on an evaluation of case studies findings, significant insurance premium subsidies may be required in order for a substantial portion of small businesses currently without insurance to provide coverage for their employees.

2) Successful program initiatives to improve small business access to health care tend to have several characteristics in common. These are:
- attractive benefit designs which are not substantially different from "typical" employee health benefit program designs
- managed care and lower than prevailing provider payment rates
- aggressive, creative and opportunistic marketing
- relatively low employer premium rates
- substantial community support.

Most of the program initiatives examined which did not include all of the program characteristics cited above did not achieve enrollment which even approached their enrollment goals. Each of these program functions is discussed briefly below.

Attractive Benefit Designs. Several programs have used benefit designs with very high deductibles or coinsurance rates (e.g., $1,000 per person; 50% coinsurance), or which significantly limit benefits (e.g., 21 days of hospital care or six physician office visits). Generally, these products have sold very poorly. Small businesses have not wanted a stripped down policy at a stripped down price; they have wanted a fully equipped policy at a stripped down price. Program administrators have found that most small businesses have not considered benefit designs which are markedly different than those typically offered by employers.

Managed Care - Low Provider Payment Rates. Virtually all of the successful programs use aggressive managed care, provided through health maintenance organization (HMO) or preferred provider organization (PPO) networks, to reduce claims cost. Most of the HMO and PPO programs have negotiated discounted payment rates with providers. The combined use of managed care and reduced payment rates has resulted in lower claims cost and lower insurance premiums than under indemnity insurance arrangements. The evaluation of case studies experience indicates that programs which use very limited provider networks which serve primarily the Medicaid covered and uninsured populations, have in most cases experienced difficulty in enrolling small businesses because of perceived unattractiveness or "second class" status of their provider networks.
Aggressive, Creative and Opportunistic Marketing. Most people involved in marketing health insurance to small business among the programs reviewed in this study have found it difficult, time consuming and frustrating. Private health insurers which sell to groups of varying sizes find marketing costs per enrollee to be considerably more costly for small businesses than for medium and large businesses. Successful marketing approaches used for small businesses generally involve a high degree of personal and organizational commitment to the marketing effort; the creativity and flexibility to tailor the marketing techniques used to the targeted audience; the use of local print and broadcast media for free publicity for the program; appearances before local industry and chamber of commerce groups and inclusion of program descriptions in their newsletters; and a substantial degree of patience. In some environments, personal visits (after program name recognition has been achieved) have been used successfully. Most small businesses, lacking the familiarity with health insurance concepts and administrative requirements possessed by personnel department staff of large firms, require more education-instructional time than do large firms.

Low Premium Rates. Virtually all of the RWJ programs have premium rates which are at least 20 percent and as much as 50 percent lower than are available to most small businesses in the area. The low premium rates are made possible by a combination of some or all of the following: provider discounts; managed care; limited benefits; and premium subsidies. In some cases, efficiencies have been achieved in marketing and administrative functions which have resulted in lower premium costs for small businesses. A majority of programs have experienced utilization which is at or below projected experience. This has enabled some programs to avoid or limit premium increases, despite administrative costs generally being above projected levels.

Substantial Community Support. The more successful programs to provide low cost coverage to small businesses have received widespread support from within their communities, including public officials, voluntary organizations, media groups and private industry groups. This support has enabled the programs to obtain favorable exposure and publicity for their programs which has assisted the marketing effort.

One of the most successful among industry initiatives is a Chamber of Commerce-sponsored effort operating in Cleveland, Ohio, called the Council of Smaller Enterprises (COSE). It has widespread community support. A subsidiary of COSE serves as an intermediary between COSE and several insurance carriers, negotiates contracts and premiums, and provides administrative services for the program. COSE insurance programs’ enrollees experienced only a 34.5 percent cumulative increase in health insurance premiums between 1984 and 1990, compared with a 154 percent increase experienced by small groups with commercial insurance in the same market area. As of September, 1991, over 8,000 companies were enrolled in a COSE-sponsored health insurance plan (over 80 percent of COSE members), many of which would be unable to obtain coverage from other sources.

Elimination of state mandated benefits requirements has had minimal impact to date on expansion of coverage to small businesses. Within the past three years, a number of states have eliminated or reduced mandated benefit requirements for health insurance programs which are offered to small
businesses. These "barebones" or "stripped down" benefit plans have not succeeded in significantly increasing enrollment of small businesses, for the following reasons:

- Often, the reduction in mandate requirements is only partial, thus having a small effect on expected claims cost and premiums.

- State legislatures have sometimes restricted access to the reduced mandate programs to employers which have not offered health insurance over some recent period, thus significantly restricting the potential market for these plans.

- Private insurers generally have not effectively marketed the "barebones" products. In some cases they have devoted very limited marketing resources to the new product ventures; rarely have they displayed the commitment or the aggressiveness in marketing the new products as has been used by the more successful, public or community-based programs reviewed in this report. The evidence from this study indicates that small businesses are a "tough sell" and that private insurers have not used the appropriate combination of commitment, resources, marketing flexibility, pricing and benefit design to successfully market their products.

- There is limited experience under the reduced mandate laws and several private health insurers are modifying their products and their strategies to increase enrollment for the new products.

4) Based on an evaluation of the case studies experience, there is evidence that most employers currently not providing health insurance to their employees have not purchased insurance unless premiums were substantially below prevailing premium rates. The lack of demand for insurance among these firms is caused by a number of factors, including low profit levels, some employees already having insurance coverage, lack of perceived need for coverage in order to attract employees and the relatively high cost of coverage relative to total labor costs (small firms use a disproportionately large number of low income workers).

5) Rapid adoption by states of the NAIC Model Legislation can help eliminate some of the more egregious insurance industry practices affecting small businesses. These include extremely large premium increases, failure to provide coverage for groups with one or more individuals with high claims cost and very large premium differentials for firms in "high risk" industries.
The review of private and public sector initiatives to improve small businesses access to health insurance coverage has identified a number of programs which work: i.e., have achieved significant enrollment among firms which previously did not provide insurance coverage for their employees. The descriptions of their program features in the body of the report and in the attached case studies can help in the design of expanded initiatives at the local, state, and possibly national levels to facilitate increased insurance coverage among small businesses.
1. INTRODUCTION
1. INTRODUCTION

1.1 BACKGROUND AND OBJECTIVES

Approximately 34 million Americans have no health insurance coverage. Of these, 85 percent are employees or dependents of employed persons. One half of the uninsured workers are self-employed or are employed in firms with 25 or fewer workers. Thus, slightly less than half of the 34 million Americans who are uninsured are employees of small business (including self-employed) and their dependents. Firms with 25 or fewer employees are approximately three times as likely not to provide health insurance coverage as firms with 100 or more employees (EBRI, 1991). It is fair to say, therefore, that the problem of lack of health insurance coverage in the United States is, to a large degree, the problem of lack of coverage by small businesses.

While much is known regarding the difficulties of small businesses in obtaining access to health insurances at affordable rates, relatively little is known about which public and/or private programs are successful in assisting small businesses obtain health insurance coverage and which are not. The primary purpose of this report is to identify and review the characteristics of programs which have been successful or show significant promise of success of improving small business access to health insurance coverage for their employees. These programs include those developed by state governments, by private insurers, by industry groups and those supported through a major national demonstration program supported by the Robert Wood Johnson Foundation. While the purpose of all of the programs examined in this report are to remove barriers and improve small employer access to health insurance coverage, the techniques used vary widely. They include efforts to improve information available to employees regarding insurance options, removing of mandated benefits requirements for policies sold to small businesses, use of significant cost sharing, obtaining premium subsidies from government or Foundation sources, obtaining significant provider discounts, group purchasing arrangements, use of managed care programs, restructuring insurance underwriting practices and others. For some of the programs examined, operational experience exists which can be evaluated (e.g., enrollment, premium levels and claims cost experience), while for others, the programs are just now being implemented and performance data are not yet available for evaluation. While we are seeking information on successful programs, several programs are described which have not achieved their enrollment or other program goals. They are included because lessons can be learned from mistakes. An examination of their program characteristics and experience provides useful lessons on what to avoid, and/or what program design or administrative changes can be made to an inherently attractive program model which would improve prospects for success.

Before the program experience is described in subsequent chapters, we provide an abbreviated description on the health insurance access problem for small businesses, its dimensions and causes.
Over the past few years, several studies have documented the dimensions of the health insurance access problem for small businesses. One study, which analyzed results of a 1986 Small Business Administration (SBA) survey of firms in different size categories, found that health insurance coverage of employees is a direct function of firm size. Only 46 percent of the 3.8 million U.S. firms with under 10 workers offer health insurance, compared to practically 100 percent of the 15,000 U.S. firms with 500 or more workers. Seventy-eight percent of firms with 10-24 workers, 92 percent of firms with 25-99 workers and 98 percent of firms with 100-499 workers offer health plans to some or all of their workers (ICF, 1987). A more recent study which analyzed 1990 Current Population Survey (CPS) data for 1989 reports a similar pattern of the likelihood of employer-sponsored insurance coverage being substantially lower for small firms than for moderate or large size firms (EBRI, 1991). This is shown in Exhibit 1-1.

The CPS survey data indicate that the percentage of employees without health insurance coverage is relatively high in construction (29.3%) and retail trade (22.2%), and relatively low in government (6.6%), finance, insurance and real estate (8.2%), and manufacturing (10.3%). Of the estimated 34.4 million non-elderly persons who were uninsured in 1989, 54.4 percent were in families where the head of the family was employed full-time throughout the year. For an additional 31.1 percent the head of the family had some employment during the year.

In addition to information on characteristics of employers and employees without health insurance coverage, considerable information exists regarding why employers, particularly small businesses, do not provide health insurance coverage to their employees. The results of several studies confirm that the primary reason why small businesses do not offer health insurance coverage is high premium cost, especially relative to their limited financial resources (ICF, 1987; NFIB, 1990; ALPHA Center, 1990). In a 1990 small business survey, 65 percent of employers without a health insurance plan mentioned high premiums as the reason for not sponsoring a plan (NFIB, 1990). Additional reasons reported by surveyed employers are:

- employees do not need insurance; many employees have insurance through another employed family member
- high employee turnover makes insurance coverage impractical
- employees do not want health insurance if its being offered results in lower wages, particularly young workers who do not expect to incur substantial medical costs
- the firm cannot find an acceptable plan
PERCENTAGE OF EMPLOYEES AGED 18-64 WITHOUT HEALTH INSURANCE COVERAGE, BY FIRM SIZE, 1989

the firm or some of its employees cannot qualify for coverage, because it is in a "high-risk" industry, because of preexisting medical conditions of employees or dependents, or for other reasons.

National survey data indicate that small businesses employ a larger proportion of workers under age 25, aged workers and part-time workers than moderate and large size firms (Berkeley Planning, 1988). Each of these categories of workers are less likely to require and/or to value health insurance over increased wages than full time employees, aged 25 to 64.

In order to identify and evaluate possible solutions to the health insurance access problem for small businesses, it is important to develop a clear understanding of the problem. As indicated above, the high cost of insurance has been identified as the primary barrier of small businesses to offer health insurance to their employees. In evaluating alternative programs designed to reduce premium costs for small businesses, it may be useful to group factors which are responsible for high premium costs into two categories:

- factors responsible for overall health care cost inflation
- cost factors uniquely or primarily affecting small business purchasers of health insurance.

These are each elaborated upon below.

Factors Responsible for Overall Health Care Cost Inflation

High employee health care costs has been and continues to be a significant problem for employers of all sizes. While there is no single authoritative figure on average percent change in per employee costs over the past several years, estimates of annual increases in per employee health benefit costs have ranged from 10 percent to over 20 percent, well in excess of increases in overall inflation, per capita Gross National Product on corporate profits. In 1989, the average monthly premium for a traditional health benefit program was $119 for employee only coverage and $268 for family coverage. HMO and PPO premiums were comparable (HIAA, 1990). The Health Care Financing Administration estimates that business health spending was 94.2 percent of after-tax corporate profits in 1987. Health spending is likely to have substantially exceeded profits in 1990 and 1991, as a result of more rapid growth in health benefit costs than profits over the past several years. Among the factors identified in the health economics literature as being responsible for health care cost increases in excess of general inflation are:

- rapid growth in use of high cost-high technology care
- lack of either competitive market conditions or effective health planning-health care cost regulation which may help constrain cost increases
• prevalence of health insurance which precludes patients from balancing marginal value of alternative medical care services with their marginal cost

• excess or redundant capacity for many services characterized by high fixed cost (e.g. imaging centers, transplant centers, coronary surgery units, etc.)

• excess supply of physicians in metropolitan areas who generate increased health care spending

• malpractice threat which encourages excessive diagnostic testing

• aggressive provider billing and practice patterns to maximize income (e.g. physician unbundling of procedures, referrals to physician owned diagnostic centers, etc.)

• physician training which emphasizes use of sophisticated, high-tech, high-cost diagnostic testing.

It is important to note that some of these factors contribute to most Americans (those with adequate health insurance) having access to high quality care, perhaps the best in the world. But these factors also result in the United States experiencing the highest level of health care costs in the world, despite having approximately 13 percent of our population without health insurance coverage. The prevailing health care environment along with the absence of either strong market focuses or an effective health care planning-regulatory framework affects the health care cost experience of employers in all size categories. However, as discussed in the following chapter, large firms generally have more resources and tools at their disposal to seek to control costs than smaller firms.

Factors Affecting Primarily Small Businesses

Within the overall environment of high and sharply rising health care costs, there are a number of factors which exclusively or primarily affect small businesses. These are discussed briefly below.

Higher insurance administrative cost. Health insurance administrative costs vary by group size. A Congressional Research Service study found that smaller businesses pay a much larger portion of their premium for administrative costs than do larger businesses. This is shown in Exhibit 1-2. Administrative costs for small businesses (25 or fewer employees) are approximately 30 percent, compared to less than ten percent for firms with 1,000 or more employees. These additional costs result in substantially higher premiums for small businesses, for comparable benefit plans.
Exhibit 1-2

Insurance Company Administrative Expenses as a Percentage of Incurred Claims by Firm Size

<table>
<thead>
<tr>
<th>Number of employees</th>
<th>General ¹</th>
<th>Profit &amp; Risk</th>
<th>Direct Marketing Expense</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 4</td>
<td>23.1 %</td>
<td>8.5 %</td>
<td>8.4 %</td>
<td>40.0 %</td>
</tr>
<tr>
<td>5 to 9</td>
<td>21.0</td>
<td>8.0</td>
<td>6.0</td>
<td>35.0</td>
</tr>
<tr>
<td>10 to 19</td>
<td>17.5</td>
<td>7.5</td>
<td>5.0</td>
<td>30.0</td>
</tr>
<tr>
<td>20 to 49</td>
<td>14.9</td>
<td>6.8</td>
<td>3.3</td>
<td>25.0</td>
</tr>
<tr>
<td>50 to 99</td>
<td>10.0</td>
<td>6.0</td>
<td>2.0</td>
<td>18.0</td>
</tr>
<tr>
<td>100 to 499</td>
<td>8.9</td>
<td>5.5</td>
<td>1.6</td>
<td>16.0</td>
</tr>
<tr>
<td>500 to 2,499</td>
<td>7.8</td>
<td>3.5</td>
<td>0.7</td>
<td>12.0</td>
</tr>
<tr>
<td>2,500 to 9,999</td>
<td>5.9</td>
<td>1.8</td>
<td>0.3</td>
<td>8.0</td>
</tr>
<tr>
<td>10,000 or more</td>
<td>4.3</td>
<td>1.1</td>
<td>0.1</td>
<td>5.5</td>
</tr>
</tbody>
</table>


¹Includes claims processing, general administration, interest credit, and premium taxes.

Lack of insurance expertise and bargaining power. Small firms generally have less expertise than larger firms regarding benefit design and health insurance options. They also have less bargaining power with insurers in terms of negotiating price or benefit design. Some utilization review, provider discount and other cost containment programs available to larger accounts are often not available to small firms. Small firms (and most moderate sized firms as well) have neither the expertise nor market leverage to negotiate specified purchase arrangements with providers, as some large firms have done.

Small firms perceived as greater risks. Small firms, especially firms with fewer than ten employees, are perceived by insurance carriers to be less stable than larger firms, generating concern about substantial employee turnover and premium collection problems. There is generally less competition for small group accounts and fewer products from which to choose.

Health insurance costs are a larger proportion of total labor costs. Small firms on average have lower wage employees than larger firms, so that health insurance premiums represent a larger proportion of total labor costs for small firms. Similarly, required employee premium contributions represent a larger portion of total income for employees of small firms than for employees of larger firms, causing a lesser proportion of employees of small firms to accept coverage for themselves and their dependents.

Benefits of self insurance not available. Between 1974 and 1990, the proportion of workers with employer-based health insurance who were covered under self insurance arrangement increased from 5 to 56 percent. Self insurance, which can result in premium tax savings and improved cash flow, is generally not feasible for small firms as it is for
larger firms. Self insured firms are exempt (through ERISA) from state mandated health insurance benefits which studies show add an average of 8-10 percent to health insurance claims cost.

In addition to the factors noted above, the decline in use of community rating has affected both the availability and cost of health insurance coverage in small firms. Insurance transfers risk of economic loss from an individual (or employer) to an insurer. The insurer is able to pool the risks of a large number of insured individuals and to predict the likely claims cost for the group as a whole. Under community rating, the premium is based on the average cost of the anticipated health care used by all enrollees in a particular broad-based group, defined by geographic area, industry, or other grouping category. Because a single premium is used (it may vary by age-sex category), companies with healthy employees subsidize the health care costs of companies with less healthy employees. Premium changes are based on claims cost experience for the entire community rated group. An individual firm’s premium is not increased if it has higher than average claims cost experience nor are premiums reduced if a company has relatively low claims cost. Thus, community rating allows small firms, even those with an employee or employees with high health care costs, to continue providing health insurance at the same price as all other firms in the group.

As the health insurance industry grew and matured in the 1950’s and 1960’s, many insurers increasingly based premiums for large groups and later for moderate sized groups primarily on their own claims experience, a practice called experience rating. Over time, commercial health insurers and some Blue Cross and Blue Shield plans narrowed the community rating categories to include only firms in selected industries with favorable claims experience. Now most insurers in most states routinely exclude firms in high risk industries for coverage. An examination of insurance training manuals for three large carriers in a recent American Hospital Association report revealed each had a list of 20-40 industry groups for which it would not generally write small group health insurance policies. Results of two small business surveys indicate that 12 to 16 percent of small businesses report insurance coverage could not be obtained (Hall, 1990 and ICF, 1987). Most insurers exclude from small group coverage individuals with potentially serious preexisting health problems (e.g., cancer, diabetes, high blood pressure, mental illness) or deny coverage to the entire group.

As a result of "cherry picking" among small groups by most health insurers, several Blue Cross and Blue Shield plans which traditionally have used community rating for small groups have had to substantially increase premiums under community rating contracts or to stop selling community rated products. Empire Blue Cross and Blue Shield, which has long used community rating for individuals and small groups, announced in August, 1991 that it intends to begin rating by claims history, location and other factors beginning in October, 1991 (New York Insurance Department press release, 1991). This announcement came soon after Empire Blue Cross and Blue Shield announced the termination of association group policies, because many of the better risks within the association groups were able to obtain lower premiums from other insurers, thus causing a deterioration in the association risk pools. Those covered under the association policies were given the option to enroll under existing small group and individual policies, generally at higher premium rates.
Pennsylvania Blue Cross and Blue Shield plans continue to use community rating for small groups. However, Blue Cross and Blue Shield plans in most other northeastern states where community rating had been common have abandoned the practice or are in the process of doing so. The use of medical underwriting and the exclusion of "high risk" groups from coverage by most health insurers has resulted in higher cost for many small businesses, and has prevented some firms from obtaining group coverage, regardless of cost.

Summarizing the discussion of factors responsible for high insurance costs for small businesses, the factors can be grouped into three categories:

1. Factors causing high health insurance costs for all sized groups
2. Factors causing higher costs exclusively or primarily for small businesses
3. Factors which directly cause high cost and/or lack of access to insurance coverage for identified "high risk" small businesses and indirectly for other small businesses as well.

1.3 OUTLINE OF REPORT

In the following chapter, we identify cost containment practices which are being successfully used by some large employers and which may be usefully employed by small businesses, either acting individually or in groups. In Chapter 3, we summarize findings from the review of 27 case studies of programs designed to improve small business access to health insurance coverage. These programs each address one or more of the cost and accessibility problems discussed above. The case studies are provided in the Appendix.
2. HEALTH CARE COST CONTAINMENT INITIATIVES
2. HEALTH CARE COST CONTAINMENT INITIATIVES

This chapter provides information on cost containment initiatives being used by large and moderate size by groups which may be suitable for implementation by (or for) small businesses. Large employers and health insurance carriers working in their behalf have implemented a wide range of programs designed to help control their health insurance costs. Some of these cost containment programs have proven to be successful; others have shown promise of success while still others are widely regarded as being ineffective and have been discarded, or are in the process of being discarded. In this section, we briefly describe the most successful and promising programs, and indicate their potential usefulness/applicability for small businesses. Also discussed is their current availability to small businesses.

2.1 MANAGED CARE INITIATIVES

The first category of cost containment programs considered are managed care initiatives. These include benefit plan provisions which provide improved coverage for services which are intended to replace more costly services (e.g., preadmission testing for inpatient hospital care); expanded utilization review activities, both prior to and subsequent to use of services; and use of limited provider networks, most commonly health maintenance organizations (HMO) and preferred provider organizations (PPO). Several of the most effective managed care programs are discussed briefly below. The primary source of information on current use of specific cost containment programs by moderate and large employers is a 1990 national survey of 900 employer-sponsored group medical plans conducted by the Wyatt company. Additional sources of information are a 1989 survey of employer health insurance plans conducted by the Health Insurance Association of America (HIAA) as well as findings from Center for Health Policy Studies (CHPS) research and evaluation activities conducted for approximately 30 private health insurers over the past three years in the areas of provider payment systems and utilization management activities.

Preadmission Certification

Preadmission certification programs require the patient or the admitting physician to call a special carrier number prior to a scheduled non-emergency hospital admission. Failure to notify the carrier of an impending admission results in a significant financial penalty to the patient and sometimes to the provider as well. The primary purpose of the preadmission certification is to prevent hospital admissions in cases where the required care can be provided in a less costly outpatient setting or where it may not be necessary at all. Based on information provided, the payor may approve the admission for coverage, request additional diagnostic information or deny coverage for the admission (subject to appeal). Many preadmission certification programs also typically assign (subject to subsequent review) a maximum number of approved days for the approved admissions.

Closely related to preadmission certification is concurrent stay review (CSR). The objective of CSR is to reduce inpatient hospital expenditures by monitoring patient length of
stay on a concurrent basis and denying coverage (after notification of patient and physician) for inpatient days which are not medically necessary.

Effectiveness and Prevalence. Preadmission certification is widely regarded as a basic component of a managed care program. Approximately 70 percent of group health benefit plans include a precertification of admission requirement (Wyatt, 1990). HIAA reports that 73 percent of employee health plans used preadmission certification in 1989, up from 65 percent in 1988 (HIAA, 1990). Precertification of admission is one of the few managed care activities for which there is widespread agreement that it is cost effective. Concurrent stay review is also widely used by health insurers and is generally regarded as cost effective. However, its importance has diminished somewhat because: 1) HMO, PPO, and Blue Cross and Blue Shield plans are increasingly using per-case payment approaches for inpatient care which places most of the risk of lengthy stays on the hospital itself; and 2) length-of-stay has declined considerably over the past five years, thereby reducing potential savings from payor practices designed to reduce excessive stays.

Applicability/Usefulness for Small Business. Both preadmission certification and CSR programs can be effectively used under health insurance programs for small businesses. These managed care activities are commonly included in health benefit plans offered to small businesses in most localities.

Individual Case Management

Under individual case management (ICM) programs, health insurers take a direct and active role in assisting the patient and/or the patient's family obtain required medical care in an appropriate setting. Under most ICM programs, benefits can be provided for medical care services and products which are generally not covered under the health insurance contract, if they are appropriate for the specific case and they result in lower claims cost (e.g., extended home health care or durable medical equipment purchases as a substitute for inpatient care). Individual case management is often used for serious accident cases which require extended inpatient care and rehabilitative care, and for patients with serious long term illnesses. Under most programs, use of ICM services is voluntary; the patient may elect to use benefits offered under the group health benefit program rather than the more flexible benefits offered under the ICM program.

Effectiveness and Prevalence. Individual case management is widely regarded as a win-win program. It benefits the payor by reducing costly and unnecessary inpatient care. It benefits the patient by providing case manager assistance in obtaining appropriate services and greater flexibility regarding medical care setting. Use of ICM has expanded rapidly and is now included in approximately 70 percent of employer sponsored health benefits programs according to the Wyatt survey findings. The HIAA survey reports growth in its use among health benefit plans from 51 percent in 1988 to 59 percent one year later (HIAA, 1990).

Applicability/Usefulness for Small Business. Individual case management can be effectively used under health insurance programs offered by small businesses. While inclusion of ICM under small business insurance programs has been growing, it is not as prevalent as under
health insurance programs offered by large and moderate size firms. One possible barrier to ICM being used optimally by small businesses is the generally less effective employee communication regarding appropriate use of health benefit programs in small firms than in large firms. A greater proportion of small business compared to large business employees may not be aware of the ICM program and fail to use ICM services at an early stage of medical care for a serious injury or medical condition. However, health insurers are increasingly using providers, hospital discharge planners or their own UR staff to identify high cost cases where ICM services may be useful, so that lack of request for ICM services by the patient or the patient’s family is now less important.

Mental Health - Substance Abuse Managed Care

Within the past three years, there has been substantial growth in use of aggressive managed care for mental health and substance abuse services. Employee benefit costs for these services are typically increasing 20-40 percent per year. The rapid cost inflation has been attributed to increased incident of substance abuse problems, greater acceptance by the public of use of mental health services and aggressive marketing by mental health and substance abuse providers. Managed care activities used for mental health and substance abuse services include aggressive precertification of admission - length of stay review for both inpatient and outpatient treatment programs, preapproval requirements for mental health visits beyond a fixed number and use of HMO or PPO provider networks. Many private insurers contract with mental health and substance abuse specialty firms for managed care and/or service delivery because of the specialized expertise required to effectively manage care and control claims cost for these services.

Effectiveness/Prevalence. Many payors which have implemented managed care programs for mental health and substance abuse services report significant savings in claims cost and in some cases, sizeable savings from previous year levels. Much of the savings results from using less costly settings and treatment approaches than occurred under the non-managed care program.

Large employers are more likely than moderate size or small employers to use managed care for mental health and substance abuse services. In 1989-90, the Wyatt employer survey reports that 43 percent of firms with 5,000 or more employees used managed care programs, compared to approximately 25 percent for firms with 251 - 1,000 employees and 18 percent for firms with 250 employees or fewer.

Applicability/Usefulness for Small Business. There appear to be no significant barriers to effective use of managed care for mental health and substance abuse services by small businesses. While a number of very large employers contract directly with specialty managed care firms, many health insurers offer managed care as a benefit option under their group contracts.

Managed care for mental health and substance abuse services may be less attractive for small businesses than for larger firms for the following reasons:
- Small firms have relatively high labor turnover -- small firms may feel less of a commitment to provide costly mental health and substance abuse benefits than larger firms with a more stable work force.

- A number of states have eliminated mandated benefits for mental health and substance abuse services for small businesses (See Chapter 3).

- Health insurers may refuse to renew coverage for small firms which employ workers who use substance abuse treatment or substantial mental health services, requiring the firm to exclude these employees from coverage or to discharge them in order to retain their coverage. (See Chapter 3 for NAIC model legislation which prohibits this practice).

**HMO and PPO Programs**

Well designed, well managed HMO and PPO programs combine aggressive managed care with provider discounts. Many incorporate "gatekeeper" roles for primary care physicians (PCP) under which the PCP is given the responsibility, often with a financial incentive, to avoid unnecessary specialty referrals, diagnostic tests and hospital admissions. Under an HMO, benefits are not provided for services outside of the HMO network (unless the enrollee requires emergency care or is in a location not served by the HMO). Under a PPO, enrollees are provided with a financial incentive (higher benefits) to use PPO network providers. Relatively new, so called "point-of-service" products have been used with both HMO and PPO networks. They blur the distinction between and HMO and PPO, but essentially operate as PPOs.

**Effectiveness and prevalence.** Many in the health insurance industry do not regard non-HMO, non-PPO health benefit programs as providing managed care, even if the programs use preadmission certification, individual case management and other managed care tools. In their view, non-HMO and non-PPO products lack a network of providers who are contractually committed to managed care. While not all HMOs and PPOs provide cost-effective medical care, they are almost always less costly for comparative benefits than traditional benefit programs. This is due in part to their use of provider discounts. However, in some cases HMO and PPO programs, which generally use small copayments rather than coinsurance and deductibles, are no less costly than traditional benefit programs which do not provide benefits for all of the preventive health services generally covered by HMOs and PPOs. The HIAA survey reports average monthly premiums for family coverage. For traditional programs, HMO plans and PPO plans vary within the very narrow range of $261 to $272 in 1989 (HIAA, 1990).

In considering the prevalence of use of HMO and PPO programs, one must consider how they are sold and how they are offered to employees. HMOs are in most cases offered as an employee option, along with traditional benefit and/or PPO programs. PPO programs may be sold on a group-wide basis or offered as an employee option along with traditional and/or HMO programs. While HMO enrollment growth has moderated in recent
years, approximately 55 percent of employers offer an HMO option. Among firms with 5,000 or more employees, 90 percent offer HMOs while 42 percent of firms with fewer than 250 employees offer HMOs (Wyatt, 1990).

Use of PPO programs has increased substantially over the past several years. Between 1986 and 1989, the proportion of employers in the Wyatt survey offering PPOs increased from 14 percent to 33 percent. While larger firms are more likely to use PPOs than small firms, differences in PPO use rates among employer size categories have diminished over the past several years.

Applicability/Usefulness for Small Business. PPO programs can be effectively used by small businesses. However, firms with 25 or fewer employees may have to enroll all of their covered employees into the PPO (or into other programs offered by the carrier offering the PPO) because most private health insurers will not offer to enroll small groups which also use a competing PPO product. In many markets, PPO programs are aggressively marketed to small groups on a group-wide basis, i.e., other benefit programs are not offered to individual members of the group.

Small group use of HMOs is more problematic because employers are reluctant to offer only an HMO program to employees and many insurers will not sell to a small group if a sizeable proportion of its employees enroll in competing HMOs. Many firms allow individuals to opt out of the firm's health insurance program and to enroll as individuals (non-group contract) in an HMO. According to insurance industry sources, small firms sometimes encourage employees with medical histories to enroll in an HMO so that the firm can obtain health insurance coverage for its other employees.

Federally qualified HMOs offer enrollment to all applicants at demographically determined rates and may not exclude individuals based on medical history. However, non-Federally qualified HMOs in some states may exclude individuals and/or may use differential rates based on group and/or individual characteristics and expected claims cost experience.

There are numerous other managed care techniques being used under employee health benefit plans. These include second surgical opinion programs (of doubtful cost effectiveness); utilization review edits to identify unnecessary services, improperly coded services, and services not covered under the contract (generally cost-effective); provider audits to detect fraud and abuse; and others. In most cases, these cost containment tools are equally as effective for small employers as for large employers. They generally become available for small firms either simultaneously or shortly after they are implemented in benefit plans for large firms.

2.2 OTHER EMPLOYER STRATEGIES TO CONTAIN COST

In addition to using aggressive managed care techniques, large firms have used other approaches to seek to control their employee health benefit costs. Several of these approaches are described below.
Increase Cost Sharing Requirements

Employers have been increasing the size of benefit plan deductibles in an effort to reduce their claims cost. Deductibles lower health insurance costs in two ways. First, they transfer medical care expenditures from the plan to the employee. Second, they decrease demand for medical services because employees and their dependents are exposed to the full cost of medical care for amounts below the deductible.

The coinsurance rate is the proportion of allowed charges above the deductible and below an out-of-pocket maximum, which is the responsibility of the employee under most benefit plans. The most commonly used coinsurance rate is 20 percent. Like deductibles, coinsurance reduces claims cost, both by transferring some cost to employees and discouraging the use of some services.

Effectiveness and Prevalence. The role of cost sharing in reducing claims cost, in the two ways noted above, is well established. Deductibles and coinsurance are used under most traditional (non network-based) benefit plans throughout the United States, with the exception of several northeastern states in which Blue Cross and Blue Shield plans sell a substantial amount of basic surgical and hospital coverage (100 percent benefits) along with major medical policies which cover in-office care (with deductibles and coinsurance). The average size of deductibles has risen over the past several years. In 1984, more than 60 percent of traditional benefit plans used deductibles of $100 or less. By 1990, this percentage had declined to 43 percent (Wyatt, 1990). In 1990, 38 percent of employers used individual deductibles of $200 or more while 21 percent used family deductibles of $500 or more.

The coinsurance rate under most benefit plans has remained stable at 20 percent. However, use of basic plus major medical plans has declined while use of comprehensive plans has increased, thus effectively increasing the average coinsurance rate under all health benefit plans.

Applicability/Usefulness for Small Businesses. Increased cost sharing as a tool to decrease employee health benefit costs is equally effective for small firms as it is for large firms. Benefit plans with substantial cost sharing requirements are highly accessible to and are widely used by small firms in most market areas (Dyckman, 1991).

Self Insurance Arrangements

Virtually all large and moderate size employers are experience rated, i.e., their health insurance cost largely reflects their own group experience (plus insurance administrative costs). By changing administrative and contractual arrangements somewhat, employers can become "self-insured" or self-funded. As a result of the Federal Employee Retirement Income Security Act (ERISA), self-insured status exempts health benefit plans from state premium taxes and state-mandated benefits for specific services and specific providers.
Effectiveness and Prevalence. Self insurance generally results in savings of state premium
taxes which range from 2 to 3 percent in most states. Savings as a result of exemption from
state-mandated benefits are more variable and less quantifiable. Most employers tend to
provide coverage for the majority of mandated benefits in most states (e.g., home health,
substance abuse treatment, outpatient mental health visits) and for at least some of the
mandated providers (e.g., psychologists, chiropractors, independent nurse practitioners). For
some employers, savings may be as high as 7-8 percent; for others savings are minimal.
However, firms with employees in multiple states achieve some administrative cost savings
as a result of not having to tailor health benefit program benefits to each state’s distinct
mandated benefit requirements.

Use of self insurance has increased substantially in recent years. In 1990, over 70
percent of firms with more than 2,500 employees were self-insured. This rate compares to
approximately 60 percent for firms with 500-2,500 employees and 27 percent for firms with
250 or fewer employees.

Applicability/Usefulness for Small Business. It is not generally possible for firms with 25 or
fewer employees to become self-insured and thereby achieve exemption from state premium
taxes and state-mandated benefits. However, small businesses can join together into groups
to establish multiple employer trusts and other similar entities, for the purpose of establishing
self-insured employee health benefit plans for their members. These self-insured entities,
organized by industry (e.g., farm bureaus, home building firms) or location (local chambers
of commerce) are commonly used in most states. In addition to achieving exemption from
state insurance regulation, small businesses joining together to form a health insurance group
purchasing entity increase their bargaining power with carriers and also achieve reduced
insurance administrative costs. Most of the innovative health benefit programs described in
the following chapter involve small businesses being joined together to achieve greater
efficiencies and reduced premium rates compared to what could be obtained by each firm
acting independently.
3. REVIEW OF PROGRAMS TO IMPROVE INSURANCE ACCESS FOR SMALL BUSINESSES
3. REVIEW OF PROGRAMS TO IMPROVE INSURANCE ACCESS FOR SMALL BUSINESSES

3.1 Introduction

In this chapter, we describe the characteristics and performance of programs designed to improve access to health insurance for small businesses. A total of 27 programs have been reviewed in this project. The 27 programs are listed in Exhibit 3-1. Case studies were prepared for each of these programs and are included in the Appendix. The programs reviewed include those funded by the Robert Wood Johnson (RWJ) Foundation as part of its Health Care for the Uninsured Program, state legislative initiatives, products specifically designed for uninsured small businesses developed by Blue Cross and Blue Shield plans, programs implemented through trade associations, and model legislation to improve access developed by the National Association of Insurance Commissioners (NAIC).

The structure of this chapter is as follows. We begin with an overview of the methodology used to select the programs to be reviewed and to prepare the case studies. Following that are summaries of study findings, with separate summaries prepared for each of the categories of programs reviewed. The final section of this chapter is a discussion of the primary lessons learned from the case studies and implications for future efforts to improve small business access to health insurance coverage.

3.1.1 Overview of Methodology

Prior to identification of the case studies, an extensive literature review was conducted. Included among the items reviewed are reports and testimony prepared by health policy and research organizations with an interest in the health insurance access problem, previous research studies sponsored by the Small Business Administration (SBA), relevant articles in health industry and professional journals, and relevant news and feature articles in The Wall Street Journal, The Washington Post, and The New York Times. It was found that much more information is available concerning the nature and dimension of the health insurance problem among small businesses than on actual approaches to solving it.

Programs used as case studies were identified through a variety of channels. A substantial amount of information was obtained through the Alpha Center, which provides technical assistance for the initiatives sponsored by the Robert Wood Johnson Foundation Health Care for the Uninsured Program. Background information about each of the fifteen RWJ-funded initiatives in the program was provided as well as quarterly reports and other information. Eleven of the RWJ programs reached the enrollment phase and were selected for use as case studies.

A large volume of information was also obtained from Blue Cross and Blue Shield plans. A letter was sent to presidents of plans across the country requesting information on the nature and extent of the health insurance access problem in their area, and efforts being undertaken by organizations in their coverage areas to respond to the problem.
PROGRAMS TO IMPROVE HEALTH INSURANCE ACCESS
FOR SMALL BUSINESSES

-CASE STUDIES-

PROGRAMS SPONSORED BY THE ROBERT WOOD JOHNSON FOUNDATION

1. Arizona Health Care Group
2. Bay Area Health Task Force
3. Washington Basic Health Plan (Health Systems Resources)
4. MedTrust-Tennessee Primary Care Network
5. Michigan One-Third Share Plan
6. Florida Health Access Corporation
7. Shared Cost Option for Private Employers (Denver)
8. MaineCare
9. Alabama BasicCare
10. Utah Community Health Plan
11. Wisconsin Small Employer Health Insurance Maximization Project

PROGRAMS SPONSORED BY STATE GOVERNMENTS

12. Rhode Island
13. Virginia
14. Missouri
15. Florida
16. Kentucky
17. Kansas
18. Illinois
19. Washington

INDUSTRY-SPONSORED PROGRAMS

20. The Construction Industry
21. The Retail Trade Industry

OTHER PROGRAMS

22. Blue Cross and Blue Shield of Oregon-Oregon Option
23. Blue Cross and Blue Shield of Oklahoma-Basic
24. National Association of Insurance Commissioners Model Act
25. Community Health Plan-New York State
26. Health Insurance Plan-New York State
27. Council of Smaller Enterprises (COSE)
Approximately 30 plans responded to the request. Seven plans had recently developed products specifically for uninsured small businesses. Information about five of these products is incorporated into the case studies on state efforts and two products are used as individual case studies. A letter requesting information was also sent to the National Association of Insurance Commissioners (NAIC), which responded with literature about its Model Act to improve rating and renewal practices of small business insurers as well as other proposals to improve access. The Health Insurance Association of America, which represents health insurance companies, provided information regarding its proposals for responding to the health insurance needs of small business.

Several business organizations were also contacted. The National Federation of Independent Business (NFIB) and the Employee Benefits Research Institute (EBRI) were able to provide useful information about the magnitude of the uninsured problem throughout the United States and small business attitudes regarding health insurance.

Information regarding state legislative efforts to improve access was obtained through state Departments of Insurance and legislative research agencies. It was decided that eight states would be used as case studies. These states are Washington, Illinois, Kansas, Kentucky, Florida, Missouri, Rhode Island and Virginia. In most of these states, new legislation was passed in 1990 establishing some form of basic benefit package for health insurance policies by exempting such policies from state mandated benefits. New York State, however, sponsors several health insurance pilot projects, including two small employer pilots, which are similar to the RWJ-sponsored programs. The two employer-based pilots were selected as case studies.

Blue Cross and Blue Shield plans in New York and Pennsylvania provided information on efforts in their states to use community rating approaches for small businesses, and on their proposals to prevent "cherry picking" by carriers which can cause a deterioration of the community rated risk pool and high premiums for companies which remain in the risk pool. The Pennsylvania Insurance Department reported a recent regulatory decision which prevents individual exclusions from small group policies, a significant problem for many small businesses.

Other sources of information used to select case studies were trade associations representing the retail and construction industries. Because these industries have two of the highest rates of uninsured employees, it was important to determine what efforts, if any, have been made to provide coverage through member organizations. Several associations were contacted and many provided useful information. A variety of programs are incorporated into one case study of the retail industry and another case study of the construction industry.

An interview guide was prepared to aid in obtaining information from each of the programs selected for review. The interview guide was prepared in order to conduct telephone and/or personal interviews with key persons involved with the various programs. The guide included sections on program history and objectives, characteristics, experience-performance, and lessons learned. Each section requested very detailed information.
including how the program was implemented, specific benefits and problems that had occurred. In most cases, the program director was interviewed as well as others who were closely involved with the program, such as HMO managers, marketing representatives and insurance brokers. For each of the programs reviewed, an effort was made to obtain alternative perspectives on the program in order to develop a balanced and objective assessment of program performance. It should be understood that all opinions stated and conclusions drawn are attributable to the parties which were interviewed for each case study.

3.1.2 Programs Reviewed

The programs selected for use as case studies were categorized according to sponsorship, i.e., Robert Wood Johnson, Blue Cross and Blue Shield, state government, trade association or NAIC.

The Robert Wood Johnson Foundation established its national Health Care for the Uninsured Program in response to the growing problem of access to health insurance. A total of $6.5 million was awarded to various state and private agencies across the country during 1986 and 1987 for the purpose of developing new public/private financing and service delivery systems at the state and local level. Because a large portion of the uninsured are employed, many in small businesses, most of the RWJ-sponsored programs concentrated efforts on improving coverage for this sector. Eleven of the fifteen originally funded programs reached the enrollment phase and were thus chosen for study. A wide variety of sponsoring organizations and methods of implementation are represented among the programs.

Several of the state-sponsored initiatives chosen for case study represent a relatively new type of health benefits plan which has become a trend during 1990 and 1991. These plans, often called "basic," "reduced," "limited," "bare bones," "low cost," "stripped down," or "no frills," are the latest attempts by state legislatures to remedy deficiencies in the small business insurance market. The widespread belief that affordability is the most significant barrier to providing coverage prompted state legislatures to exempt insurance policies written for small groups from many state mandated benefits, which insurers claim contribute significantly to the high cost of coverage. Mandate-free policies are then offered at a lower monthly cost. The eight states chosen for case study approached the mandate issue in a variety of ways. Some have had more success than others in persuading insurance companies to develop new products to comply with the legislation.

Initiatives sponsored by trade associations were incorporated into case studies of two industries, construction and retail trade. These industries, which are characterized by a large proportion of workers being employed by small firms, substantial seasonal employment (construction) and part-time employment (retail trade), have higher rates of uninsured than other industries. Several trade associations representing construction businesses which offer some type of group health plan for members were surveyed including the National Association of Home Builders, Associated General Contractors of America and Associated Builders and Contractors. These health insurance programs are described, along with
problems which have been experienced. There appears to be greater awareness of the health insurance access problem among retail trade associations. In fact, the National Retail Federation commissioned a study which was completed in August, 1990, and examined the extent of coverage among employees in retail businesses. Examples of the types of health insurance plans which are offered through associations are also presented in the case study.

Finally, several other programs were chosen for use as case studies. Two are state-sponsored initiatives which have gone beyond basic benefits legislation and established programs similar to those sponsored by RWJ. Both are HMO programs for employers of 25 or fewer employees in selected areas of New York State. Names of contact persons were obtained from the Alpha Center and detailed information was obtained through telephone interviews using the previously described interview guide. Case studies were also prepared for two recently developed Blue Cross and Blue Shield products which are intended for the small group market as well as for the NAIC model legislation which is intended to limit premium increases and to prevent arbitrary denials of coverage for small businesses.

3.2 SUMMARY OF FINDINGS

3.2.1 Programs Sponsored by the Robert Wood Johnson Foundation

PROGRAM CHARACTERISTICS

The programs sponsored by the RWJ Foundation include a wide variety initiatives. Some are administered by government agencies while others operate through private organizations or health plans. Most utilize a health maintenance organization for service delivery, although one is an indemnity plan, and two offer a variety of plans, including indemnity products, HMOs and PPOs. Most are targeted at small businesses with approximately 25 or fewer employees. The programs utilize a variety of mechanisms to reduce the cost of premiums including state subsidies, major cost sharing and large provider discounts.

Four programs, the Wisconsin Small Employer Health Insurance Maximization Project, the Michigan One-Third Share Plan, MaineCare, and the Arizona Health Care Group, are state-sponsored initiatives. In Wisconsin, the Department of Health and Social Services was awarded the RWJ grant to fund a portion of its State Health Insurance Program (SHIP) which was created by the Legislature. The program offers a variety of existing insurance plans which are sold through brokers to firms of 19 or fewer employees. The State subsidizes premiums for low-income employees. The Michigan program is similar in that it also makes use of existing insurance products and state subsidies. The program is administered through the Department of Social Services as a part of the State's Health Care Access Project (HCAP). The MaineCare program, administered by the Department of Human Services, utilizes state subsidies for employees below 200 percent of the Federal poverty level. It contracts with an IPA model HMO for service delivery. HealthSource Maine, a for-profit HMO, provides services to enrollees at discounted rates. In Arizona, the Health Care Group was created by the State Legislature when the provisions for the state
Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) were established. However, it does not receive state funding and does not offer premium subsidies.

The Washington Basic Health Plan (BHP) was also created by the State Legislature, but the original RWJ grant was awarded to a private organization called Health Systems Resources (HSR). HSR created two managed care plans which later became part of BHP. The program is marketed directly to individuals who are at 200 percent of the Federal poverty level or below, and state subsidies are provided on a sliding scale basis.

Programs in Alabama, Utah, Tennessee, San Francisco and Denver received grant funding from RWJ through private coalitions or other health care groups. The Alabama BasicCare program is administered through the University of Alabama at Birmingham, under the direction of the Central Alabama Coalition for the Medically Uninsured. The Coalition contracts with Complete Health, a for-profit HMO which provides care on a limited basis for enrollees. The program relies mainly on premium payments to fund its operations, although it has received some contributions for marketing from local organizations. The Utah Community Health Plan (UCHP) was originally developed by a Health Care Access Steering Committee comprised of representatives from state agencies as well as private organizations. Intermountain Health Care (IHC), a private non-profit provider system assumed sponsorship for the program and used RWJ grant funds for its implementation. Operational funding is provided through IHC and premium payments.

MedTrust, the RWJ-funded program in Tennessee, is managed by the Tennessee Primary Care Network (TPCN), a non-profit HMO which serves Medicaid recipients. The Tennessee Primary Care Association (TPCA), a non-profit association of community health centers and other health care groups, organized the initiative, procured the RWJ funding, and created TPCN to manage the plan. The program currently operates on premium payments. The Bay Area Health Task Force in San Francisco approached the uninsured problem from a different angle, by using its RWJ funding to establish a health insurance information service. Under the sponsorship of the United Way and several local organizations, a hot line service targeted at uninsured small businesses was implemented. Callers may receive a free guidebook listing available health insurance plans and/or be referred to insurance brokers.

In Denver, several groups collaborated to develop the Shared Cost Option for Small Employers (SCOPE) program. In addition to RWJ funding, the program received other foundation funding for the implementation of an insurance plan which is available throughout most of Colorado. SCOPE uses PPO provider networks, a "gatekeeper" primary care physician model and high coinsurance rates to hold down premium costs.

The Florida Legislature authorized the creation of a non-profit organization to address the State's uninsured problem. With this authorization, a public-private partnership was formed through the Florida Health Access Corporation (FHAC). FHAC has enrolled small businesses in health insurance plans as part of an "organized buying group" which contracts with IPA model HMOs in different areas of the state. The program is subsidized by the State but also relies on premium payments for operations.
Managed care has proven to be a nearly universal concept among RWJ-sponsored programs. Although programs in Michigan, Wisconsin and San Francisco all promote indemnity products in some way, they also promote managed care programs. All programs which have actually implemented a health care delivery system have utilized HMOs or PPOs (except Denver, which markets an indemnity product). Most of the programs based the decision to use limited provider network-managed care approaches on extensive market research. In Florida, in particular, market research showed that the majority of small businesses preferred a managed care-type plan (along with the reduced premiums which accompany it) as opposed to an indemnity product. Some programs have created networks of several health plans, such as the Washington Basic Health Plan, while others have contracted with one HMO in a restricted service area, such as Alabama BasicCare.

The Washington Basic Health Plan utilizes a system of 11 managed care networks in 15 locations, which include staff model HMOs, IPAs and fee-for-service payment systems. Each network is contracted with BHP to provide a uniform set of services and is paid on a monthly capitated basis. Preventive care is 100 percent covered and there is no deductible and modest copayments. Inpatient hospital care is also covered. The average discount received from providers by the networks is 20 percent.

The Arizona Health Care Group (HCG) contracts with two health plans (gatekeeper model HMOs) which are also under contract with the state Medicaid program (AHCCCS). One plan serves the Phoenix metropolitan area and the other serves the Tucson area as well as rural Cochise County. Unlike most other RWJ-sponsored programs, HCG offers four different benefit options with varying deductibles, copayments, out-of-pocket maximums and premiums. Three of the four options offer coverage for basic inpatient and outpatient services with modest deductibles and copayments while the fourth serves as a catastrophic plan. Most providers within the health plans offer discounts of varying degrees. In addition, the HCG five-member staff provides technical and administrative support to the plans and handles all enrollment and billing operations in order to reduce the HMOs’ administrative expenses.

Florida’s program, FHAC, is similar to Arizona’s in that it also contracts with two HMOs (IPAs). It uses an organized buying group approach which provides it with leverage to negotiate for competitive premium rates and a comprehensive benefit package. The organized buying group is comprised of all small businesses enrolled in FHAC in a certain service area. This aggregation of small businesses into a larger group provides a much larger area over which to spread risk. In addition to basic inpatient and outpatient benefits, the program offers coverage for a broad array of other services including maternity care and mental health services. The MaineCare program also utilizes an IPA model HMO service delivery system through HealthSource Maine. The benefit emphasis is on inpatient care although some outpatient services are offered and modest copayments are required. Discounts and risk-sharing arrangements were also negotiated with providers to reduce the cost of premiums.

The managed care programs developed in Alabama and Tennessee are each confined to one service area. The BasicCare program in Alabama serves the Birmingham
area through the Complete Health HMO. Two different benefit packages are offered. Enrollees who choose the "public" option must receive care from public providers, such as the county indigent care hospital, while "private" option enrollees may choose from seven hospitals and a variety of physicians. The public option premiums cost about half as much as the private option. While both options offer a full range of services, both limit the number of covered office visits to six per year. All providers accept various discounted rates. The Tennessee MedTrust program serves the Memphis area and is administered through the Tennessee Primary Care Network (TPCN). Enrollees choose a primary care physician from the Network who monitors all referrals to specialists. Benefits include a wide range of inpatient and outpatient services as well as home health care. Three hospitals participate in the program and offer discounts ranging from 20 to 80 percent.

Utah's managed care system differs slightly from the other programs because its base of primary care is provided by community health centers. UCHP relies on a limited provider network to keep costs down. Two plans are offered, both covering the same range of inpatient and outpatient services, but which require different copayments and deductibles. Participating primary care physicians accept capitated fees and hospitals accept fairly large discounts.

Denver's SCOPE is the only indemnity product among the RWJ-sponsored programs. The program utilizes a PPO network which was previously established by United States Life Insurance Company, the underwriter of SCOPE. It is a cross between an HMO, emphasizing preventive care and a catastrophic plan. Major cost sharing is the mechanism used to make premiums affordable.

Premiums vary widely among the RWJ-sponsored programs. Some programs are able to significantly reduce the premium cost to enrollees while others keep costs close to market levels but offer guaranteed issue products. Strategies for making premiums more affordable fall into three general categories: insurance plan innovations, subsidies, and ties to other state programs. These are summarized for the RWJ programs in Exhibit 3-2. Insurance plan innovations include limited benefits, major cost sharing and very exclusive provider networks. As already noted, virtually all of the programs use managed care approaches, relying on HMO or PPO networks. Subsidies may be provided directly, usually through state government, or indirectly through provision of administrative services, marketing support, risk sharing and reinsurance, or pooling. In addition, provider discounts may also be considered a form of subsidy. Finally, some programs are able to reduce premiums through affiliation with a state program such as a high risk pool.  

Programs in Alabama and Arizona utilize limited benefit options to reduce premium costs. Alabama's BasicCare program offers its public option to enrollees at $47.32 per month for individuals and $115.94 per month for families. The private option is available for a monthly premium of $80.41 for individuals and $202.59 for families. These low premiums are made possible largely because of a limitation of six office visits per year.

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1 Source: Alpha Center.
EXHIBIT 3-2

STRATEGIES FOR MAKING HEALTH INSURANCE MORE AFFORDABLE
USED BY RWJ PROGRAMS

<table>
<thead>
<tr>
<th>PROJECTS</th>
<th>INSURANCE PLAN INNOVATIONS</th>
<th>SUBSIDY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LIMITED BENEFITS OPTIONS</td>
<td>MAJOR COST SHARING</td>
</tr>
<tr>
<td>Central Alabama Coalition: BasicCare</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>*Arizona Health Care Group</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Colorado: SCOPE</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>*Florida Health Access Corp.</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>*MaineCare</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>*Michigan: One-Third Share Plan</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Tennessee: MedTrust</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Utah Community Health Plan</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>*Washington Basic Health Plan</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>*Wisconsin Maximization Project</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>

*Indicates that project is sponsored by state government.

SOURCE: Alpha Center
for both options. In addition, the choice of providers is very limited and providers accept
discounts. Primary care physicians are paid on a capitated basis while specialists are paid 70
percent of charges and hospitals are paid 80 percent of charges. Arizona Health Care Group
offers a choice of benefit options, some of which are more limited than others. The most
popular option covers 100 percent of inpatient services up to $250,000 and requires modest
copayments for most outpatient services and prescription drugs. The monthly premium for
this option is $103.32 for individual coverage and $378.81 for family coverage (Phoenix
area). Another option covers inpatient services up to $20,000 and another provides only
catastrophic coverage. In addition to offering limited benefit options, HCG handles most
administrative duties for the HMOs under contract and negotiates discounts from providers in
order to help make premiums more affordable. However, premium costs to enrollees are not
significantly less expensive than other products on the market. HCG's biggest selling point
is that it is not medically underwritten and therefore accepts high risk enrollees.

Colorado's SCOPE program and the Utah Community Health Plan (UHCP)
employ major cost sharing as a strategy for reducing premiums. In the SCOPE program, the
emphasis is on preventive care, which is 100 percent covered within specified guidelines.
However, there is a $250 annual deductible for inpatient services, a $50 deductible for
prescription drugs and a coinsurance rate of 50 percent for the first $5,000 of covered
charges. The program also receives a discount from participating hospitals. Premiums are
about 40 percent lower than market rates. For example, the medical rate for a single male
under age 30 is only $46.37 per month. UCHP also relies on major cost sharing to reduce
premiums as well as an exclusive provider network and provider discounts. In addition,
UCHP has its own separate administrative staff rather than a contracted arrangement. Two
benefit options are offered with varying copayments. The more expensive option, which
costs $63.37 per month for a single male, has a $10 copayment for primary care office
visits, a $20 copayment for specialists and a $150 per day copayment for the first four days
of hospitalization.

Programs in Maine, Michigan, Washington, Wisconsin and Florida offer direct
premium subsidies, although mechanisms for determining these subsidies vary widely. In
Maine, enrollees whose income is below 200 percent of the Federal poverty level are eligible
for premium subsidies from the State. Employers must contribute 50 percent of the premium
and employee contributions are determined on a sliding scale basis. Employees who are
below 100 percent of the Federal poverty level may have half of their premium paid by their
employer and the other half by the State. The Michigan One-Third Share Plan was so named
because the employer, employee and the State each contribute one-third to premiums. The
program has an unusual eligibility requirement in that employers may only receive the
subsidy if they have hired a former welfare recipient since September 1, 1987, except during
periods of open enrollment. Employees which are below 100 percent of the Federal poverty
level are not required to contribute to their premiums and therefore have one-third paid by
their employer and two-thirds paid by the State.

The Washington Basic Health Plan, a non-employment based program, restricts
enrollment to individuals at or below 200 percent of the Federal poverty level. Enrollees
contribute a certain percentage of their premiums depending upon their income level and the
State pays the remainder. Persons below 75 percent of the Federal poverty level may have their entire premium paid by the State. In Wisconsin, enrollees are eligible for state subsidies if household income falls below 175 percent of the Federal poverty level. Employer contributions are not required and the State may pay only up to 75 percent of premiums, regardless of employee income level. If an employer contributes more than 25 percent to the premium, the state subsidy decreases accordingly.

The Florida Health Access Corporation uses the direct subsidy approach in a different way. Rather than subsidizing certain individuals in the program based on income, FHAC uses the funding it receives from the State to reduce the cost of premiums for everyone in the program, regardless of income level. This approach not only benefits all enrollees but it saves in administrative expenses because there is no income determination process.

Several programs are linked to other state programs, including high risk pools. The Wisconsin program allows individuals who are uninsurable to join the state health insurance risk sharing plan or buy into the Medical Assistance program. The MaineCare program is linked to the state Medicaid program and the state risk pool. Individuals with certain medical conditions and cannot enroll in MaineCare are referred to the Maine High Risk Insurance Organization and may receive a premium subsidy as if they were enrolled in MaineCare. Low income persons who apply for MaineCare coverage but are eligible for AFDC benefits may enroll in the FamilyCare program which provides Medicaid benefits. These people may then join MaineCare if they accept a job and become ineligible for FamilyCare. Denver's SCOPE enrollees who qualify for indigent care may have some or all of SCOPE's coinsurance requirements waived by receiving care at a hospital which participates in both the state indigency care program and SCOPE.

Marketing strategies among the programs also vary depending upon the amount of funding available and the small business environment in the target area. Some programs have been able to market their products rather aggressively while others have been constrained by budgets and limited marketing expertise. Direct mail is most often used, although its success among the programs has not been universal. Many programs supplement direct mail efforts with some form of media advertising and often rely on public service announcements and other free advertising. Some programs have tried several different approaches such as billboards, fliers sent home with schoolchildren and articles printed in trade newsletters.

Direct mail has proven to be the marketing medium of choice among RWJ-sponsored programs. Programs in Wisconsin and Utah have found direct mail to be particularly successful. UCHP's initial mailing achieved a response rate of over ten percent which was considered very good. Both programs have supplemented their direct mailings with media coverage as well. The Michigan program found that two different marketing strategies were necessary to reach the target market at the two demonstration sites. At its Genesee County (Flint) site which is an urban area with strong unions, direct mail was found to be the most successful while in Marquette County, a rural, low wage area, newspaper ads proved more effective.
The Arizona Health Care Group has developed a marketing partnership with its contracted HMOs. HCG staff are responsible for "name and product recognition," which is accomplished through direct mailings, presentations and interaction with legislators and interested constituencies. The HMOs supplement the marketing campaign with advertising on television, radio, newspapers and billboards. Brokers as well as in-house representatives sell the products.

Some programs have not found direct mail to be useful. The Florida Health Access Corporation has not used it because of a lack of good mailing lists. Instead, FHAC uses radio and print advertising and any form of free media coverage available. FHAC staff have found radio advertising to be particularly effective during the morning and afternoon rush hours when small business owners are on the road. The marketing campaign for Denver's SCOPE is managed by a private employee benefits company. It has found direct mail to be waste of time in targeting small businesses and instead uses television, radio and print advertising. The product is sold through agents and brokers.

The Washington Basic Health Plan has used a variety of marketing strategies. Before beginning an advertising campaign, a marketing committee was formed to devise a strategy. Since its inception, the program has used public service announcements, newspaper ads, radio ads, direct mail, word of mouth, leaflets distributed to elementary school students, bus signs, letters to legislators and letters to supporting agencies. Public service announcements have generated the largest response, although BHP marketing staff have found that consistency, no matter what type of advertising is used, is most important.

Tennessee's MedTrust program plans to revitalize its marketing campaign in an attempt to boost enrollment. Thus far, its direct mail and media advertising have not generated the interest that was expected. Alabama's program also plans to embark on a new marketing campaign but its efforts have been constrained by a lack of funds. Although several local organizations donated funds for marketing, the program has not advertised consistently.

EVALUATION OF EXPERIENCE

Some of the RWJ-sponsored programs have been very successful while others have experienced only moderate success, and still others have been forced to stop enrollment. There is no clear formula for success since a variety of factors, including availability of funding and the environment come into play. However, some programs have been more innovative than others in taking all of these factors into consideration and in using them to their advantage. Enrollment experience for the RWJ-sponsored programs is shown in Exhibit 3-3.

The Florida Health Access Corporation, Denver's SCOPE program and the Washington Basic Health Plan have been the most successful in achieving their enrollment targets. As of June 1, 1991, after two years in operation, FHAC had enrolled 6,424 persons (1,399 firms). FHAC's project director attributes much of the program's success to its...
# Exhibit 3-3

## Enrollment Firm Size and Premium Discounts for RWJ Programs

As of May 1, 1991

<table>
<thead>
<tr>
<th>Project</th>
<th>Months Enrolling</th>
<th>Lives Enrolled</th>
<th>Firms Enrolled</th>
<th>Approximate Premium Discount Below Market Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Health Care Group</td>
<td>40</td>
<td>2,935</td>
<td>892</td>
<td>1% (Option 2)</td>
</tr>
<tr>
<td>Maine Managed Care Insurance Demonstration: MaineCare</td>
<td>29</td>
<td>1,100</td>
<td>333</td>
<td>24%</td>
</tr>
<tr>
<td>Washington Basic Health Plan</td>
<td>28</td>
<td>20,700</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Tennessee Primary Care Association: MedTrust</td>
<td>25</td>
<td>924</td>
<td>236</td>
<td>50%</td>
</tr>
<tr>
<td>Florida Health Access Corporation</td>
<td>23</td>
<td>5,934</td>
<td>1,262</td>
<td>25-40%</td>
</tr>
<tr>
<td>Michigan Health Care Access: One-Third Share Plan</td>
<td>23</td>
<td>972</td>
<td>186</td>
<td>VARIES</td>
</tr>
<tr>
<td>Wisconsin Small Employer Insurance Project</td>
<td>22</td>
<td>319</td>
<td>82</td>
<td>VARIES</td>
</tr>
<tr>
<td>Colorado: SCOPE</td>
<td>20</td>
<td>6,938</td>
<td>682</td>
<td>40-50%</td>
</tr>
<tr>
<td>Utah Community Health Plan</td>
<td>19</td>
<td>1,497</td>
<td>257</td>
<td>40%</td>
</tr>
<tr>
<td>Central Alabama Coalition for the Medically Uninsured: BasicCare</td>
<td>13</td>
<td>308</td>
<td>44</td>
<td>30-50%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>N/A</td>
<td>41,627</td>
<td>3,974</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Source:** Alpha Center
accommodation of changes in the market. It also does not rely on certain provider conditions such as deep discounts from indigent care hospitals. Its biggest innovation has been the development of the organized buying group which has become a very large account for Av-Med, one of the HMOs under contract. Marketing efforts undertaken by FHAC are very labor intensive and require serious dedication, since small businesses are often difficult to reach. Although the program does not use any unusual marketing strategies, it does typically run radio ads during rush hours which has proven effective. In addition, marketing efforts have been very consistent which has also been a proven key to success among programs. FHAC has also performed very well financially. It has found, however, that a constant flow of new people into the program is necessary because they generally do not have high claims costs within the first several months of enrollment, and provide needed cash flow, some of which can be set aside for when they do become ill. In addition, there is speculation that the State’s budget deficit will eventually put an end to the subsidies, therefore, funds are being set aside to prevent drastic rate increases if the subsidies are in fact eliminated.

Denver’s SCOPE program has also performed very well. As of June 1, 1991, there were 6,932 persons enrolled (709 firms). Its average group size is very large (9.8) compared to most of the other RWJ-sponsored programs whose group sizes are usually around 4 or 5. Some of SCOPE’s success has been attributed to its “grass roots community-based” emphasis. During SCOPE’s development stage, various members of the health care community were brought together to contribute different ideas as well as relay information and garner support from their respective constituencies. This alliance has made the public more receptive to the program and gained free advertising from the media. In addition to its community focus, SCOPE also has a strong marketing plan. Small businesses throughout Colorado are consistently exposed to SCOPE from a variety of advertising mediums. From an administrative standpoint, SCOPE is unique among RWJ-sponsored programs. The program is administered through several organizations rather than a single agency. A project director oversees the program but most administrative tasks are handled through an employee benefits company, while an insurance company underwrites the plan and manages the billing process.

Programs in Arizona, San Francisco, Maine and Utah have also experienced varying degrees of success in enrolling small businesses in health insurance plans. The Arizona Health Care Group had enrolled 3,093 persons (939 firms) as of June 1, 1991 and is experiencing more rapid growth in its fourth year. This has been attributed to an aggressive marketing campaign. Thus far, despite the fact that it is not medically underwritten, the program has attracted a relatively healthy population. There has been discussion among the contracted HMOs about adopting an underwriting policy out of fear that more high risk people will enroll, but the issue has not been decided. It is hoped that the highly structured managed care program will be enough to keep costs down but a continued influx of AIDS patients may make medical underwriting necessary. The Bay Area Health Task Force has been successful in providing small businesses with the necessary information to obtain health insurance. As of January 1, 1991, 190 businesses had been placed with an insurance carrier as a result of the hot line. Its success depends on the dedication of the brokers which accept hot line referrals. Because small businesses tend to be less informed about the cost and
availability of health insurance, brokers and hot line operators must devote a substantial amount of time to educating them.

After almost two years of enrollment, the Utah Community Health Plan had 1,550 members (263 firms) as of June 1, 1991. Although the program has not enrolled as many people as expected, UCHP staff feel that the program has tapped its target market. Approximately 90 percent of enrollees have never had health insurance coverage and the average household income level is about 200 percent of the Federal poverty level. One of the program's biggest difficulties is its base of primary care providers, Salt Lake Community Health Centers, which are operating at capacity and are not able to provide medical care to more UCHP enrollees. UCHP has begun to pursue other sources of providers in order to remedy this problem.

Although the MaineCare program has not experienced the high absolute enrollment levels of programs like FHAC or SCOPE, it has penetrated approximately 17 percent of its target market. The program has been enrolling new members at one of its demonstration sites since December, 1988, and at the other since February, 1991. As of June 1, 1991, 1,170 persons had enrolled (380 firms). The original enrollment projection was 1,400 persons over the course of three years but enrollment has slowed in the last year. This has been attributed to a volatile small business market, poor economic conditions and lay offs. The program has not done a great deal of advertising but has instead focused marketing efforts on organizations which have direct contact with small employers, such as the Department of Marine Resources (lobstermen and fishermen). Standard forms of advertising which other programs have typically used, such as television, radio and direct mail have not been used at all.

Programs in Wisconsin, Michigan, Alabama and Tennessee have experienced greater difficulties in implementation. The Wisconsin program discontinued enrollment in January, 1991 and the Michigan program stopped enrolling new members in April, 1990. Wisconsin's difficulties have been largely attributed to organizational problems and conflicting interests among involved parties. Apparently the program's design did not allow for a great deal of flexibility in the products which could be offered. Also, many benefits were mandated for coverage under the program which resulted in higher premium costs. In addition, some program planners feel that small businesses were reluctant to become involved in the program knowing that it was to end after a certain number of years. Michigan's fiscal crisis forced a discontinuation of the subsidies to the program which made it necessary to stop enrollment. The State's floundering economy, which prompted business closures and lay offs, had also begun to affect enrollment. In addition, there were problems in regulating underwriting practices among participating insurers and the eligibility criteria proved to be too exclusive. There was also a certain amount of skepticism among small businesses because the program was government funded.

Alabama's BasicCare has experienced declining enrollment. As of June 1, 1991, only 246 people were enrolled (41 firms). Part of the program's difficulties have been attributed to a lack of advertising. Organizationally, the program got off to a rough start because it had to change underwriters at the last minute. In terms of the target market, a
survey conducted after BasicCare was implemented determined that the marginal value of health insurance among small businesses was perceived to be low, at least in the Birmingham area. Although many small businesses wanted coverage, they were simply not willing to pay for it. Tennessee's MedTrust has experienced some similar difficulties in convincing small businesses to purchase health insurance. Many employers do not feel they need it to attract workers and would rather spend their money elsewhere. MedTrust has also had difficulty making the plan attractive because it utilizes an indigent care hospital. In addition, there have been disruptions in continuity of care for enrollees which have added to plan costs.

3.2.2 State Sponsored Initiatives

CHARACTERISTICS AND EVALUATION OF EXPERIENCE

A trend in state legislative initiatives to improve access to health insurance for small businesses began in 1990. During that year, eight states passed legislation aimed at reducing costs of health insurance through exemption of mandated benefits for policies sold to small businesses. The results of the efforts in Washington, Illinois, Kansas, Kentucky, Florida, Missouri, Rhode Island and Virginia are discussed in the paragraphs that follow.

The Basic Health Care Act, which was passed in Washington state in 1990, allows groups of fewer than 25 employees to be exempt from health insurance minimum standards. The original bill was drafted in large part by a lobbyist for health care contractors and was supported by a state business association. The only mandates which must be included in basic packages issued to small businesses are inpatient hospital care and benefits for adopted children. Insurers are therefore allowed a great deal of flexibility in devising plans at minimum cost. As of July, 1991, 27 products offered by 13 insurers had been approved by the Insurance Commissioner. According to legislative testimony, the demand for these products has been very high.

The Governor of Illinois appointed representatives in the health care industry to begin study of the availability of health insurance in 1989. The group determined that the most promising approach to improve access was to focus efforts on small businesses. Therefore, a mandate-free plan was devised for groups of 25 or fewer which had not offered coverage for the past year. The new law, which became effective on January 1, 1991, exempts small businesses from several mandated coverages, including mental health services, blood processing and inpatient alcohol treatment. It maintains requirements for coverage of adopted children, well-baby care and mammograms. As of June, 1991, four insurance companies had petitioned the Department of Insurance for approval of products which meet the conditions set forth in the legislation, including Blue Cross and Blue Shield of Illinois. The Blue Cross plan, called Basic I, is a medically underwritten PPO plan with a $1,000 annual deductible and 70/30 coinsurance. The plan offers comprehensive coverage and costs approximately 40 percent less than Blue Cross's standard comprehensive major medical product. Because the product has had relatively few sales, Blue Cross plans to develop a similar product with a lower deductible and 80/20 coinsurance in hopes that it will be more successful.
In Kansas, the Commission on Access to Services for the Medically Indigent and Homeless was created in 1986 to address the State's uninsured problem. The results of the Commission's efforts were used by the State Legislature in July, 1990, to institute a program to encourage small employers to offer health insurance to employees. As part of a two-pronged strategy to reduce the number of uninsured in Kansas, the program allows businesses of 25 or fewer employees to form multiple employer health plans and receive tax credits for providing coverage to employees. The law does not specify individual benefits that must be part of the basic package but instead mandates coverage up to a specific maximum after a deductible has been fulfilled. As of June, 1991, only Blue Cross and Blue Shield had submitted provisions for a new product to the Insurance Commissioner and no businesses had applied to become part of multiple employer health plans.

The Health Care Reform Act was passed in Kentucky in March, 1990. The Act was broad-based but included specific health insurance provisions for improving access for small businesses. The legislation created trusts through multi-county planning regions, called Area Development Districts (ADDs), through which small businesses (fewer than 50 employees and no health insurance coverage for the past three years) may associate and purchase health insurance for their employees. In addition, the legislation specifies certain minimum hospitalization standards and exempts mandated benefits from small business policies. As of June, 1991, three insurers were marketing products in compliance with the new standards. Blue Cross and Blue Shield of Kentucky offers a limited inpatient benefit HMO product at reduced cost. Outpatient services are not covered. Enrollment has been slow, although it has not been determined whether this is due to very restrictive eligibility standards or the limited benefit package.

In Florida, basic benefits legislation was passed in 1990 authorizing health insurance policies for businesses of fewer than 25 employees to be exempt from certain mandated benefits. However, some of the more costly mandates were preserved in the legislation, resulting in a package which could not be offered at a significantly lower price than existing policies. In addition, many of the mandates were retained as benefit options, which must be available to policyholders at an additional premium cost. As of June, 1991, insurers had not developed any new products in compliance. Follow-up legislation was passed authorizing the implementation of a National Association of Insurance Commissioners (NAIC) model for small group rating practices, with the intention of stabilizing premium increases for small groups over time. The Florida Health Care Cost Containment Board (HCCB) has developed an outreach program for small businesses which provides information and assistance in obtaining health insurance.

Missouri passed the Limited Mandate Insurance Act as part of a larger package of legislation which included the establishment of a state risk pool and a new long-term care program through the Department of Social Services. Effective January, 1991, the Act authorizes insurers to sell mandate-free policies to groups of 50 or fewer. However, certain mandates such as child health supervision, mammograms and mental health services must be offered as options. As of July, 1991, no new products had been filed with the Department of Insurance.
In its efforts to make health insurance more affordable for small businesses, the Rhode Island Legislature authorized a low-cost, limited-mandate health benefit plan in July, 1990. In developing a plan however, several minimum standards were established which resulted in a product which was not significantly different from policies which included the original mandates. Firms of 25 or fewer employees which have not offered health insurance in the previous 24 months are eligible to enroll in the health plans during periods of open enrollment. Plans may not be medically underwritten although some pre-existing condition limitations are permitted. Blue Cross and Blue Shield was expected to have a plan on the market during the summer of 1991. A local HMO has also applied for the Insurance Commission's approval for its plan.

In 1989, the Joint Subcommittee on Health Care for All Virginians of the Virginia General Assembly began to address the State's health insurance access problem in response to a report by the Bureau of Insurance on the high cost of mandated benefits. As a result of a recommendation by the Bureau and Joint Subcommittee that mandate-free policies be authorized, Blue Cross and Blue Shield of Virginia developed First Option, a low-cost product for businesses of 49 or fewer employees. Most mandated benefits are not included, except for primary care, well-baby and maternity services because of the product's emphasis on preventive care. It also covers inpatient services up to 30 days. As of July, 1991, First Option was the only product in compliance with the new legislation on the market.

3.2.3 Industry-Sponsored Initiatives

CHARACTERISTICS AND EVALUATION OF EXPERIENCE

According to studies performed by the Employee Benefits Research Institute (EBRI), retail trade and construction are two industries with comparatively high rates of uninsured workers. EBRI estimates that 25 percent of persons employed in retail trade and 26 percent of construction employees are without health insurance. Furthermore, a large proportion of these persons are employed by small businesses. As a result, some trade associations representing retail and construction industries have become involved in sponsoring health insurance plans to assist small businesses in gaining access to coverage. Their efforts are discussed in the paragraphs that follow.

Among the trade organizations contacted which represent the construction industry, three sponsor some type of group health insurance plan. Associated Builders and Contractors offers two different plans, one for groups of three or more and one for groups of fewer than three. Associated General Contractors of America, which has a significant small business membership, offers a group health insurance plan through a trust. Most of the 550 businesses which take advantage of the comprehensive benefit package have fewer than ten employees. The National Association of Home Builders (NAHB) also offers a comprehensive plan which is administered through a trust. After two years in existence, the program has enrolled approximately 10,000 persons.

Associations representing retail businesses appear to be more aware of the difficulties small businesses face in obtaining health insurance coverage. The National Retail
Federation (NRF), an organization based in Washington, D.C., commissioned a study of health insurance availability for retail employees which was prepared in August, 1990. The study examines common characteristics of uninsured retail employees as well as the characteristics of employer-sponsored health plans among retail businesses. The NRF has also established a Benefits Committee to evaluate and respond to Congressional proposals. The International Mass Retail Association, based in New York, is currently developing proposals to address health insurance access and cost containment issues.

In addition to general retail associations, some industry-specific organizations have also become involved in improving access to health insurance for their members. The National Shoe Retailers Association offers its members the services of an employee benefits consulting firm to assist them in obtaining coverage. However, most of NSRA's small business members have still found it difficult to obtain health insurance because of medical underwriting practices of insurers and because part-time employees are often not eligible. The Jewelers of America, a national organization whose membership is 98 percent small businesses, began sponsoring a health insurance program in June, 1991. The program is administered through a trust and offers comprehensive major medical coverage at competitive rates. In its first two months of existence, the organization received over 700 inquiries from members.

3.2.4 Other Initiatives

This category includes a variety of programs, including two sponsored by New York State, two Blue Cross and Blue Shield products and the National Association of Insurance Commissioners (NAIC) Model Act to promote the availability of health insurance to small employers.

The New York programs have been classified in this category because they are more far-reaching than the other state-sponsored initiatives described. They are similar to many of the programs sponsored by the Robert Wood Johnson Foundation, although neither received RWJ funding. In 1988, the New York State Legislature established the Committee on Expanded Health Care Coverage (CEHCC) which studied methods of improving access to health insurance for the uninsured and underinsured and initiated the design of regional pilot projects. The result was a joint public-private venture to sponsor three individual subsidy pilots and two employer incentive pilots. The employer incentive projects, Community Health Plan (CHP) and Health Insurance Plan (HIP) are discussed here.

Firms must have 20 or fewer employees to be eligible for the programs. Employers are required to contribute 50 percent of employee premiums and the State subsidizes the other half. Employees may not contribute to their premiums. CHP is a staff model HMO which serves Albany and surrounding areas and the Hudson Valley. It was contracted with by the State to serve enrollees in the pilot project. A wide range of services are offered but with limited numbers of visits. Modest deductibles and copayments are also required but may be reduced for lower income persons. Monthly premiums in the Albany region are $110.71 for individuals and $279.65 for families. Rates are slightly higher for the Hudson Valley region. Marketing efforts have focused on direct mail and follow-up
telephone calls, although other advertising strategies such as television and radio interviews as well as community outreach programs have also been used.

Health Insurance Plan of Greater New York is a group model HMO. For its pilot project contract with the State, it serves certain areas in the borough of Brooklyn, which is only a small portion of its regular service area. The Brooklyn Economic Development Corporation (BEDC) is subcontractor for HIP and assists in recruitment and enrollment for the project. The benefit package includes a wide range of inpatient and outpatient services and there are no deductibles or copayments. Premiums are about equal to CHP’s Albany rates. HIP’s marketing strategy also focuses on direct mail and telemarketing in addition to press announcements, articles in business journals and community outreach activities.

Blue Cross and Blue Shield Plans in Oregon and Oklahoma developed products targeted at uninsured small businesses. These products are also included as case studies. The Oregon Option plan was developed in 1989 as part of a new state program aimed at reducing the uninsured population. The Oregon Legislature authorized tax credits for businesses which begin offering health insurance coverage. The health care plans may exclude certain state-mandated benefits. The tax credits are reduced incrementally over a five year period. Oregon Option was developed to meet the regulations and is available to businesses with fewer than 25 employees and have not offered health insurance for the previous two years. The program is a PPO plan with basic medical coverage as well as options for preventive care, dental services and vision care. Deductibles vary, and coinsurance for most services is 80/20 for preferred providers and 70/30 for non-preferred providers. The monthly premium for basic medical coverage is $53.33 per individual.

Blue Cross and Blue Shield of Oklahoma’s "Basic" plan was developed in response to a study which revealed that 54 percent of Oklahoma businesses with fewer than 10 employees did not offer health insurance. The plan requires enrollees to use a specified network of physicians and hospitals across the State. A wide range of services are covered, except for routine care, physician office visits and prescriptions. There is a $200 annual deductible and inpatient hospital care is covered up to a 21 day limit. There are also copayments and limitations for well-baby and prenatal office visits. The average monthly premium is approximately $80.

An important development affecting the cost and availability of health insurance for small businesses was the development of model legislation by the National Association of Insurance Commissioners (NAIC) in 1990. The Act’s main objectives are to improve access and efficiency as well as promote fairness in the small group market. The Act includes provisions concerning prevention of abusive rating practices, disclosure of rating practices to purchasers and rules for continuity of coverage. There are several restrictions on premium rates in the model legislation. Index rates may not differ by more than 20 percent across classes of business and cannot vary by more than 25 percent across employers of similar case characteristics or coverage. In addition, increases in premiums may not exceed a certain rate as calculated by a prescribed formula. With regard to renewability, the Model Act stipulates very specific circumstances under which policies may be terminated by insurers. Policies must be available for renewal except in the case of nonpayment of premiums, fraud on the
part of the policyholder, noncompliance with plan provisions, inadequate number of eligible group members, or a change in business status. Insurers are required under the Model Act to "make reasonable disclosure" of stipulations and/or changes in rating and renewal practices to policyholders. In addition, all rating and renewal procedures must be documented and maintained as records, and must be made available to the Insurance Commissioner upon request.

EVALUATION OF EXPERIENCE

The CHP program in New York's Hudson Valley began enrollment on June 1, 1989 and was projected to enroll 2,500 persons over an 18 month period. As of mid-July, 1991, the program had enrolled approximately 1,800 persons (382 businesses) and its end date has been extended to December 1, 1993. Enrollment has been slower than anticipated and a high rate of disenrollment has exacerbated the problem. Much of the problem has been attributed to a volatile small business environment and a transient employee population. In addition, despite the plan's comparatively low cost, a survey of eligible businesses which declined to enroll found that the majority declined because they felt it was too expensive. However, the program does expect to meet its goal of 2,500 enrollees by 1993.

HIP began enrollment in May, 1989 and, as of June 30, 1991, had enrolled approximately 1,400 persons. It has also been extended to December, 1993 and is expected to meet its goal of 2,500 enrollees. Several factors have been identified as barriers to meeting enrollment targets, including a sluggish economy, restrictive eligibility requirements, restrictive service area, and the fact that the program is a pilot and is scheduled to end in 1993. Despite its problems, however, the program's disenrollment rate has slowed considerably. In addition, many of the people who disenrolled did so because they lost their jobs. In some cases, however, people who lost their jobs have chosen to remain in the program and pay their own premiums.

The Oregon Option Plan, developed by Blue Cross and Blue Shield of Oregon, has been on the market since 1989 and had enrolled approximately 8,000 persons as of April, 1991. The original enrollment projection was 25,000, but the size of groups which have enrolled has been much smaller than expected (approximately two). The Plan has experienced a loss ratio of 40 percent with the product which is considered good and Plan staff are optimistic about its continued success, although, there is speculation that sales may decline once the tax credits are phased out. Blue Cross and Blue Shield of Oklahoma's Basic plan is awaiting certification by the Oklahoma Basic Health Benefits Board before it is released on the market.

The objectives of the NAIC Model Act are to prevent large and unreasonable premium increases, to prevent arbitrary cancellations and to preclude very high premiums for small firms in high risk industries and firms with one or more high risk employees. The NAIC Model Act seeks to provide small groups with comparable "spreading of risk" for their projected claims cost as are afforded to large groups. Within six months of its adoption in December 1990, at least ten states have enacted legislation which incorporates all or several provisions of the NAIC Model Act (Health Benefits Letter, 1991). While provisions
of the NAIC Model Act cannot be expected to significantly lower the average premium cost for small businesses, they should reduce the incidence of extraordinary premium increases and unreasonable consultations which have been cited frequently both in the media and in congressional testimony.

3.3 LESSONS LEARNED

3.3.1 Robert Wood Johnson Foundation Programs

Although the RWJ-sponsored programs have experienced different problems and varying levels of success, several themes recur throughout. While some programs have been able to overcome setbacks as a result of funding shortages, depressed economies or poor small business markets, others have been forced to scale back or end enrollment altogether.

PRODUCT DEVELOPMENT:

One of the biggest obstacles to successful development and marketing of products in the small business health insurance market is a lack of information. Many programs found it difficult to make enrollment projections, determine adequate benefit levels and establish underwriting policies because there simply was not great deal of information on the small business experience. In addition, many insurers simply classified small businesses as high risk groups and some excluded small groups from their clientele altogether. For this reason, most programs experienced difficulties in contracting with underwriters. Many insurers were not willing to accept the risk. The Alabama Program originally contracted with Blue Cross and Blue Shield, but the Blue Cross and Blue Shield plan ultimately backed out at the last minute because it could not find another insurer to share the risk. This not only delayed the program's implementation but also put a strain on the BasicCare program's relationship with providers. In Florida, however, some insurers are now wishing they had gotten involved with the program when they were given the opportunity. FHAC experienced a great deal of difficulty in contracting with a health plan but its excellent track record has now made insurers anxious to participate.

MARKETING:

Another common lesson learned among the programs is that marketing to small businesses is an extremely labor intensive effort. Several program administrators indicated that direct mail marketing does not work without extensive follow up efforts, because small business owners tend not to read mail which is not directly related to their business operations, e.g., sales, purchases, payment of expenses, etc. Successful marketing requires imagination, flexibility and substantial resources relative to expected enrollment. In Michigan, project staff found that often small business owners could not take the time to go through the enrollment process. However, they could be persuaded to enroll if project staff performed most of the legwork. In Utah, it was also found that a great deal of time and money was necessary to penetrate a very small fraction of the market. FHAC's marketing
staff go to great lengths to track down small business owners who are often hard to reach by telephone and "have their records in shoeboxes and offices in their trucks."

In addition to funding from the RWJ Foundation, many programs receive some sort of state support. Unfortunately, many states are experiencing financial crises and/or looming deficits, and some are no longer able to support the programs, as is the case in Michigan. Other programs are attempting to reorganize finances in order to prepare for a time when state funds are no longer available. The FHAC program anticipates losing its state funding sometime in the near future due to the State's budget deficit and is currently establishing a reserve fund to guard against huge rate increases if and when that occurs. Some programs simply cannot operate without state funding. This is true for the Washington Basic Health Plan, which subsidizes premiums for its over 20,000 enrollees, all of whom have incomes at or below 200 percent of the Federal poverty level. On the other hand, some programs, such as Denver's SCOPE program have received no state funding and are very successful. The SCOPE program is now self supporting, although it did receive other foundation funding in addition to the RWJ grant.

**MARKET PENETRATION:**

Finally, many programs have found that regardless of the amount of money and labor expended, only a small fraction of the target market can be penetrated. In Alabama, a survey of small businesses was conducted which determined that many employees would like to have health insurance but they either feel it is not necessary because they are healthy, they receive coverage through a spouse's policy or they simply do not want to pay for it. The Utah Community Health Plan has been unable to meet its enrollment goals but attributes this to an inherent problem in the uninsured small business market rather than deficiencies in the program itself. UCHP staff expect to penetrate only about ten percent of the target market because small businesses have proven to have a relatively inelastic demand for health insurance. In other words, no matter how inexpensive it is or how comprehensive the benefits are, only a small fraction of businesses will buy it.

### 3.3.2 State Government-Sponsored Initiatives

**PRODUCT DEVELOPMENT:**

In many cases, it is too soon to draw conclusions about state experiences in improving access, since many of the plans just recently became effective. Most states have not experienced overwhelming responses to the legislative changes and reduced mandates, although many insurers, it appears, are holding back and allowing Blue Cross and Blue Shield plans to take the lead. Depending on the success of the various Blue Cross products, other insurers may begin to join in and develop new small group products.

Washington is the only state with a wide range of small group products currently available, which, according to legislative testimony are selling very well. In most other states, only a handful of insurers, if any, are marketing new products. One problem appears to be in developing products which are less expensive but are in compliance with legislation.
In many cases, legislation reduced or eliminated state mandated benefits but then added back minimum standards, making it difficult to reduce the costs of the policies. Often if the premium rates are reduced, costs must compensated for elsewhere in the form of large deductibles or copayments, which makes plans less attractive.

**MARKETING:**

In addition to the lack of availability of attractive products, there also appears to be a lack of awareness among small businesses that state governments are actually taking action. In most cases, little or no marketing or public relations efforts have been undertaken, although the Kansas Department of Insurance has made an initial attempt at generating interest. Small employers which begin offering health insurance may apply for certification for tax credits through the Department. As an incentive, the Department mailed the certification applications to many small businesses but has received no response. Other states have relied on insurers to market the new products. In many cases, such as in Illinois, there was a large response to initial advertising but businesses were either ineligible or did not find the benefit package attractive once they took a closer look.

Finally, some insurers are finding it necessary to reevaluate their products and make changes. Since Blue Cross and Blue Shield plans were often at the forefront of the state initiatives, their development of new products was sometimes rushed. At Blue Cross and Blue Shield of Virginia, there is an interest in improving its First Option product which went on the market almost immediately following the effective date of the legislation. Now it appears that changes may be necessary to generate more interest. The Plan is also considering adding another low cost product so that small group consumers will have more choices.

3.3.3 Other Initiatives

CHP program staff in New York State have found, like many of the RWJ-sponsored programs, that enrolling small businesses in a health insurance plan is a very labor intensive process. Even if employers are convinced of the need to provide health insurance for their employees, the program has found many balk at paying 50 percent of the premium cost. It is difficult to get employees involved in the decision-making process since they may not contribute to premiums. Unfortunately, however, when the program ends, employees may be faced with paying not only the portion which is currently state subsidized but their employer's share as well if the employer chooses not to continue contributing. As a result, many employees may be forced to drop out of the program.

The HIP program has also found enrollment to be labor intensive. Administrative expenses have been very high and have produced very marginal enrollment returns. HIP staff have also been concerned about the prohibition of employees contributing to premiums. Although it is not clear whether allowing employee contributions would significantly boost enrollment, HIP staff would like to see employees be more involved in the decision to purchase health insurance.
One of the most successful among the initiatives studied is a Chamber of Commerce-sponsored effort operating in Cleveland, Ohio, called the Council of Smaller Enterprises (COSE). It has grown since 1973 to become the largest local small business organization in the United States. Group Services, Inc. (GSI), a purchasing group for COSE, administers affordable group health insurance plans to COSE members. As an intermediary between COSE and insurance carriers, GSI negotiates contracts and premiums and provides administrative services for the program. COSE offers several plans through Blue Cross and Blue Shield of Ohio, Kaiser Permanente and CIGNA, including basic benefit/major medical plans, HMOs and PPOs. After 18 years in existence, the program is performing well. COSE takes pride in the fact that its enrollees experienced only a 34.5 percent cumulative increase in health insurance premiums between 1984 and 1990, compared with a 154 percent increase experienced by small groups with commercial insurance in the same market area. As of September, 1991, over 8,000 companies were enrolled in COSE-sponsored health insurance plans (over 80 percent of COSE members), many of which would be unable to obtain coverage from other sources.

3.3.4 Overview of Lessons Learned

In this final section of the report, an overview is provided of the lessons learned from the evaluation of the programs examined in this project.

- High cost of coverage is the major barrier for most small businesses currently without health insurance coverage. Insurance premiums for small businesses are higher than for large firms, because of substantially higher marketing and administrative costs. Even where these additional costs have been eliminated (as some programs reviewed in this study have done), most small businesses currently without health insurance have not purchased coverage. Based on an evaluation of case studies findings, significant insurance premium subsidies may be required to lower premiums sufficiently in order for a substantial proportion of small businesses currently without insurance to purchase coverage for their employees.

- Successful program initiatives to improve small business access to health care tend to have several characteristics in common. These include:
  - attractive benefit designs which are not substantially different from "typical" employee health benefit program designs
  - managed care and lower than prevailing provider payment rates
  - aggressive, creative and opportunistic marketing
  - relatively low employer premium rates
  - substantial community support.

Most of the program initiatives examined which did not include all of the program characteristics cited above did not achieve enrollment which even approached their enrollment goals. Each of these program functions is discussed briefly below.
Attractive Benefit Designs. Several programs have used benefit designs with very high deductibles or coinsurance rates (e.g., $1,000 per person; 50% coinsurance), or which significantly limit benefits (e.g., 21 days of hospital care or limited physician office visits). Generally, these products have sold very poorly. Small businesses have not wanted a stripped down policy or a stripped down price; they have wanted a fully equipped policy at a stripped down price. Program sponsors have found that most small businesses have not considered benefit designs which are markedly different than those typically offered by employers.

Managed Care - Low Provider Payment Rates. Virtually all of the successful programs use aggressive managed care, provided through HMO or PPO networks, to reduce claims cost. Most of the HMO and PPO programs have negotiated discounted payment rates with providers. The combined use of managed care and reduced payment rates has resulted in lower claims cost and lower insurance premiums than under indemnity insurance arrangements. The evaluation of case studies experience indicates that programs which use very limited provider networks which serve primarily the Medicaid covered and uninsured populations, have in most cases experienced difficulty in enrolling small businesses because of perceived unattractiveness or "second class" status of their provider networks.

Aggressive, Creative and Opportunistic Marketing. Most people involved in marketing health insurance to small business among the programs reviewed in this study have found it difficult, time consuming and frustrating. Private insurers which sell to groups of varying sizes find marketing costs per enrollee to be considerably more costly for small businesses than for medium and large businesses. Successful marketing approaches used for small businesses generally involve a high degree of personal and organizational commitment to the marketing effort; the creativity and flexibility to tailor the marketing techniques used to the targeted audience; the use of local print and broadcast media for free publicity for the program; appearances before local industry and chamber of commerce groups and inclusion of program descriptions in their newsletters; and a substantial degree of patience. In some environments, personal visits (after program name recognition has been achieved) has been used successfully. Most small businesses, lacking the familiarity with health insurance concepts and administrative requirements possessed by personnel department staff of larger firms, require more education-instructional time than do large firms.

Low Premium Rates. Virtually all of the RWJ programs have premium rates which are at least 20 percent and as much as 50 percent lower than are available to most small businesses in the area. The low premium rates are made possible by a combination of some or all of the following: provider discounts; managed care; limited benefits; and premium subsidies. A majority of the programs reviewed have experienced utilization which is at or below projected experience. This has enabled some programs to avoid or limit premium increases, despite administrative costs generally being above projected levels.

Substantial Community Support. The more successful programs to provide low cost coverage to small businesses have received widespread support from within their communities, including public officials, voluntary organizations, media groups and private
industry groups. This support has enabled the programs to obtain favorable exposure and publicity for their programs which has assisted the marketing effort.

- Elimination of state mandated benefits requirements has had minimal impact to date on expansion of coverage to small businesses. Within the past three years, a number of states have eliminated or reduced mandated benefit requirements for health insurance programs which are offered to small businesses. These "barebones" or "stripped down" benefit plans have not succeeded in significantly increasing enrollment of small businesses for the following reasons:

  - Often, the reduction in mandate requirements is only partial, thus having a small effect on expected claims cost and premiums.

  - State legislatures have sometimes restricted access to the reduced mandate programs to employers which have not offered health insurance over some recent period, thus significantly restricting the potential market for these plans.

  - Private insurers generally have not effectively marketed the "bare bones" products. In some cases they have devoted very limited marketing resources to the new product ventures; rarely have they displayed the commitment or the aggressiveness in marketing the new products as has been used by the more successful, public or community-based programs reviewed in this report. The evidence from this study indicates that small businesses are a "tough sell" and private insurers have not used the appropriate combination of commitment, resources, marketing flexibility, pricing and benefit design to successfully market their products.

  - There is limited experience under the reduced mandate laws and several private health insurers are modifying their products and their strategies to increase enrollment for the new products.

- Based on an evaluation of the case studies experience, there is evidence that most employers currently not providing health insurance to their employees have not purchased health insurance unless premium rates were substantially below competitive premium rates. The lack of demand for insurance among these firms is caused by a number of factors including low profit levels, some employees already having insurance coverage, lack of perceived need for coverage in order to attract employees and the relatively high cost of coverage relative to total
labor costs (small firms use a disproportionately large number of low income workers).

- Rapid adoption by states of the NAIC Model Legislation can help eliminate some of the more egregious insurance industry practices affecting small businesses. These include extremely large premium increases, failure to provide coverage for groups with one or more individuals with high claims cost and very large premium differentials for firms in "high risk" industries.

The review of private and public sector initiatives to improve small businesses access to health insurance coverage has identified a number of programs which work: i.e., have achieved significant enrollment among firms which previously did not provide insurance coverage for their employees. The descriptions of their program features in the body of the report and in the attached case studies can help in the design of expanded initiatives at the local, state, and possibly national levels to facilitate increased insurance coverage among small businesses.
BIBLIOGRAPHY


APPENDIX A - CASE STUDIES
CASE STUDY 1

ARIZONA HEALTH CARE GROUP
BACKGROUND AND PROGRAM OBJECTIVES

The state of Arizona was without a Medicaid program until 1982, at which time a statute established the Arizona Health Care Cost Containment System (AHCCCS). The statute contained a provision for establishing the Health Care Group (HCG), a division of AHCCCS which would focus on the working uninsured, especially small groups. It was not until 1986, with the awarding of a grant from the Robert Wood Johnson Foundation (RWJ) Health Care for the Uninsured Program, that HCG actually embarked on its mission to provide health coverage to the working uninsured in Arizona.

The program was developed from 1986 to 1988 with funding from the RWJ Foundation and the Flinn Foundation. An advisory committee representing businesses, the insurance community, health care agencies and the community at large provided support for the program's development and its continued operations. The primary objectives of the program were: to offer comprehensive health care coverage to small groups of 25 or fewer employees which had not offered coverage in the previous six months, to reach an enrollment level (6,000 lives) which would allow the program to be self-supporting and to reach as many of the working uninsured in the state as possible (a study conducted by the Flinn Foundation estimated this number to be approximately 500,000).

In the developmental stages, it was decided that the program's role as a division of AHCCCS would enable it to utilize the same network of health plans (HMOs) for delivery of care. However, the plans' participation in HCG was not guaranteed because HCG operated independently of AHCCCS. Therefore, HCG solicited health plans' participation through a request for proposal (RFP) process. In addition, regulations differing from those governing AHCCCS and other insurers were established for HCG. HCG was able to secure two of the 13 AHCCCS health plans which operate in three counties: Pima (Tucson), Maricopa (Phoenix) and Cochise (a rural community).

PROGRAM DESCRIPTION

HCG contracts with two HMO plans (serving three geographic areas) which, in turn, contract with providers. The health plans pay providers and accept full risk. Reinsurance begins at $20,000. University Physicians Health Care Group was contracted when the program began in Pima County and established a subsidiary when the program expanded to Cochise County. Phoenix Memorial Hospital (PMH) Health Care Group was contracted to serve Maricopa County. As of March 1991, PMH was serving approximately 33,000 AHCCCS eligibles and 700 HCG enrollees.
Generally, providers for HCG enrollees are a subset of AHCCCS providers. However, there are areas which do not have AHCCCS providers but do have HCG enrollees. Therefore, new provider networks in these areas were established for HCG. A primary care physician gatekeeper model is used to provide managed care under the program. Primary care physicians are paid on a capitated basis and specialists are paid on a discounted fee-for-service basis. PMH Health Care Group contracts with 150 physicians and six hospitals and is in the process of recruiting more participants.

Hospitals are paid discounted charges. Discounts vary across hospitals and fluctuate monthly. The largest hospital discount is about 32-33 percent. HCG also contracts with a pharmacy network which is paid at a rate approximately 10 percent above its costs. Administration of the program is handled by five staff members at HCG. These staff members provide technical and administrative support to the health plans and oversee day-to-day operations. In addition, they handle all enrollment and billing operations.

Benefit Structure and Premiums

HCG is unique among the RWJ programs because it offers four different benefit options. For Option 1, the enrollee pays 20% of inpatient charges up to $20,000, at which point HCG covers all expenses up to $250,000. There is a $10 copayment for office visits and specialist referrals, and a $5 copayment for prescription drugs. A $50 copayment is required for emergency room visits while x-ray, lab and ambulance are covered at 100 percent. The second and most popular option pays 100 percent of inpatient charges up to $250,000. Office visit and specialist referral copayments are $5, prescription drug copayment is $3 and emergency room copayment is $25. As in Option 1, x-ray, lab and ambulance are 100 percent covered.

Option 3 is the least popular option. It covers 100 percent of inpatient charges up to $20,000 per year and has a copayment of $25 for emergency services. The fourth option serves as a catastrophic plan and has a $2,000 deductible. HCG pays 100 percent of inpatient charges up to $250,000 annually after the deductible has been met. All other services are 100 percent covered after the deductible has been met. There are several proposed option changes which are being considered.

Monthly premiums vary significantly by region because rural providers tend to charge less than their urban counterparts. The average monthly premium in Cochise County, for example, is about half the premium cost in Phoenix (Maricopa County). Premiums also vary according to age, selected option and type of coverage (single, two-party or family). In addition, members pay a $3 administrative fee each month. For Option Two, the most popular plan, rates as of February 1, 1991 in Maricopa County were $103.32 for single coverage and $378.81 for family coverage. There is no required employer contribution and no tax incentives.
Marketing

HCG and its contracted health plans have developed a marketing partnership. HCG is responsible for "name and product recognition" which is accomplished through participation in various health care industry and medical association meetings, conferences and talk-shows as well as through direct mail. HCG also encourages write-ups in local publications and works with legislators and constituencies which have an interest in health care and health insurance. Grant funds pay the costs of direct mailings and other marketing documents.

The two health plans are responsible for the actual selling of the product. The primary marketing strategy utilizes media campaigns, including TV, newspaper advertisements and billboards, usually lasting three to five weeks. During the first two years of operation, news releases or stories appeared in 12 major Arizona newspapers and The Wall Street Journal. At PMH, the plan was originally sold exclusively through brokers but two in-house representatives have recently been added with the idea that they would be more knowledgeable and closer to the plan. PMH has trained over 100 brokers and has 20 currently active. Each of the two contracted plans must submit a marketing plan to the Director of HCG every six months. In addition, they must submit a marketing report once every month which itemizes marketing activities completed, including number of cold calls, contacts, leads and closes.

Eligibility

In order to enroll in HCG, a business must have 25 or fewer employees and no group medical coverage during the previous six months. Self-employed individuals are also eligible. An employee who works at least 20 hours per week, has been employed for the two months prior to coverage and will continue to work for at least five months subsequently, is eligible for coverage. At least 50 percent of eligible employees in a firm must enroll. Dependents of covered employees may also enroll. There is no medical underwriting, no exclusion of certain industries and a very limited waiting period for pre-existing conditions.

PROGRAM PERFORMANCE

Enrollment

As of June 1, 1991 there were 3,093 people (939 firms) enrolled. Average group size is approximately 3.3, which is significantly smaller than the projected group size of 4.7 to 5. PMH projected more enrollees than it currently serves but the projected number of groups is in line with actual figures. This is the result of smaller-than-projected group sizes (2.3 to 2.4 compared with projections of 4.0 to 4.5). HCG is experiencing approximately ten percent growth each month. Much of the rapid growth has been attributed to aggressive marketing campaigns.
One of the health plans under contract with HCG became involved in order to help fill a need in the Phoenix community. Now three years later, the plan considers the program a success and a positive experience. Initially there was some apprehension about becoming involved in the program because there was no medical underwriting and only a one-year pre-existing condition waiting period. Therefore, there was potential to attract a more unhealthy population. However, the program appears to be serving a relatively healthy population. In addition, the plan is experienced in operating a very controlled managed care program for AHCCCS and thus follows this model for HCG.

The plan would like to see some aspects of the program changed however, including a new medical underwriting policy to curb the current influx of persons with major health problems (mostly HIV, heart disease and hypertension). Because the plan's cost is not significantly lower than market rates, there are many other products available to the young healthy population. Therefore, the plan would like to devise a scheme to attract enough healthy people to offset costs so that the more unhealthy people would not be excluded. There is an increasing fear that the program could experience significant adverse selection, especially because of the AIDS epidemic. The prospect of a state risk pool is currently being considered but how it will be funded is a major question. Another structural change recommended is an expanded rate schedule. There are three age rating categories, 0-39, 40-55 and over 55, which is less than the number of age categories used by many insurance companies and HMOs. With broader age categories the younger people at the bottom of their age category often pay higher rates than they should.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

HCG originally projected enrollment of 20,000 members within two years but this projection was later deemed unrealistic because it assumed the participation of all 13 AHCCCS health plans. One of the most difficult tasks of the program was encouraging health plans to participate. Their reluctance to participate was due in part to having no prior experience with this type of program and because it appeared to have the potential to attract a high risk population.

Another challenge HCG faces is maintaining good relations with the private insurance industry. According to an HCG staff member, the private insurance sector has elected not to cover the small group market but does not want HCG to become too involved in serving this market either. Recently, HCG proposed to raise the small group eligibility number to 50 employees but the private insurance industry expressed very negative feelings about this. Therefore, HCG continues to serve only businesses with 25 or fewer employees.

HCG is actively pursuing statewide expansion. A third health plan has submitted a proposal to participate and fourth is expected in the near future. Addition of these two plans would expand the program to seven counties. HCG would not need all 13 AHCCCS health plans to provide statewide service since some plans operate in multiple counties. In addition to an expansion, HCG has also modified the four benefit options. It is hoped that the
modified options will allow consumers to better understand what they are buying. HCG is also working on providing more technical assistance and improving utilization review and marketing.

It is hoped that the program will be self-supporting by June, 1992. However, grant funds from the RWJ Foundation and Flinn Foundation which currently pay for internal administrative costs expire on October 31, 1991. HCG has therefore requested $98,000 from the state in order to maintain operations until June, 1992, at which point it is expected to reach a self-supporting enrollment of 6,000 enrollees.
CASE STUDY 2

BAY AREA HEALTH TASK FORCE
BACKGROUND AND PROGRAM OBJECTIVES

The Bay Area Health Task Force was convened by the United Way, business representatives, medical and hospital association representatives and academics to address the issue of the uninsured. It was determined that the Bay Area was not necessarily lacking health insurance products suitable for small businesses, but the potential consumers of these products were lacking information. Therefore, it was decided that the Task Force would be a health insurance information service, easily accessed by a telephone "hot line." With a grant award from the Robert Wood Johnson Foundation in 1987, the hot line was implemented initially in San Francisco and later expanded to Marin, San Mateo, Contra Costa and Alameda Counties.

Many local organizations contributed match monies to the project, including the San Francisco Medical Society, Bank of America, Wells Fargo, the Hospital Consortium of San Mateo County and Kaiser Permanente Foundation. In addition, the United Way has supplied telephones, an office and funds for operations. There is no state funding. One of the driving forces behind the development of the Task Force was a fear of a state mandate requiring businesses to provide health insurance. It was hoped that an information and referral service could help to remedy the uninsured situation and avoid, or least postpone legislation requiring employer-sponsored health insurance.

PROGRAM DESCRIPTION

The hot line is accessible to anyone who wishes to call, but marketing efforts target small businesses. An intake form is completed for every caller. The form includes basic information as well as characteristics of the business, whether health insurance is currently offered and pre-existing conditions of employees. The caller is then given the option of receiving a free guidebook published by the Task Force or being referred to a broker. The guidebook, titled "How To Find Quality, Reasonably Priced Health Insurance," includes every insurer in the Bay Area, plans offered to groups of ten or fewer and characteristics and requirements of each plan.

Referrals to area brokers are an integral part of the Task Force’s success. The Task Force solicits brokers through letters which include a survey about the extent of the broker’s involvement as well as level of interest in the small group market. The Task Force focuses on recruiting brokers who are committed to selling to small groups because it is such a difficult market to penetrate. Referrals to participating brokers are provided on a rotational basis. Upon referral, the original intake form is sent to the broker. In return, the broker must provide the Task Force with a report on the disposition of each case, i.e., whether the
group bought insurance and reasons if the group did not. The Task Force is currently a free source of referrals for brokers.

The most popular individual product sold through Task Force referrals is a Blue Cross and Blue Shield plan and the least popular is a "cadillac plan" underwritten by Principal Mutual. For small groups, comprehensive plans offered by John Alden, Principal Mutual and two HMOs are the most popular. There is fairly extensive underwriting for groups with less than 15 people.

Administration and Marketing

The Bay Area Task Force employs a staff of three, who handle all inquiries and paper work. If phone lines are unusually busy or if a large mailing must be prepared, the United Way provides additional staff. Marketing efforts primarily focus on free advertising through local radio and television stations. These stations periodically run features on health insurance and refer to the Task Force as the organization to contact for more information. Task Force staff are also asked to participate in talk shows, conferences and symposiums. Mailing lists of businesses with 19 or fewer employees are sometimes purchased for direct mail campaigns. In addition, an expansion to the East Bay Area using a 900 number is under consideration.

PROGRAM PERFORMANCE

The Task Force averages approximately 12 to 20 calls per day, unless the media runs an advertisement, which usually increases the number of calls. No enrollment projections were made. As of May 1, 1991, 3,000 calls had been received, 25 percent of which were referred to brokers. A total of 255 businesses (875 people) enrolled in a new insurance plan as a result of a Task Force referral. Average firm size was 2.0 and average group size was 2.9. Another 50 percent of callers do not need a referral but receive the guidebook entitled, "How to Find Quality, Reasonably Price Health Insurance."

Procuring a continuous flow of funding has proven to be one of the biggest challenges. Task Force staff are continually writing proposals and soliciting contributions from various organizations because the RWJ grant expired in May, 1991. Two other means of obtaining needed operating funds are also being considered. Task Force staff have proposed to charge a small fee for the guidebook and an annual membership fee for participating brokers. As of March 1, 1991, the Task Force's expenses had not exceeded the amount of grant funding.

Another concern that has been raised is the fact that there are still people who "fall through the cracks" and are unable to obtain health insurance. In response to this concern, the Task Force is working with a group of insurance carriers to develop a product which would be marketed by the Task Force and administered by the United Way Group Trust.
(which currently administers insurance for non-profit organizations). The product would have no medical underwriting and would be available to groups of 3 to 14.

Most participating brokers feel the Task Force has performed very well thus far. One broker who has been involved with the Task Force since it began says that the system works well and that it has certainly tapped the right market. She says that Task Force referrals differ from her usual clientele because most have not researched health care costs and are therefore less educated about the cost of care, what kind of coverage is available and the costs of insurance.

Although Task Force referrals do not constitute a significant source of business for this broker, she says she thinks the Task Force is still "making a dent" in the uninsured population. She receives about 20 referrals per month and makes three to five sales from those referrals. These sales are mostly to individuals rather than businesses. She says that the Task Force does an excellent job of educating callers before they reach the brokers. Thus, the broker can concentrate on selling a product. However, she added that working with this program requires a broker to go the extra mile in following up and pursuing potential buyers and there is extra paperwork.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

It appears that hot line callers have been pleased with the service provided. Part of this sentiment can be attributed to the fact that the service is provided free of charge. In addition, there is a good selection of plans to choose from, all represented in the guidebook. The Task Force appears to have a promising future, although problems could arise if state legislation is passed mandating employer-sponsored health insurance. Such programs could significantly alter the environment and cause the current hot line system to falter.
CASE STUDY 3

WASHINGTON BASIC HEALTH PLAN
BACKGROUND AND PROGRAM OBJECTIVES

The Washington Basic Health Plan (BHP), a system of managed care networks, was created by the state legislature in 1987 to provide coverage to low-income uninsured individuals. Also during 1987, Health Systems Resources (HSR), a health systems planning agency, received a grant from the Robert Wood Johnson Foundation to organize new networks of private providers, health clinics and health departments at three demonstration sites in Washington, which could then become part of BHP. HSR was successful in organizing networks in Pierce County and Clallam County (its efforts failed in King County), both of which are under contract with BHP. The organization of BHP took place during 1988 and enrollment began in January, 1989. Health Systems Resources subsequently ceased operations after the networks it created became part of BHP. It is important to understand that BHP is strictly a state-supported program. While HSR did receive funding from RWJ, BHP itself never received such funding. It is presented as an RWJ program because it absorbed the HSR networks which were originally formed with support from RWJ.

BHP subsidizes health care coverage for low-income persons. A household income of 200 percent of the Federal poverty level or less is required to be eligible for the program. Premiums are based upon a family's ability to pay. The program offers basic benefits emphasizing preventive care but also offers coverage for major medical needs. Unlike most other efforts to address the uninsured problem, BHP is not available through employers but is marketed directly to individuals.

BHP is strictly a state funded program and did not receive RWJ funding. The State Department of Social and Health Services is a key player in the operations of BHP. Because the Department oversees Medicaid, a great deal of information is interchanged with BHP. In addition, there are efforts to enroll people in BHP who become Medicaid ineligible. BHP also interfaces regularly with the Department of Employment Security, the Labor and Industries Department, and Department of Corrections. BHP has a blanket exemption from regulations, although it does comply with some regulations. It is not required to offer state mandated benefits.

While the BHP enrolls individuals and not small businesses, it is included among the case studies because it is one of the most successful state initiatives to provide access to health insurance for the uninsured, many of whom are employees of small businesses and their dependents. Also, as discussed below, there is consideration to allow small businesses to enroll as groups under the program. It should be understood that this program was created through legislation prior to the passage of Washington’s Basic Health Care Act in 1990. It is a different type of program than the "bare bones" packages authorized in the Basic Health Care Act.
PROGRAM DESCRIPTION

The Washington Basic Health Plan is a five-year pilot program currently operating in 14 of 39 counties. The Legislature mandates that the Plan must operate in at least five of the eight congressional districts in order to ensure diversity. The program has 11 contracted networks which operate in 15 locations (including the two which were formally part of HSR), with a separate contract for each location. Each contractor is a managed health care system. There are varying types of systems, including staff-model HMOs, IPAs and fee-for-service provider networks. Contractors choose how providers are paid (capitated fees, fee-for-service, etc.) depending on the type of system. Although discounts were not an explicit goal of the program, there is an average discount among providers of 20 percent, which is about the norm for managed care programs around Washington.

BHP negotiates with contractors individually by location and pays each a prepaid capitated monthly rate. At the start of the program, contractors were solicited by an RFP process (in addition to those already contracted by Health Systems Resources). For the most part, existing networks of providers were used but in some rural areas managed care systems did not exist and thus had to be created.

Benefit Structure and Premiums

All contractors offer the same BHP benefit package. There is no medical underwriting, although there is a 12 month waiting period for pre-existing conditions (except pregnancy) to minimize contractors' risk. There is no deductible. The Plan covers all hospital inpatient services prescribed by a participating physician as well as authorized hospital or office physician services, surgery, x-ray and laboratory. There is a $5 copayment for visits to a primary care provider but no copayments are required for authorized referral visits or preventive care. Emergency care requires a $25 copayment for participating providers and a $50 copayment for non-participating providers. The copayment is waived if the patient is admitted to a hospital. Preventive care is 100 percent covered, including routine exams, blood pressure testing, cholesterol measurement, gynecological exams and pap smears.

Premiums are developed by four age categories: under 19, 19 to 39, 40 to 54 and 55 to 64. Coverage is not available for persons 65 or older. In order to meet its objective of covering entire families, BHP has only one family rate, regardless of the number of children. Household incomes are compared to the Federal poverty guidelines to establish subsidized amounts. If an enrollee's household income is less than 75 percent of the Federal poverty level (FPL), he/she contributes $7.50 per person per month. For a two-parent family with one or more children, the maximum contribution at this income level is $22.50 per month. For income levels which are 75 percent to 200 percent of FPL, the enrollee pays a certain percentage of BHP's cost to pay the contractor chosen to provide care (contractor costs vary). These percentages are shown on the next page.
Employee Contribution Percentages

75%-100% FPL: 15%
100%-125% FPL: 20%
126%-150% FPL: 30%
151%-175% FPL: 50%
176%-199% FPL: 75%
200% FPL: Full cost

Persons above 200 percent FPL are not eligible to enroll in BHP. However, if a person is already enrolled and household income becomes greater than 200 percent FPL, he/she may remain in the program for six months. Although rates vary across contracted plans, the average family contribution is $35.15 per month and the average state subsidy per family is $168.03 per month, for a total monthly premium of $203.18. Family premiums range from $160 to $280 per month. According to BHP staff, those whose incomes fall below 100 percent FPL reap the biggest benefits from the program, while those between 100 percent and 200 percent FPL could probably find comparable coverage and rates in the private insurance market.

Administration and Marketing

A staff of 30 is responsible for the administrative functions of the Plan. This staff includes a director, medical director, three directors of operations, four information services personnel and 20 membership services personnel. In addition, there is a marketing staff of three. Administering the program is very labor intensive because income eligibility of applicants must be determined (it was originally thought that a staff of 15 could manage operations effectively). Administrative costs of the program have been growing fairly rapidly. This has been attributed to the fact that the program is still developing and it is being evaluated simultaneously. Operating costs have been slightly under budget.

In devising a marketing strategy, BHP formed a marketing group of representatives from each contracted network. The marketing group is a committee which devises marketing campaigns which the BHP marketing staff is responsible for implementing. A wide variety of marketing tools have been used since the program began including public service announcements (TV), newspaper ads, radio ads, direct mail, word of mouth, leaflets distributed to elementary school students, bus signs, letters to legislators and letters to supporting agencies. The most successful marketing strategies have proven to be public service announcements and word of mouth. Letters to legislators and interested organizations have also been helpful. The key factor in BHP’s marketing campaign is said to be consistency. Program administrators have found that people who are unemployed or have had problems getting health insurance do not expect the government to offer an alternative,
much less pay for it. Therefore, these people must be constantly exposed to information about the program.

PROGRAM PERFORMANCE

Enrollment

A legislative mandate limits enrollment to a total of 30,000 and the program has been budgeted for 25,000. Program planners were careful to maintain enrollment at a pace that administrative staff could effectively handle, but also requested high target enrollment figures to the Legislature to allow the budget to be more flexible. As of June 1, 1991, there were 20,374 enrollees, about half of whom are children. BHP staff are satisfied with this figure although many legislators and health care officials have apparently had very high expectations. There were difficulties in obtaining support from a wide range of persons involved in the health care industry. Once support was finally obtained, these people expected an overnight success. The Plan has even been criticized for being too slow in its implementation. Nevertheless, BHP staff and other supporters are very optimistic.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

The Washington Basic Health Plan is viewed favorably. There are opposing views as to whether small businesses should be included in the program. Advocates for small businesses say that including them would not be a very cumbersome process because the program is already structured in such a way that it could easily accommodate them. In addition, the Plan would have a larger population over which to spread risk. Those in opposition to the inclusion of small businesses say that small businesses would "pollute" the Plan with high risk persons. However, advocates contend that small businesses are not necessarily a riskier population. In fact, some say the risk of the Plan could be improved by including small businesses.

According to some persons involved with BHP, insurance companies are the strongest opposition to the inclusion of small businesses in BHP because it means competition. Other opponents contend that it would be too great an expense for the state. Apparently however, small businesses just want access to coverage, not the subsidies. Some say that including them would actually save money in the long run. The inclusion of small businesses in the program has not met with opposition from BHP. Legislators recently exempted small businesses from mandated benefits and are waiting to see if this might increase coverage. The effects of this recent legislation are not yet known. Whether small businesses will be included in BHP in the future is questionable.

BHP staff would like to determine the elasticity of the sliding scale subsidies and possibly modify the structure of the scale. It was originally thought that enrollee
contributions were too high but this does not appear to be the case. Administrators are considering "stretching" contributions, i.e., requiring enrollees to pay more. The average member contribution is only 15 to 18 percent of the monthly premium and the balance is paid by the state. It is feared that this may prove to be a financial hardship for the state in the long run.

Although this type of program appears to work very well in Washington, it is believed that it is not completely transferrable to other environments. The primary reasons for this are that many states do not have the financial means to support a health care plan and also do not have highly developed managed care systems. A provider community must be willing to modify its behavior by accepting less than billed charges and accommodating the managed care concept.

Since the program was developed as a pilot, it has an official end date of June, 1992, however, the Legislature is scheduled to review the program in January, 1992. The University of Washington is currently evaluating the program and will provide detailed information for the Legislature. There is good reason to believe it will continue past June, 1992 because of its excellent track record thus far. There have been discussions in the Legislature about universal health insurance and about including small businesses in BHP. There is also a consideration to remove the stipulation that enrollees must be below 200 percent of poverty and to implement a statewide expansion to boost enrollment.
CASE STUDY 4

MEDTRUST
TENNESSEE PRIMARY CARE NETWORK
BACKGROUND AND OBJECTIVES

In 1982, the Tennessee Primary Care Association (TPCA) began to explore alternative health care financing arrangements for its' members. TPCA is a not-for-profit statewide association comprised of community health centers and other groups with an interest in health care access. The first project, launched in 1984, is a prepaid, capitated plan for AFDC recipients called Medicaid Plus. The TPCA simultaneously created and spun off a not-for-profit entity called the Tennessee Primary Care Network (TPCN) to manage the plan. TPCA and TPCN are two separate organizations, which have independent boards of directors. The TPCN was designated a health insuring organization (HIO) by the Health Care Financing Administration and became a state licensed HMO in 1988. The TPCA subsequently developed a commercial insurance plan called MedTrust, which is also carried by TPCN.

Market research conducted prior to implementation of the MedTrust program indicated that low price and comprehensive coverage were necessary to persuade employers to buy health insurance. Thus, TPCA embarked on a mission to determine how employers not currently providing health insurance could be led to do so. Two benefit plans with different premiums and cost sharing requirements were originally proposed. However, it was decided that small businesses and their employees would not be receptive to the large cost sharing requirements which would be necessary to make premiums affordable. Instead, one plan, made affordable by large provider discounts, was offered. Grants from the Robert Wood Johnson Foundation and the HCA Foundation, in addition to a state matching grant, provided the funding for the development of the program in 1987. Originally, TPCA proposed to offer the low-cost, prepaid plan for the working uninsured throughout the state. However, it was decided that the project would operate as a pilot in Memphis and if successful, would be expanded. As of March, 1991, the project was still confined to the Memphis area. The health plan became operational in February, 1989.

The program's main objective is to sell a comprehensive health benefit package to uninsured employers and employees in Memphis. These benefits are made available at about half the usual cost. Low premiums are made possible by sizable provider discounts (primarily hospitals) and capitation arrangements with primary care physicians. Contracted hospitals currently serving a large proportion of uninsured patients collect a very small fraction of incurred charges. They agreed to participate in because they are guaranteed payment from MedTrust of more than twice what they receive from uninsured patients.
The program operates strictly in Shelby County (Memphis) and targets small businesses with less than 40 employees which have not offered health insurance for at least three months. There is no restriction on the size of a business which can enroll. Groups with fewer than 20 employees are medically underwritten. Individuals and groups considered high risk are usually accepted after a waiting period, as long as there are sufficient low risks to offset them. The pre-existing condition limitation does not allow immediate coverage of conditions which have been treated during the six months prior to enrollment in MedTrust. Such conditions are covered after one year or after any three month period during which no treatment has been rendered.

MedTrust is sponsored by the Tennessee Primary Care Network. Enrollees must choose primary care physicians (PCPs) from this network who then monitor referrals to specialists who are paid by MedTrust on a fee-for-service basis. Most MedTrust enrollees are seen at Health First, a large multi-specialty group of physicians which contracts with the Network. Two other non-profit health clinics and four private practitioners also provide services. PCPs also arrange for treatment by certain physicians affiliated with the University of Tennessee Physician Foundation, which staffs the Regional Medical Center.

Three hospitals serve MedTrust: Regional Medical Center at Memphis--"The Med", St. Joseph Hospital and La Bonheur Children's Medical Center. For inpatient care, most MedTrust enrollees are seen at The Med which provides services at an 80 percent discount. Hospital care for newborns and adults is provided at $120 per day and includes both inpatient care and outpatient surgical and diagnostic procedures. Regular charges are usually at least $1,000 per day. The Med offers this large discount because it serves a large volume of uninsured patients for which it receives about ten cents on the dollar. For MedTrust patients, it is guaranteed 20 cents on the dollar. In addition, the Medicaid Disproportionate Share issue plays an important role. The Med receives a large portion of the state's Medicaid Disproportionate Share payments because it provides services to comparatively large volume of Medicaid patients. These payments comprise a substantial portion of the hospital's operating budget so it can afford to accept large discounts from MedTrust patients without incurring huge losses. The other two hospitals provide services at discounted rates which are approximately equivalent to the rates a PPO would be able to obtain.
Benefit Structure and Premiums

MedTrust benefits include physician services, hospitalization, outpatient surgery, skilled nursing care (100 days per year), home health care, emergency care, ambulance, x-ray, laboratory and other diagnostic services. An additional premium payment is required for mental health and substance abuse services. Physician office visits and home health visits require a $5 copayment and emergency room visits are $25. A $200 copayment is required for each hospitalization. Prescription drugs and routine dental care are not covered. An individual's maximum out-of-pocket expense is $500 per year and the family maximum is $1,250.

As of February 1, 1991, the monthly premium for a single person was $65.84 and $177.75 for a family. Employers must pay at least $30 of each employee's monthly premium.

Administration and Marketing

MedTrust utilizes the Tennessee Primary Care Network's staff of 38 to administer the program. TPCN and TPCA interact regularly to ensure MedTrust's successful and efficient operation.

MedTrust is marketed primarily through direct mail to businesses with fewer than 40 employees. Newspaper advertisements are used to supplement direct mail campaigns. Sales representatives give presentations to interested employers and employees to follow-up on advertising. In addition, press releases, news conferences and public appearances relating to MedTrust have also been used in the marketing program. There are plans being developed to revitalize the marketing campaign in order to increase enrollment.

PROGRAM PERFORMANCE

Enrollment

As of June 1, 1991 there were 918 people (239 firms) enrolled in MedTrust with an average firm size of 1.9 and an average group size of 3.8.¹ The program had an original enrollment goal of 1,068 persons. This was the maximum number of enrollees The Med agreed to serve. The rate of growth has been slower than anticipated because average enrolled group size is very small. In addition, some businesses have failed or been unable to pay monthly premiums and have dropped out. According to TPCA staff, the task of bringing

¹ Source: Alpha Center.
small businesses into the health insurance system has been a very labor intensive effort. In addition, educational efforts and constant guidance are needed to keep the businesses functioning within the system.

One of the biggest problems with MedTrust from a marketing perspective is that the lead hospital is an indigent care hospital. If it were possible to garner more financial support so that the deep discounts were not the focal point, it might be feasible to use other more attractive hospitals.

Another apparent problem involves the sale of the product and the attitudes of small businesses toward health insurance. In Tennessee, some feel that insurance plans in general are "meddling in people's personal affairs." In addition, many small businesses in Tennessee simply do not have the money to spend or do not feel they must offer insurance in order to attract workers.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

MedTrust has had two problems which have added to plan costs. The first is a problem with enrollees using hospitals other than the three contracted hospitals. There is no enforced requirement that enrollees use the three hospitals but there are no discounts on services provided at other hospitals. Thus, if enrollees choose alternative hospitals, MedTrust must pay full charges. Controls on utilization have been strengthened as a result.

The other problem is the interruption in continuity of care when hospitalization is required. The only physicians who can admit to The Med are UT Medical School faculty, who comprise the University Physicians Foundation (UPF). Regrettably, the plan was unable to recruit the UPF group as participating providers. Another large multispecialty group, Health First, was recruited and its' primary care physicians serve as primary care case managers for 95% of plan enrollees. Specialty care is also provided by Health First on a fee for service basis. However, when hospitalization is thought to be necessary, rather than be referred for specialty care within the group, the enrollee must be referred out of group to specialists in UPF. The cost effects of this arrangement are undetermined.

There is continuing interest in an expansion to other counties. State development funds were originally procured for regional expansion in other parts of the State including a rural area, but hospitals, fearful of pending changes in Medicaid Disproportionate Share Adjustment (MDSA) funding, declined to obligate themselves to very heavily discounted rates. Clearly, a MedTrust type plan would be attractive only to "last resort" hospitals, who treat disproportionately large numbers of indigents. Others have no incentive to contract with MedTrust. The feasibility of plan expansion is dependent on the uncertain future of Tennessee's MDSA program and on other developments within county or federally subsidized indigent care institutions.
CASE STUDY 5

MICHIGAN HEALTH CARE ACCESS PROJECT
ONE-THIRD SHARE PLAN
BACKGROUND AND PROGRAM OBJECTIVES

A consortium of interests, including state and non-state agencies, had already begun to address the uninsured problem in Michigan when the Robert Wood Johnson Foundation released its RFP for the Health Care for the Uninsured Program in 1986. The consortium developed the Health Care Access Project (HCAP), a broad welfare reform and health insurance project consisting of two parts. The first was an initiative to improve access to health care for persons receiving General Assistance (a state-administered fund which provides aid to qualified persons based on specific definitions and guidelines). The second, called the "One-Third Share Plan," was a program to expand access to health insurance for former welfare recipients entering the workplace and was funded by an RWJ grant in 1987. The program began enrollment in January, 1988 and officially ended on March 1, 1991.

The One-Third Share Plan was a "voluntary incentive approach" administered by the Department of Social Services (DSS) to benefit former welfare recipients and other low-wage workers employed by businesses not offering health insurance. Employers hiring a former Medicaid or General Assistance recipient could receive a subsidy from the State to cover health insurance costs for low-income employees and their families. State officials felt it was appropriate for employers, employees and the State to contribute equal shares to premium payments, except when an employee was at or below the Federal poverty level, in which case the State would pay the employee share as well. The goal was to increase the number of insured persons while decreasing the number of people who quit their jobs to go on welfare in order to be eligible for Medicaid benefits.

The grant was actually awarded to the Michigan League of Human Services (MLHS), a statewide citizens advocacy group, because DSS felt that funds could be better appropriated and would not interfere with state funds. Because the location of the program was also a major consideration, county governments became involved as well and submitted proposals urging their selection as demonstration sites. Genesee County (Flint) and Marquette County (a rural area in Michigan's upper peninsula) were ultimately chosen.

A Policy Board was also established for the project. The Executive Director of MLHS served as chair with members of the board representing the State Medicaid office, the hospital association, medical society and other health care organizations. In addition to the $350,000 grant awarded by RWJ, MLHS also received substantial funding from the Charles Stuart Mott Foundation. The State provided the bulk of the funding.

The original plan for the program called for the development of a new insurance product administered by the State. However, it was decided later that this was not feasible because the State had no experience in operating a for-profit insurance business and because there was a fear of creating competition in the insurance marketplace. Instead, program
planners and other members of the community decided that the State should subsidize the cost of existing insurance products.

PROGRAM DESCRIPTION

Benefit Structure and Premiums

The program utilizes existing HMO, Blue Cross and Blue Shield Plans and commercial products which meet certain criteria. These criteria include an annual deductible of no more than $100 per individual or $300 per family and copayments of no more than 20 percent of major medical benefits with an annual maximum of $2,500 per individual or family. In addition, a plan must have full coverage for hospitalization and must cover emergency services, outpatient services, medical/surgical physician benefits, office visits, prescription drugs and maternity and prenatal care.

In Genesee County, a Blue Cross and Blue Shield fee-for-service plan and Blue Cross's HMO plan, called Blue Care Network, are available to all enrollees on a guaranteed issue basis. Some commercial plans are available but may exclude individuals from coverage through medical underwriting. Marquette County only offers indemnity products because no HMO exists in that area. Some providers agreed to offer special arrangements, including four hospitals in Genesee County which agreed to provide care at 20 percent below Medicaid rates.

Premiums vary according to the insurance plan chosen by an employer. In Genesee County, employers may select a plan other than Blue Cross if it meets program standards but the amount paid by the State is based on rates negotiated with Blue Care Network. Employees with household incomes between 100 and 200 percent of the Federal poverty level are responsible for one-third of their monthly premium, while the employer and the State each pay one-third. Employees at 100 percent of the poverty level or below may have two-thirds of their monthly premium paid by the State and one-third by their employer. Workers with incomes exceeding 200 percent of the poverty level are not eligible for state subsidies but may still enroll in the program. Employers pay premiums directly to insurers each month and are reimbursed by DSS for subsidies. Blue Care Network agreed to assist employers in reducing their premium payments by allowing a 12 to 17 percent discount.

Administration and Marketing

A project director at the state level (Department of Social Services) oversees the program. In addition, each of the two demonstration sites has a project director and a marketing director/sales representative. There are also state and local oversight committees and advisory boards. During the program's implementation, the local offices were responsible for soliciting information about the program to insurance companies, chambers of commerce and other agencies to garner support from the community.
Staff at each demonstration site are responsible for marketing. The marketing directors devise marketing strategies as well as determine business eligibility and employee income eligibility. A wide variety of advertising media have been used including direct mail, newspaper ads, cold calls and Chamber of Commerce interviews. Because the populations in the demonstration sites are very different, the marketing directors have had success with different advertising strategies. In Genesee County, direct mail generated the largest amount of business while in Marquette, newspaper ads were most successful. In addition, insurance companies became an excellent marketing network in both counties once they realized the program was not in competition with them.

PROGRAM PERFORMANCE

Enrollment

Originally, the program was restricted to businesses which had hired a former welfare recipient since September 1, 1987. However, an open enrollment period from October, 1988 to December, 1988 in Genesee County was used to increase membership. In Marquette County, the program was able to enroll three to four businesses per month without open enrollment. During the fall of 1989, both demonstration sites allowed an open enrollment period. Businesses with fewer than 20 full-time employees which had not offered health insurance in the last two years were eligible.

No enrollment projections were made and no limits on the number of businesses accepted into the program were established. However, there was a budget of $400,000 established for subsidies. The enrollment level reached 220 businesses (approximately 1,100 individuals) at one point and had declined to 185 businesses as of April, 1991. During the fall of 1990, grant funds were depleted and the State's fiscal situation precluded it from contributing further funding. Therefore, enrollment was halted. In addition, a number of businesses failed due to the floundering economy, and dropped out of the program.

Staff members at the demonstration sites experienced different problems under the program. In Marquette County, staff spent a great deal of time and energy on enrollment. Many employers simply did not have sufficient time or interest to deal with the process of obtaining health insurance. However, program staff found that if they performed a substantial amount of legwork, businesses would enroll. Another problem was the available selection of insurance products. Many carriers utilized extensive medical underwriting practices and often rejected individuals or entire groups based on medical histories. Some carriers required blood tests and other exams before allowing applicants to enroll. Unfortunately, the State could not regulate carriers' underwriting practices. Blue Cross and Blue Shield often accepted many of the rejected groups because it did not medically underwrite.

In Genesee County, the biggest problem was not only making people aware of the program but ensuring their understanding of what was offered. Unfortunately, businesses were very skeptical about the program because it was government funded. Another problem
was the fact that it was a pilot program. Businesses were hesitant to get involved knowing that the program (and the subsidies) would end on a certain date.

Both demonstration sites experienced problems with business eligibility. The stipulation that a business had to have hired a former welfare recipient excluded many businesses. Although the open enrollment periods removed this requirement, many businesses did not become aware of them until they had ended. In addition, many businesses were "one man shops" which also were not eligible except during open enrollment.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

The program's biggest challenge was reaching the target market. It was originally expected that people would have to be turned away but this has clearly not been the case. Program planners question why a program with seemingly everything in its favor generated such a weak response. There are 7,000 small businesses in Flint (Genesee County), half of which are uninsured. Yet, the program only enrolled about 100 of them. In addition, the program had tremendous visibility, including front page news stories, favorable editorials and coverage on radio talk shows. It also had a great deal of community support. It has been speculated that the program simply did not have enough time to get off the ground and that it had ended enrollment by the time many potential customers heard about it. In addition, the average business size for enrolled firms was only four with most having less than ten employees.

The environment in the Genesee demonstration site was also a probable contributor to the low enrollment. The economy in Genesee County is depressed and its environment centers around auto makers and auto unions. Although it has many small businesses, they are not the focus of the economy. Marquette County fared much better, enrolling about the same number of people as Genesee County, even though it is about half the size. This could be due to the fact that it is a rural, low wage, low union area where small businesses are more visible and more people qualify for subsidies.

Enrollment in the One-Third Share Plan ended in October, 1990 and premium subsidies were officially discontinued on March 1, 1991. At that point, approximately 200 businesses (100 at each site) were enrolled. Whether these businesses will continue to offer health insurance to their employees is questionable. It has been speculated that although many businesses would like to continue to offer coverage, many simply cannot afford it without the state subsidies. The project director at the Marquette site now offers her services as a consultant to businesses to help them continue coverage. She assists them in seeking less expensive policies and encourages employees to contribute more of their monthly premiums. It is hoped that the State will be able to support another effort to address the uninsured problem in the future. At this point, there is interest but no funding is available.
CASE STUDY 6

FLORIDA HEALTH ACCESS CORPORATION
BACKGROUND AND PROGRAM OBJECTIVES

The state of Florida passed legislation in 1987 which called for the creation of a non-profit organization to address the uninsured problem and create a means for increasing access to health insurance for small businesses. The Florida Health Access Corporation (FHAC) was formed with a grant from the Robert Wood Johnson Foundation and a Board of Directors was appointed by the Governor. The program began enrollment in June, 1989 in Tampa and is now operating in four service delivery areas in 13 counties, including the Gainesville area, St. Petersburg/Clearwater and Tallahassee. Expansion activities in Orlando were taking place during the spring and summer of 1991. It should be understood that this program was developed prior to legislation passed in 1990 authorizing basic health insurance policies for small groups.

Prior to product development, FHAC conducted extensive market research for a year and a half. First, agents serving small groups were interviewed to gain an insight into the nature of the market and its problems. Second, small employers and their employees were interviewed to determine what type of benefits and service delivery structure were most important to them as well as how much they were willing to pay for monthly premiums. Research showed that affordability was the most significant barrier to providing health insurance. In addition, it was determined that small employers and employees would prefer an HMO plan rather than traditional indemnity insurance. Finally, FHAC concluded that there were approximately 10,000 eligible small businesses in the Tampa area.

FHAC is a public-private partnership. It relies on state funds and employer and employee premium payments to operate. The RWJ grant funds were used for development. Basic objectives are to reduce the number of uninsured, increase access to health insurance and target small business participation.

FHAC has devised a unique strategy for providing health insurance to small businesses. All businesses enrolled in the program form an "organized buying group," nicknamed "The Gorilla", with FHAC as its agent. This gives the group clout and leverage in negotiating with HMOs because the entire group is offered as an account rather than fragmented parts of it. In addition, because FHAC is the agent, the small businesses and individuals who are members of the buying group are shielded from negotiations and business arrangements, thereby providing a means of security.
PROGRAM DESCRIPTION

Benefit Structure and Premiums

FHAC contracts with an HMO (IPA model) in Tampa, Gainesville and Tallahassee. Av-Med operates in Tampa and Gainesville and Capital Health Plan operates in Tallahassee. In Tampa (the largest enrollment area), Av-Med has between 60 and 70 participating physicians and 12 participating hospitals.

There are small differences in benefits and copayments among the three contracted HMO programs. However, the benefit structures are similar for the various categories of patient care services. A broad array of services are covered, including basic inpatient and outpatient services, maternity and emergency care, as well as limited home health, convalescent care, mental health and alcohol abuse services. Inpatient care is 100 percent covered in participating hospitals. There is a $5 copayment for office visits and prescriptions and a $25 copayment for emergency room services (non-participating facility $50). There is no charge for diagnostic tests. At the Tampa, St. Petersburg/Clearwater and Orlando locations, members may choose between a standard option and a high option plan. Both cover the same services but the high option has higher premium payments and lower copayments.

Premiums are made affordable through state subsidies. Unlike most other RWJ programs which rely on state funds, FHAC utilizes a "blind" subsidy. FHAC collects a specific dollar amount from the state each month and applies it toward all premiums, thereby subsidizing everyone in the program rather than certain individuals based on income. This allows for premiums to be set lower for all businesses. In addition, the businesses are not really aware they are being subsidized. This type of subsidy results in less administrative labor expended and less paperwork since income eligibility does not have to be determined. Employers are required to pay 50 percent of premiums. For the first quarter of 1991, the employee's share of an average single monthly premium ranged from $32 to $56. The most popular category is the one-parent family (average 28 years old). The employee share of the premium for this category is approximately $123 per month (employer share is also $123). FHAC has been able to reduce family premiums an additional 15 percent by allocating a greater proportion of state subsidies to this sector. Premiums have increased at a rate of approximately 16 percent per year.

Administration and Marketing

There are 19 employees on the staff of FHAC, including 11 in the three "field offices" in Tampa, Tallahassee and Gainesville and eight at the headquarters office in Tallahassee. The Executive Director and the central billing staff operate out of the Tallahassee headquarters. FHAC staff handle all administrative tasks, including market research, eligibility screening, advertising and marketing, and billing and collection activities.
for the contracted HMOs, for which FHAC receives a discount of approximately 20 percent in return. HMOs are paid monthly according to the number of people currently enrolled. State funds as well as employee premiums are used to pay the HMOs.

Administrative and marketing costs are subsidized by the state and have been contained within the projected budget. In addition, FHAC's method of paying the HMOs does not allow for budget shortfalls since the HMOs are paid on a capitated basis. Utilization records thus far show that the FHAC population is not a sicker or riskier population, even though FHAC rejects only three to five percent of its applicants through medical underwriting. The medical underwriting process at FHAC is more of a screening process rather than the highly regimented underwriting process often used by insurance carriers. Many times, cases are pursued further than the medical application to determine if there are any special or mitigating circumstances, rather than simply rejecting an applicant based only on information contained in the application.

A public relations and advertising agency coordinates marketing efforts, while each of the local FHAC field offices handles the actual marketing paperwork. Radio and print advertising are used rather than direct mail because there are apparently no "good" mailing lists to buy. Radio advertisements during morning and afternoon hours when people are on the road have proven very successful. In addition, the program relies on a substantial amount of free media coverage. A network of agents actually sell the product. In addition, the Chamber of Commerce assists in marketing the product by referring small businesses which are seeking health insurance and by inviting FHAC staff to speak at conferences and meetings.

PROGRAM PERFORMANCE

Enrollment

Enrollment began in June, 1989 in Tampa. It was originally projected that 1,200 people would enroll in the first year. Projections proved modest when approximately 3,000 people actually enrolled by the end of the year. As of June, 1991, nearing completion of its second enrollment year, FHAC had 6,424 enrollees (1,399 businesses), about 30 percent of which were children. It appears that FHAC has penetrated approximately 10 percent of the target market so far and claims to have very high retention rates and excellent customer satisfaction. The average business size is approximately equal to three and the average group size is about five, although both fluctuate periodically. A recent study of enrolled members showed that one-third had never had health insurance before and the remaining two-thirds had not had insurance for an average of 18 months. The average member is 29 years old and earns $17,000 per year.

1 Source: Alpha Center.
Environment

According to FHAC staff, this program could be successful in almost any environment because it accommodates changes in the market. It also does not rely on certain provider conditions such as deep discounts from indigent care hospitals. The program uses market mechanisms to its advantage and has created bargaining leverage through its organized buying group.

There are some aspects of Florida's environment which could be considered assets or pitfalls, depending on one's perspective. Florida has a comparatively large number of uninsured people and small businesses. It also has an economy which, because of a substantial volume of tourism, is comprised largely of service and retail industries. Research has shown that these types of businesses often do not provide health insurance for their employees. In addition, a large and in many cases excess supply of providers has resulted in a very competitive health care environment.

From Av-Med's perspective, FHAC has performed very well so far. In getting involved with the FHAC, Av-Med had certain expectations. First, there was the opportunity to tap a new market and in doing so, expand access for the uninsured population. Second, because Av-Med is owned by Sante Fe Health Care, a non-profit hospital company on the receiving end of the uninsured problem, there was an incentive to get involved in FHAC and try to decrease the amount of the charity care being provided in area hospitals.

Thus far, FHAC has lived up to Av-Med's expectations. Av-Med has been a successful contractor for the program and has not incurred financial losses. The organized buying group concept works well for Av-Med because it spreads the risk over a large population. However, much of the financial success of the program depends on two very important concepts. First, a constant flow of new people into the program is critical because they tend not to have large claims early on and provide cash flow, some of which can be set aside for when they do become ill. Secondly, funds need to be set aside to support the program if the state subsidies are phased out in order to prevent drastic rate increases. A financial downturn in one year can prompt a rate increase which, in turn, can cause people to drop out. This usually precipitates another rate increase and the process continues a cyclical manner. Therefore, reserves are required to stabilize rates over an extended period of time.

In general, Av-Med's experience with FHAC has been positive. Small businesses have proven to be very loyal customers and Av-Med realizes that they are a very important part of the economy. Av-Med would, however, like to see all other insurance organizations play by the same rules in the small business market in terms of underwriting. There is a current state initiative which aims to curb the "cherry picking" process of selecting the best risks, an effort which is also being undertaken in other states as well. Research has shown that about 40 percent of hospital charity care actually arises from insured individuals whose pre-existing condition limitations result in non-payment by their carrier. Av-Med does not have a pre-existing condition requirement and would like to see other carriers eliminate such limitations. The state legislature is making an effort to address this issue.
LESSONS LEARNED AND FUTURE OF THE PROGRAM

One of the biggest lessons learned by FHAC is that most insurers are skeptical about small business health insurance programs. In seeking an underwriter during the program's initiation, FHAC struggled to convince insurance companies and HMOs that the program would be successful. Health insurers were cynical because the uninsured small business market has traditionally been labeled a high risk population. FHAC used state funds to take over the insurer's administrative and marketing functions and assume part of the risk. Insurers' attitudes have improved tremendously due to FHAC's excellent track record. In fact, some companies which had originally rejected the idea are now wishing they had gotten involved. Today, the FHAC organized buying group is a significant source of business for Av-Med and is apparently as large as some of its major accounts such as the local school board, with a greater potential for growth.

Reaching the uninsured small business market has also proven to be a difficult task. It is a very labor intensive effort for relatively small returns and often requires very dedicated efforts to track down the right people. Many small businesses can be described as having "their offices in trucks and their records in shoeboxes" and often cannot be reached by telephone. In addition, once they have bought the product, they often do not understand that FHAC is not an insurance company and cannot offer them special credit arrangements.

The program's biggest enemy is the state of Florida's budget deficit. It is hoped that the state subsidies can be phased out over time but if the state were suddenly unable at this point to continue its support, the program would be in serious trouble. The state considers the program a good investment because it appears to curb some cost shifting and helps mitigate the drain on local tax dollars.
CASE STUDY 7

SHARED COST OPTION FOR PRIVATE EMPLOYERS
DENVER, COLORADO
BACKGROUND AND PROGRAM OBJECTIVES

The Shared Cost Option for Private Employers (SCOPE) is a collaborative effort of several organizations. The Denver Department of Health and Hospitals (DDHH) received a three-year grant from the Robert Wood Johnson Foundation in 1987. With this funding and matching funds from the Colorado Trust (a philanthropic foundation), the Piton Foundation, the Hill Foundation and DDHH, a low cost health insurance plan for small businesses was developed. Other organizations involved include University Hospital, Colorado Business Coalition for Health and the Denver Medical Society. There is no state funding.

The program’s development was organized into four specific tasks. The first task involved a market research effort to determine the size, composition and location of the potential market. A survey was conducted in December, 1987 using a random sample of businesses with 20 or fewer employees in the five-county Denver metropolitan area. The survey provided information regarding product design and pricing issues. One issue involved designing and marketing a plan which would fit the needs and constraints of small employers. A second issue focused on developing realistic risk estimates based on the characteristics of the small business workforce.

In 1988, product development (the second task), was completed. The third task was to contract with an underwriter. United States Life Insurance Company was selected to perform this role. Finally, a network of physicians and hospitals was established in 1989.

PROGRAM DESCRIPTION

SCOPE is a low cost indemnity insurance product which utilizes providers associated with U.S. Life’s Colorado PPO (previously established). The result is a cross between an HMO plan emphasizing preventive care and a catastrophic plan. The program was introduced in the Denver area in August, 1989 and is now available in other areas of the state. As of March, 1991, it was available to 80 percent of Colorado’s population. Businesses with 50 or fewer employees are eligible. Although the program is geared toward businesses which do not offer insurance, businesses wishing to change to a less expensive plan are also eligible. At least 75 percent of employees in a firm must enroll.

There are seven SCOPE provider networks operating throughout the state which include 2,700 physicians (primary care and specialists) and 27 hospitals. Enrollees must select a primary care physician to act as a gatekeeper. Physicians are paid on a fee schedule and hospitals are paid discounted charges.
Benefit Structure and Premiums

SCOPE relies on major cost sharing to make premiums affordable and enrollees must use participating hospitals and physicians. There is a $250 per person per year deductible for inpatient services and a $50 deductible for prescription drugs. The coinsurance rate is 50 percent of the first $5,000 of covered charges and 100 percent thereafter. Pregnancy is paid for as an illness and well baby care is free. The program emphasizes preventive care, which is 100 percent covered within specified guidelines. Office visits other than preventive services require a $15 copayment. Limited substance abuse services and outpatient psychiatric care are covered at a rate of 50 percent. Other benefits include podiatry services, private duty nursing, oxygen, durable medical equipment and survivors' benefits. The annual out-of-pocket maximum is $2,750 per person and $5,500 per family.

The medical indigency program in Colorado is also linked to SCOPE. A SCOPE enrollee who qualifies for indigent care may have some or all of the coinsurance waived by receiving care at a hospital which participates in both the indigent care program and SCOPE. A person must have a household income below approximately 185 percent of the Federal poverty level to be eligible for the Medicaid indigent care program.

Premium rates are about 40 percent lower than market rates for comprehensive health plans in the Denver area. The medical underwriting system used by U.S. Life is the standard system used for all other products. For groups of one to nine persons, each employee and spouse must prove insurability by providing a medical history. Children are not required to do so. Persons with certain conditions such as terminal cancer or lung disease are not eligible for coverage. Unfortunately, there is no high risk pool to absorb these persons. Groups of ten or more have guaranteed issue. Premiums are rated by age and sex and vary by location. U.S. Life does exclude certain industries from coverage because of their potential high risk, including barber/beauty shops, police, mining/quarrying, exterminators/crop dusters, professional athletes and the taxi industry. As of May 1, 1991 the monthly rate schedule for selected age groups for the Denver area is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Single Male</th>
<th>Single Female</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$46.37</td>
<td>$86.97</td>
<td>$154.47</td>
</tr>
<tr>
<td>40 to 44</td>
<td>$76.22</td>
<td>$101.24</td>
<td>$190.14</td>
</tr>
<tr>
<td>55 to 59</td>
<td>$135.04</td>
<td>$178.72</td>
<td>$262.08</td>
</tr>
</tbody>
</table>

Premiums shown are the medical rates for groups of one to nine persons. A minimum of $10,000 of life insurance must be purchased which adds approximately $.50 to $1.00 to the monthly premium. Employers must contribute at least 25 percent to employees' monthly premiums.
The SCOPE program is actually several organizations and people joined together in the administration of an insurance product. A project director devotes about 15 percent of her time to SCOPE to oversee operations. Benefit Management and Design, Inc., a private employee benefits company acts as marketing coordinator, answers SCOPE telephones, handles requests and coordinates potential enrollees with brokers. In addition, the company monitors sales and broker performance and serves as an insurance consultant. U.S. Life is the underwriter and administers the product. There is also a part-time coordinator at the Department of Health and Hospitals.

A news conference attended by the Governor of Colorado marked the official kickoff of the program. The product is sold by agents and brokers, with about 30 to 40 brokers selling the product regularly. The program is advertised through television, radio, print and direct mail, generating leads for brokers. Benefit Management has found that direct mail marketing is not effective in the small business market. U.S. Life markets SCOPE as it does all other products by hosting traditional "broker breakfasts." It also has a sales office in Denver which is used by brokers and agents.

PROGRAM PERFORMANCE

The program is now in its second year of enrollment and the insurance plan is self-supporting. An initial enrollment projection of 1,000 persons or 100 businesses by the end of the first year proved too modest and was later changed to 5,000 persons. This goal was reached during the week of the program's first anniversary. As of June, 1991 there were 6,932 members (709 businesses). Even though the product is offered to businesses with up to 50 employees, the average firm size is 4.2 and the average group size is 9.8.

It has been suggested that development of the program could have been approached differently. First, it may have been more prudent to form SCOPE as a non-profit organization rather than as an insurance product, thus creating a vehicle for administering and controlling the program as well as procuring future funds. In such an arrangement, U.S. Life would have responsibility for processing claims payments and accepting the risk for the plan but would not have as much control over operations as it does now. However, if such an arrangement had been proposed at the outset, U.S. Life might not have agreed to underwrite the plan.

1 Source: Alpha Center.
LESSONS LEARNED AND FUTURE OF THE PROGRAM

One of the biggest problems during SCOPE's development stage was contracting with an underwriter. Insurance companies were leery of getting involved with a population traditionally labeled high risk. SCOPE finally contracted with U.S. Life after a one year RFP process. Since the program's implementation, it has appeared that persons enrolling in SCOPE are generally young and healthy. According to U.S. Life, there have been "a couple" large claims but generally, claims costs have been in line with projections.

Two problems occurred during the implementation phase of SCOPE. First, the marketing survey showed that the small business population relied primarily on agents and brokers for information about health insurance. Therefore, when the program began, potential members were referred to agents and brokers. Unfortunately, brokers were not carefully selected at the outset and some did not perform well in dealing with small groups. As a result, several businesses became frustrated with the program. Another problem was underestimation of demand. There were not enough phone lines and staff to handle the number of inquiries. It is believed that the program lost some momentum because of this and possibly some potential members.

An ongoing problem with the program has been tension between potential SCOPE enrollees and U.S. Life. Part of the problem lies in U.S. Life's efforts to conduct "business as usual," forgetting that the small business market is highly unusual. U.S. Life claims that the uninsured small group market is no different from any other market. Although it has apparently done very well in administering SCOPE, it must often be reminded of what the program seeks to accomplish. In addition, this market requires extra effort to reach and it has not always been easy to get U.S. Life to go the extra mile.

From U.S. Life's point of view, there are two major difficulties with the uninsured small business population. First, it is often an arduous task to obtain employees' past medical histories, especially trying to locate physicians who rendered treatment. Second, the target population generally works for less affluent employers who are often missed by broker marketing efforts. Therefore, advertising must provide the critical link between small businesses and brokers.

SCOPE was developed to be transferrable to other environments and could be easily replicated. In order to be successful, however, a program must have several key elements. First, the program must be a "grass roots community-based project." During SCOPE's development stage, various members of the health care community were brought together to contribute different ideas as well as relay information and garner support from their respective constituencies. This alliance has made the public more receptive to SCOPE because it dispels the image of being just another insurance product. In addition, it has been easier to gain media attention and support. SCOPE was given much free advertising because of its community focus.
A program such as SCOPE also requires a promotional strategy which does not conform to standards. Instead of the traditional methods which most insurance companies use to introduce products, a strategic marketing plan must be developed. Small businesses in Colorado are constantly exposed to SCOPE advertising campaigns and cannot help but take notice. SCOPE is also price sensitive. The product was "built backwards," meaning that the price people were willing to pay was determined first and the product was developed to conform to that price. The experienced HMO community in Colorado also made implementation easier.

Other insurance companies such as John Alden, Pacific Mutual, Pan American Life have begun to offer "copy cat" products which are apparently not selling very well. This has been attributed to marketing strategies which lack the proper focus to reach small groups.

The future of SCOPE appears to be very positive. The various organizations and persons involved are very committed to its continued success. It has been especially important to U.S. Life that people not become involved in the program only to have it come to an end and be without health insurance again. For this reason, U.S. Life is very committed to the program's continued success. Other proponents of the program are also very committed and optimistic that the program will make a significant difference in the uninsured environment in Colorado.
CASE STUDY 8

MAINECARE
The Maine Department of Human Services (DHS) was awarded a three-year grant from the Robert Wood Johnson Foundation in 1987 to develop an insurance program for the working uninsured. The grant award followed a study conducted in 1986 by the University of Southern Maine Human Services Development Institute which concluded that the uninsured population was largely comprised of employed individuals. DHS appointed the University as a subcontractor, responsible for a large part of the development, implementation and evaluation of the program. In addition, an advisory committee was formed with representatives from the insurance industry, providers, advocates of opportunities for low-income persons, AFL-CIO, hospitals, ambulatory care centers and others. In addition to RWJ grant money, the program receives funding from the state to subsidize premiums and in-kind contributions from the University of Southern Maine.

MaineCare was authorized by the state legislature in 1987, although plans for the program's development and implementation were not specified. The program was exempted from the state insurance code. Over time, the following objectives were developed: to provide access to primary and acute care for uninsured people, especially the self-employed and small businesses; to develop a public-private partnership to address the uninsured problem; to stimulate the infusion of new private sector funds into the health care delivery system; to encourage the development of managed care systems and improve efficiency; to provide information about health insurance to the small business community; and to obtain utilization patterns and other related characteristics for the uninsured. Enrollment began in December, 1988.

PROGRAM DESCRIPTION

The state Legislature initially authorized demonstration sites for the program in one urban site and one rural site. The urban site chosen was Bath/Brunswick while Somerset County was chosen as the rural site. The State contracted with HealthSource Maine, a private, for-profit HMO (IPA model) to administer the program. DHS was able to reduce premium rates by adjusting the benefit structure and negotiating discounts and risk-sharing arrangements with providers. In addition, DHS pays the salaries of HealthSource staff who perform administrative and marketing duties for MaineCare. At the Bath/Brunswick demonstration site, HealthSource uses an independent physician network, two community hospitals and one tertiary referral hospital. The hospitals use part of their bad debt/charity care allocations established by the Maine Health Care Finance Commission to discount MaineCare rates. Primary care physicians are paid on a capitated basis and specialists are paid on a fee-for-service basis using a withhold policy (i.e. a portion of the fee is withheld and may subsequently be paid to the provider based on whether specific claims cost
objectives are met). To protect HealthSource from catastrophic losses, DHS has an agreement to reimburse HealthSource for medical expenses in excess of 105 percent of total premiums. The State Legislature established a $350,000 risk reserve fund for this purpose. If the costs of providing services are less than premiums collected, HealthSource pays DHS the difference.

Businesses with 15 or fewer employees and have not offered health insurance for one year are eligible for the program. Self-employed persons and part-time workers are also eligible, although seasonal workers are not. There is a 90-day waiting period for pre-existing conditions (applies mainly to elective surgery and does not apply to pregnancy) and applicants with specific conditions such as cancer, diabetes, AIDS and severe mental disorders are not eligible to enroll. These people are referred instead to the Maine High Risk Insurance Organization for coverage and may also receive premium subsidies.

During the development of the MaineCare program, there was a concern about former welfare recipients who take low-paying jobs without insurance and then quit when they become ill in order to qualify for Medicaid benefits. Therefore, low income enrollees who apply for a subsidized premium contribution are screened for AFDC eligibility and if eligible, may enroll in the FamilyCare Program which provides Medicaid benefits. If the person later loses eligibility due to employment, he/she automatically qualifies for enrollment in MaineCare.

**Benefit Structure and Premiums**

MaineCare offers a comprehensive benefit package. Physician office visits are covered and require a $5 copayment and emergency services require a $25 copayment. Inpatient care is 100 percent covered as well as diagnostic tests, home health care, ambulance and short term physical therapy. In addition, mental health services and substance abuse treatment are 100 percent covered but limited to 20 outpatient visits and 31 inpatient days per year. Outpatient prescription drug coverage can be purchased for an additional premium payment. The FamilyCare benefit plan is slightly more comprehensive and requires no copayments.

There are four categories of premiums: single, single parent with one or more children, two adults, and two adults with one or more children. Employers must contribute 50 percent of employees' monthly premiums (unsubsidized rate, shown below). For part-time workers, the employer's share is pro-rated based on the number of hours worked per week. Enrollees whose income falls below 200 percent of the Federal poverty level are eligible to have their premiums subsidized by the State on a sliding scale basis. Enrollees below 100 percent of the poverty level do not have to contribute to their monthly premium payment. Instead, the state and the employer split the cost equally.
Monthly Unsubsidized Premiums

Single: $99.94
Single parent with one or more children: $189.89
Two adults: $219.86
Two adults with one or more children: $298.81

Subsidized premiums vary according to income. As an example, a family of four with an income of $20,000 per year (between 126 and 150 percent of poverty) has a total premium of $298.81 per month but the employee pays only $63.50. The employer pays $149.41 and state pays $85.90. If the enrollee is self-employed, the state pays the employer share as well. Certain firms which are not very profitable or financially strained may also be subsidized. In return, they are supposed to participate in state job training and placement programs but this requirement is not enforced. This is said to be a "weak link" in the subsidy component of the program.

Administration and Marketing

The MaineCare program is directed through the DHS Bureau of Medical Services. The individual who directs non-Medicaid activities of the Bureau is responsible for oversight of MaineCare. The assistant director is responsible for day-to-day operations and acts as liaison with HealthSource Maine. There is also a contact person for technical assistance at the University of Southern Maine. Two HealthSource staff members whose salaries are paid by DHS handle enrollment and marketing for MaineCare. If the program were to expand statewide, the program's directors estimate that it would require 9.75 Full Time Equivalents (FTEs) including 4 marketing specialists who would oversee a network of brokers.

Administrative costs have been high because of the labor intensive nature of the program. However, medical services costs have been lower than anticipated, suggesting that the reason this population has not been previously insured is simply that they could not afford it, not because they were uninsurable.

Two HealthSource staff members (mentioned above) handle all marketing activities and report to the HMO's marketing director. The MaineCare marketing campaign began in January 1989 with a press conference which generated a substantial amount of business for about six months. This press conference also precipitated a great deal of word of mouth advertising which has proven to be essential. Other marketing efforts have been concentrated on organizations which have direct contact with certain small employers. Some examples include the Department of Marine Resources (lobstermen and fishermen) and the Department of Agriculture. Another group targeted is day care providers. Cold calling was tried but proved to be a waste of time and direct mail was not used because of a lack of suitable mailing lists. The program did have a small paid advertising campaign where "success
stories" were published in newsletters of targeted organizations. However, limited funding has prevented a widespread advertising campaign. The program has not paid for television or radio advertising.

PROGRAM PERFORMANCE

Enrollment began in December 1988 at the Bath/Brunswick site. At that time, it was projected that 1,400 people would enroll over the course of three years. Actual enrollment as of June 1, 1991 was 1,170 people. This includes 380 businesses, 210 of which are self-employed individuals. Average group size is 4.0 and average firm size is 2.5.1 The enrollment rate at this site was on track with projections for the first year and a half but began to decline due to variety of factors including a volatile small business market, poor economy and lay offs. Enrollment did not begin at the Somerset County site until February, 1991 with a projection of 700 persons. As of April 1, 1,125 people had enrolled (30 self-employed individuals and 9 groups). DHS staff emphasize that projections were "pulled out of the air" because they really had no basis for making accurate estimates. To date, MaineCare has enrolled approximately 17 percent of eligible businesses in the demonstration areas.

At HealthSource, the MaineCare program is regarded very highly. In general, the relationship between HealthSource and DHS is said to be very good. Often the two "speak different languages" because one is a state agency and the other is a commercial business but the differences have not caused problems. The product itself is also regarded very highly and is apparently a richer package than most of the packages offered by HealthSource. Its only drawback is that it does not cover prescription drugs and the rider that can be purchased is fairly expensive.

The population served by MaineCare does not appear to be as risky as expected. In one opinion, however, the fact that the program is relatively small and has not been operating very long must be taken into consideration. On one hand, it appears that members of this population are not big users of primary care which keeps costs down. On the other hand, however, it may be these same people who wait until they are very ill to go to the doctor which ultimately is more expensive. It is difficult to determine which is the case at this point.

HealthSource supports the program's continuation, especially to gain experience in marketing to the uninsured and serving small businesses. It is also believed that the program also needs more time to show that utilization is in fact low, especially because the commercial insurance industry has labeled this population high risk.

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1Source: Alpha Center.
LESSONS LEARNED AND FUTURE OF THE PROGRAM

MaineCare has experienced two major problems. First, implementation was a long process, as is evident in the long lag time between enrollment start dates at the two sites. Securing a contractor for Somerset County proved to be a major setback. Synernet Quality Health Plan, a PPO initially planned to participate but a reinsurance mechanism was needed which would have been provided through Blue Cross and Blue Shield. This agreement did not work out. HealthSource was finally contracted with during the summer of 1990 but not without a struggle. It was originally thought that a contract would be awarded through a competitive bidding process but most health plans and insurance carriers were not interested so DHS staff felt they almost had to beg for a participant.

The second problem was that the original program specifications, which were somewhat a combination of an indemnity product and a managed care plan, limited their ability to work with certain contractors, especially HMOs. In addition, HMOs were apprehensive about working with MaineCare because they felt that the self-employed and small business population had high risk potential. DHS staff suggest that MaineCare might have been more easily implemented in a more experienced HMO community in the western U.S.

Several other lessons have also been learned about the MaineCare program. First, the program has not successfully reached part-time workers, although DHS staff cannot pinpoint the reason. Second, MaineCare's link to the Medicaid expansion program has proven effective in combining an employer-based insurance program with a non-employer-based program. Third, although MaineCare has done reasonably well in attracting employers through voluntary incentives, DHS staff feel that other incentives may be needed to increase enrollment. Tax incentives have been suggested but the issue is apparently highly politically sensitive. Finally, there is a need to make changes in eligibility criteria in order to better reach businesses which are truly "locked out" of the commercial insurance market.

The MaineCare program is due to end in December, 1991, but DHS staff are lobbying to continue the program and are hoping to secure another 18 months of state funding. The future of the program is questionable because the State is experiencing a fiscal crunch. The mechanics have been formulated for an expansion plan to a third demonstration site (Bangor) but this has been stymied by a lack of funds as well. An evaluation of the program conducted by the University of Southern Maine is to be submitted to the legislature for use in considering an extended appropriation of funds.
The Central Alabama Coalition for the Medically Uninsured was formed in 1986 to develop and implement a health care program for the uninsured. The program was created under the direction of the Governor’s Blue Ribbon Task Force to Study Uncompensated Care with grant funds from the Robert Wood Johnson Foundation. The Coalition was the result of joined forces from the University of Alabama at Birmingham and “Crucible,” an alliance dedicated to increasing access to health care for the poor. Originally, the Coalition was to be an independent non-profit organization but was instead formed as an advisory group to the University. The University is the administrator of the RWJ grant.

Several groups with an interest in health care, including insurers, providers, volunteer agencies, religious groups and government offices, are represented in the Coalition, which is governed by a 21-member volunteer board. The Coalition was awarded a three-year, $480,000 grant from RWJ. Marketing funds were donated by several local companies. The program receives no state funding and relies primarily on employer and employee premiums to operate.

Originally, Blue Cross and Blue Shield of Alabama was contracted with to underwrite the plan. However, two years of negotiations concerning provider arrangements and risk assessments proved difficult and Blue Cross backed out. The Coalition was eventually able to contract with Complete Health, an HMO which is a subsidiary of the Health Services Foundation, a physicians’ group affiliated with the University. However, the change in underwriters set the development process back about one year because many details of the plan had to be renegotiated. In order to be underwritten as an HMO, waivers had to be approved by the Insurance Commissioner which allowed the plan to limit the amount of benefits and exclude mental health services (a state mandated benefit).

The primary objective of the project was to develop a limited benefit plan for the working uninsured. During the program's development, the Coalition first determined affordable premium costs and then devised a benefit structure which fit these costs. The program offers a full range of services but limits the amount of services which can be used (i.e., the number of visits). The plan emphasizes primary and preventive care and does not provide catastrophic coverage.

The program operates in Jefferson County (Birmingham) and in the northern portion of Shelby County, and relies on deep discounts from providers to reduce premiums. The Coalition was not able to secure large discounts from providers in other counties. This has been attributed to the change in underwriters.

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PROGRAM DESCRIPTION

Benefit Structure and Premiums

There are two benefit packages available to enrollees. The first, called the public option, requires that enrollees use only the Jefferson County Indigent Care Hospital, Cooper Green (Jefferson County's public hospital) and certain other public providers to receive care. All providers accept capitated rates under the public option. Members are allowed six physician office visits per year, with an $8 copayment for each. Pre- and post-natal care also have an $8 copayment per office visit. Inpatient hospital care requires a $20 per day copayment and inpatient physician and surgeon services, anesthesia and ambulance services are covered at a rate of 80 percent after a $100 deductible has been fulfilled. Outpatient surgery requires a $50 copayment per day while all other outpatient services including lab and x-ray services have a $20 copayment per visit up to $300 per year. A $50 copayment must be paid for emergency services. Prescription drugs are covered with a $3 copayment for generic brands and $8 for brand names.

Benefits, deductibles and copayments for the second package, called the private option, are the same as the public option but enrollees may choose from seven hospitals. In addition, physicians on staff at the hospitals provide primary care and specialist services. For this option, primary care physicians are paid on a capitated basis and specialists are paid 70 percent of charges. Hospitals are paid 80 percent of total charges for outpatient services. For inpatient services, hospitals receive per diem rates of $500 for the first day and $300 for the second through tenth day (only ten days are covered under the plan). PCPs have apparently been unhappy with the capitated rate because BasicCare requires them to perform gatekeeper duties which they feel they are not adequately compensated for.

BasicCare premiums are not rated based on age or sex. Therefore, there are only four possible rates depending upon the option chosen. Employers must contribute 50 percent of the monthly premium, even if family coverage is chosen. BasicCare revised its rates as of April 1, 1991. Monthly premiums are shown below.

<table>
<thead>
<tr>
<th>Public Option</th>
<th>Private Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single: $47.32</td>
<td>Single: $80.41</td>
</tr>
<tr>
<td>Family: $115.94</td>
<td>Family: $202.59</td>
</tr>
</tbody>
</table>
Administration and Marketing

Originally, the Coalition staff working with BasicCare consisted of a project director, two assistant project directors and a half-time secretary, in addition to the advisory board. Because the RWJ grant has expired and the program has not generated sufficient revenue, staff has been reduced to an assistant project director (part-time) and a half-time secretary. These staff members receive inquiries and screen potential applicants to determine eligibility. Complete Health is responsible for administering and underwriting the plan, as well as contracting with providers and selling policies to employees.

Marketing for BasicCare has been described as "scarce." Before the change in underwriters, an advertising agency was hired to develop a marketing plan. When Complete Health was contracted with, it took over all marketing activities. There was some confusion, however, because Complete Health's marketing philosophy was completely different from what was initially planned. The original plan was to use public service announcements, television ads and all possible forms of free advertising. However, Complete Health advocated radio advertising.

The program was initiated with a press conference and a radio advertisement which ran for three months. The ad generated a significant response but many of the respondents were businesses which already offered health insurance and wanted to switch to a cheaper plan. It appears that the marketing campaign used did not tap the target market. There are plans to begin a new marketing campaign in attempt to penetrate the uninsured market. The new campaign includes a three-month radio ad as before but will be accompanied by more public relations efforts targeted at churches, schools and civic groups.

Eligibility

To be eligible for BasicCare, a business must have at least three employees working a minimum of 24 hours per week. Groups of less than ten must enroll all employees while larger groups must enroll 75 percent. In addition, a business cannot have offered health insurance coverage in the last 12 months. This stipulation was included by the Coalition for two reasons. First, there was a concern about creating tension with private insurers by taking away a portion of their business. Secondly, providers were not interested in treating people enrolled in BasicCare if they could afford to pay for regular insurance policies. BasicCare does not have individual underwriting or require pre-enrollment physical exams or extensive medical histories. However, there is a 12 month waiting period for pre-existing conditions, unless no treatment has been received for 180 consecutive days.
PROGRAM PERFORMANCE

From an enrollment perspective, BasicCare has not performed very well. Although no enrollment projections were made at the outset, enrollment has not come close to the established limit of 2,000. At one point, 428 people enrolled but that number declined to 246 as of June 1, 1991. Although small businesses with at least three employees are the target market, there is no ceiling on firm size. Average group size is 6.0 and average firm size is 4.2.\(^1\) Low enrollment has been attributed partly to a lack of advertising. However, on a survey conducted after BasicCare was developed, small businesses responded that the marginal utility of health insurance is low. In addition, it was found that employees wanted health insurance but some felt they were healthy and did not need it, others were on a spouse's policy, and still others simply did not want to pay for it. According to some sources in Alabama, it appears that there is not much of a market for health insurance among small businesses in the State.

One person who has worked closely with the program believes that the product is simply too expensive (because most small businesses want free health insurance) and the basic assumptions in the organization of the program are flawed. In this view, the bottom line is that small businesses are not going to buy health insurance and that there simply is not a demand for a program like BasicCare. Thus, under this view, coverage for the uninsured should be provided through a mechanism other than employers.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

One of the biggest problems for the Coalition and BasicCare was contracting with an underwriter. Much of the groundwork for the program was laid out over two years with Blue Cross as the underwriter but apparently Blue Cross was apprehensive about taking on too much risk. It proposed to contract with a co-underwriter to share the risk but other insurance companies were unwilling to enter into such an agreement. This reluctance is blamed on lack of information on the uninsured market and lack of claims experience. No market research was completed prior to the implementation of BasicCare. Finally, Complete Health offered to take over Blue Cross's position as underwriter and accept full risk. Unfortunately, this put the Coalition in a somewhat undesirable position with providers because Complete Health is one of Blue Cross's biggest competitors and many providers preferred to deal with Blue Cross.

Another problem has been contracting with primary care physicians. Most are unwilling to work for the small capitated fee paid by BasicCare. As of March, 1991, the program had only four contracted pediatricians. One the other hand, the program is not lacking specialists because they receive 70 percent of their fee-for-service rates.

\(^1\) Source: Alpha Center.
Administrative activities have also caused problems. Apparently, difficulties have arisen because BasicCare is very small compared to Complete Health's other accounts.

Two other problems related to marketing have been identified. First, it was difficult to educate the public as well as providers about the product because it was very different. Second, there simply has not been enough funding for advertising. Apparently the original budget shortchanged the marketing aspect of the program and did not include funds for adequate staffing or for persistent radio, television or print ads.

The program is due to end in April, 1992. During its last year, the program will be evaluated and the utilization patterns will be studied. Unfortunately, there is not much support from the State or local organizations for continuing the program, and although a positive evaluation could change that, funding would still be a problem and the State is not able to provide subsidies. Some changes which have been considered, including modifying the reimbursement method for PCPs and devising better marketing strategies. In addition, there is an interest in expanding statewide but there are deficiencies in rural provider systems which would make an expansion difficult. The future of the program is questionable.
CASE STUDY 10

UTAH COMMUNITY HEALTH PLAN
BACKGROUND AND PROGRAM OBJECTIVES

The Utah Community Health Plan (UCHP), a Robert Wood Johnson Foundation funded project, focuses on providing health care to low income employees in small businesses. Prior to UCHP’s development, a Health Care Access Steering Committee comprised of the Director of the Department of Health, hospital administrators, the Insurance Commissioner, medical society members and others was assembled to address the uninsured problem. UCHP’s development began in 1986 with the receipt of an RWJ grant and the sponsorship of Intermountain Health Care (IHC), a private non-profit provider system. Almost simultaneously, primary care clinics (Salt Lake Community Health Centers) were being established, three under Federal funding, and two with funding from IHC. This group of community health centers agreed to provide UCHP with a base of primary care providers, which has been regarded as one of the key factors in the successful development of the program.

Formal implementation of UCHP began with receipt of a Certificate of Authority in 1988, allowing the organization to operate as an HMO. In addition, a Board of Directors was established, with seats filled by members of Intermountain Health Care, Salt Lake Community Health Centers (SLCHC) and two large hospitals in Salt Lake City. Enrollment began in October, 1989.

In addition to the RWJ Foundation, UCHP is funded by IHC, which provides a direct subsidy as well as dedicated reserves. There is no state funding. The objectives of the program focus on meeting the needs of low income employees of small businesses. The program aims to provide primary care while maintaining basic inpatient coverage and to make premiums affordable through provider discounts. In addition, it was hoped that Salt Lake’s health care delivery system would enjoy a new source of income from premium payments of the formerly chronically uninsured.

PROGRAM DESCRIPTION

The program serves Salt Lake and southern Davis Counties and focuses on low income workers in small firms that have not provided health insurance for one year. The emphasis on the chronically uninsured is an effort to avoid displacing current private insurance coverage, although UCHP has still met with significant opposition from the insurance industry in trying to serve the uninsured population.

UCHP relies on a limited provider network, major cost sharing and provider discounts to make premiums affordable. It currently contracts with six hospitals, 18 primary care physicians (through SLCHC and other practices) and over 300 specialists. Hospitals
accept a 35 percent discount and take full responsibility for inpatient stays over 30 days. PCPs are paid on a capitated basis. Because of SLCHC's current capacity constraints, UCHP has contracted with two private PCPs. In addition, the University of Utah's Department of Family Practice and three other private family practitioners have been recently contracted to accommodate the growth of the program and the need for improved geographical access. Specialists are paid on a discounted fee-for-service basis. UCHP originally hoped to have at least two physicians per major specialty per hospital. This has been achieved at the three hospitals which accept the greatest number of UCHP patients.

Benefit Structure and Premiums

UCHP offers a choice of two plans. The high option plan has a $10 primary care office visit copayment, a $20 specialist office visit copayment and a $150 per day inpatient copayment with full coverage after four days. In addition, there is a $350 per day copayment for the first three days of inpatient maternity care. Immunizations, laboratory, x-ray, physician's inpatient services, outpatient surgery and most outpatient services are covered in full. The low option plan has a $15 office visit copayment, a $200 per day inpatient copayment and a $300 deductible for outpatient ancillary, emergency and ambulance services. Limited mental health and substance abuse services are also covered. These plans are the result of changes made during 1990. Premiums had been increasing at a rate of 18 percent annually and the plan was becoming more difficult to sell. Copayments were modified in order to lower premiums without changing the scope of benefits and creating collection problems with providers.

Premiums are rated by age and sex. Medical underwriting is fairly extensive, although it is considered lenient compared to other insurance products. On average, ten percent of applicants are turned down due to medical underwriting. The monthly premium for a family of two 30-year old adults and one or more children ranges from $170 to $200. A single male's premium is $63.37 for the high option plan and $57.31 for the low option plan (rates valid on February 1, 1991). Pre-existing conditions are covered at 50 percent during the first year of enrollment. Employers must contribute $30 to an employee's monthly premium.

Administration and Marketing

Administrative staff includes seven employees in an HMO structure. The staff is led by an Executive Director who is supported by a Business Manager, Claims Manager, Secretary, two marketing representatives and a half time contract utilization control nurse. UCHP had projected a loss of $330,000 in its first year but actually incurred a loss of $220,000. Actual administrative expenses were less than the budgeted amount and medical services were found to cost $.65 for each premium dollar which is $.19 less than the budgeted amount.
Marketing is done primarily through direct mail with the assistance of Smith Harrison, a direct response marketing consulting firm. The initial mailing achieved a response rate of over 10 percent. Subsequent mailings received a five to six percent response rate due to repeat mailings. The program also received media coverage during its early enrollment stages. Two salaried marketing representatives are responsible for selling the product.

PROGRAM PERFORMANCE

Enrollment

Enrollment began in October, 1989 with a projection of 200 new members per month. Actual enrollment has been less than 100 members per month. As of June, 1991 there were 1,550 people enrolled in UCHP, with 40 percent of those self-employed and the majority of the remaining 60 percent employed in firms of five or fewer employees. Average firm size is 3.5 and average group size is about 5.9. Although the enrollment rate is lower than expected, it appears that UCHP is hitting its target market based on characteristics of the enrolled population. Approximately 90 percent have never had health insurance coverage and average household income is about 200 percent of the Federal poverty level.

Although UCHP staff are enthusiastic about the program's performance, others who have worked closely with the program display a more reserved optimism. One person involved with UCHP characterizes its development and implementation as an uphill battle with successes few and far between. However, people involved have never given up, and although resources are dwindling and growth is slower than expected, the program has a chance for survival.

In this view, there have been three major problems with UCHP's development and operation. First, SLCHC had committed to provide services to UCHP enrollees when the program was first being developed, but by the time of enrollment, SLCHC had reached capacity. This has created problems with appointment scheduling. UCHP has added contracts with other service providers to try to remedy this problem. This leads to the second problem, which is soliciting provider participation. UCHP receives a fairly large discount from SLCHC which most other providers are unwilling to accept. Finally, enrollment rates have not met expectations. This could be related to price and the fact that many small businesses have not provided health insurance for so long that it simply is not a priority. Another reason is that people who perceive themselves as healthy and not in need of health insurance simply do not want to pay for it. In addition, small businesses are more likely to hire younger workers.

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1 Source: Alpha Center.
LESSONS LEARNED AND FUTURE OF THE PROGRAM

One of the most obvious shortfalls of the program is its inability to meet enrollment goals. Unfortunately, this appears to be more of an inherent problem with the uninsured small business population than with the UCHP program itself. On the one hand, this market appears to be more price sensitive than benefit sensitive. Although UCHP's price is approximately 40 percent below market rates for comparable coverage, it is only slightly below the costs of "bare bones" packages which predominate in the small group market.

On the other hand, according to program administrators, small businesses also seem to be relatively price insensitive as well, i.e., they are not willing to pay for health insurance. UCHP staff estimate that even if the premium price were 40 percent below its current level, the program would still only penetrate about ten percent of the uninsured small business market. In many cases, the low income people being targeted simply do not have the money, although it is difficult to tell whether it is the employees or employers who are more unwilling to pay. Unfortunately, the State is not willing to subsidize the program so there is really no mechanism for making premiums less expensive.

Because enrollment has been slower than predicted, and a total membership of 6,000 people is needed to achieve self-supporting status, there is an interest in expanding to Ogden and Provo to boost enrollment. In addition, UCHP is considering pursuing other lines of business such as a Medicaid capitation contract and an uninsured risk pool to bolster its position in the insurance marketplace.

The outlook for the future is positive due in part to widespread support from the corporate community. However, UCHP staff recognize that marketing expectations must be more realistic. They have learned two major lessons about the small business market in Utah. First, they cannot expect to penetrate more than ten percent of the market. Second, if a program relies on a voluntary system (i.e., non-mandated health insurance) it must be prepared to expend large amounts of labor and dollars for a relatively small number of people covered.
CASE STUDY 11

WISCONSIN SMALL EMPLOYER HEALTH INSURANCE MAXIMIZATION PROJECT
BACKGROUND AND PROGRAM OBJECTIVES

The problem of access to health insurance has been on the legislative agenda in Wisconsin since 1981. A special committee was created in 1983 to study the scope of the uninsured problem and possible solutions. In 1985, the Legislature created the State Health Insurance Program (SHIP), a series of pilot projects in selected demonstration areas which were to ultimately become a statewide program. State funds were appropriated for three pilot projects in 1988. In addition, the Wisconsin Department of Health and Social Services was awarded a grant from the Robert Wood Johnson Foundation for the development of the first pilot project, called the Non-Insuring Firm Pilot.

The Non-Insuring Firm Pilot was prompted by a study which determined that 80 percent of the uninsured in Wisconsin were employed or dependents of an employed person. It was decided that efforts should therefore be concentrated on employment-based insurance. Objectives of the project included testing for market interest in a subsidized insurance product, testing administrative capabilities in implementing such a program, demonstrating products already available in the marketplace, and testing new solutions to the health insurance problem. Enrollment in the pilots ended January 1, 1991.

PROGRAM DESCRIPTION

Benefit Structure and Premiums

The Non-Insuring Firm Pilot (developed with RWJ funds) utilizes existing insurance plans which offer comprehensive benefits (according to state guidelines) and comply with state mandated benefits and medical underwriting standards. Operations began in February, 1989 in Outagamie County (south of Green Bay) and were expanded to Portage County in February, 1990. Firms with 19 or fewer employees which have not offered health insurance coverage in the last 12 months are eligible. The State subsidizes premiums for low income employees and employer premium contributions are voluntary.

The other two state health insurance pilot projects were not funded by RWJ. The Insuring Firm Pilot, which operates in Portage and Rock Counties provides subsidies to employees with incomes at or below 175 percent of the Federal poverty level, for the purpose of purchasing health insurance through group plans already offered by employers. Firms must have 99 or fewer employees. The Health Care Coverage Pilot, which operates in Milwaukee County provides a source of affordable health insurance for people with
disabilities or who have health conditions which render them uninsurable, by allowing them to buy into the Medical Assistance program.

Insurance companies are given a relatively free rein with regard to medical underwriting and thus may exclude certain individuals or entire groups. However, in order to participate in the Non-Insuring Firm Pilot, insurance carriers must comply with a State Insurance Commission regulation requiring them to insure dependents, even if the employee is uninsurable. This regulation was apparently not very well received by insurers. Although most of the large carriers agreed to develop a mechanism to comply, many companies felt that to do so would require too many changes in their current systems and therefore declined to participate in the program.

If a person is uninsurable, he/she may choose to join the state health insurance risk sharing plan or "buy into" the Medical Assistance program. The Medical Assistance buy-in requires the same premium cost as employer-sponsored coverage. The state risk sharing plan was modified during the development of the first pilot to facilitate the entry of high risk persons employed in small businesses.

Insurance companies participating in the program include Employers Health Insurance, Midwestern National Insurance, Network Health Plan of Wisconsin, Principal Mutual Life Insurance, Wisconsin Physicians Service Insurance and Rural Insurance Company. Plans are required to include coverage for inpatient and outpatient services, may not be a policy which covers a specific illness such as cancer and must comply with state mandated benefits. Mandated benefits include psychiatric and substance abuse services, skilled nursing care, kidney disease treatment, home health care, chiropractic care, newborn services and maternity services. Annual out-of-pocket expenses may not exceed $1,000 for single coverage and $2,500 for family coverage.

Premiums vary according to insurance plan chosen, employee income and family size. Enrollees are eligible for state subsidies if household income falls below 175 percent of the Federal poverty level. DHSS encourages but does not require employers to contribute to employee premiums. However, certain insurers may require a specific monthly contribution. The State may pay up to 75 percent of the premium. However, if the employer contributes less than 25 percent, the employee must make up the difference. Likewise, if the employer contributes more than 25 percent, the State subsidy decreases accordingly. The following table shows the ranges of minimum annual employee contributions to premiums by income category.
<table>
<thead>
<tr>
<th>Family Size</th>
<th>Below 75%</th>
<th>75%-100%</th>
<th>101%-124%</th>
<th>125%-149%</th>
<th>150%-175%</th>
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<tr>
<td>Single</td>
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<tr>
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<td>$48</td>
<td>$155</td>
<td>$254</td>
<td>$764</td>
<td>$1,274</td>
</tr>
</tbody>
</table>

Administration and Marketing

Four and a half FTE staff at DHSS are responsible for the operations of the three pilot projects. This includes three analysts (one assigned to each pilot), a director and a half time clerical employee. The local DHSS agencies in the four demonstration counties have one FTE and one clerical staff member working on the projects. Administrative and operating costs have been fairly close to projections. Office costs will likely be lower than anticipated because the program ended sooner than originally planned.

The DHSS local agencies in each county are responsible for marketing the program. A "kickoff" conference for small employers initiated the program. Direct mail has been the most successful advertising strategy while public service announcements and newspaper inserts have been used as well. Insurance agents sell the various plans offered but the program utilizes a network of "preferred" agents which have a special interest in the program.

PROGRAM PERFORMANCE

Enrollment in the program has been much slower than projected. Program planners expected to turn people away but that has not been the case. Initially, it was expected that 834 people would enroll in each of the first two pilot programs and 400 would enroll in the third. Actual enrollment figures are much lower. The first pilot enrolled 290 people (78 firms), the second enrolled 170 people (25 firms) and the third, which only enrolls individuals, enrolled 288 people (enrollment ended January 1, 1991).
LESSONS LEARNED AND FUTURE OF THE PROGRAM

Several problems occurred during program implementation. There were difficulties persuading insurance carriers to identify the plans which met the requirements set forth by DHSS. Coordination of the plans, agents and enrollment operations required about one year. Another problem has been low enrollment. Some program planners speculate that potential enrollees were leery of becoming involved in a pilot program knowing it would end on a specific date. Others say that employers would prefer tax breaks in exchange for providing coverage and are uncomfortable being state subsidized.

Low enrollment has also been attributed to faulty design of the pilot projects, exacerbated by a change in the insurance market during the course of the program. DHSS had established rules and regulations which were ultimately considered too specific as insurance companies began developing new products. Many new products could not be offered in the program because they did not conform to regulations. Therefore, choice of products became too limited. There have been recommendations to change the requirements for health insurance products but nothing has been decided. Insurers would like to see the state mandated benefits eliminated for small businesses.

In one government official's opinion, the program's biggest problem has been organization. Implementation was too slow and a change in state government administration during the program's development also made matters difficult. In addition, insurers sent mixed messages to program planners. On the one hand, they were reluctant to make changes to accommodate the program but, on the other hand, they felt they were not consulted on many issues.

Enrollment was discontinued on January 1, 1991 and the program officially ended on June 30, 1991. The Council of Pilot Projects for the Uninsured, University of Wisconsin-Madison's Center for Health Policy and Program Evaluation (CHPPE) and the Outagamie, Portage and Rock County Local Advisory Committees recommended continuation of the employment-based projects. The recommendation suggests combining these two pilots and modifying the insurance product requirements. The group also suggested a "voucher" type subsidy where the State would pay a certain amount of money to an individual each month, which could be used to pay the premium of employer-sponsored insurance or an individual policy. This recommendation was submitted to the legislature in December, 1990. The legislature may elect to continue the program and appropriate more funds. However, the State's fiscal situation may prevent it from doing so.
CASE STUDY 12
RHODE ISLAND
BACKGROUND AND OBJECTIVES

The Rhode Island Legislature passed a law authorizing a low cost health benefit plan for small businesses in July, 1990. After regulations were developed and implemented, the law became effective in April, 1991. Eligibility is limited to firms with 25 or fewer employees which have not offered health insurance coverage to their employees in the preceding 24 months. The Legislature's goal in developing guidelines for the plan was to eliminate state mandated benefits in order to make the cost affordable to small businesses, while still ensuring minimum access and benefit standards.

The regulations governing the operations of the plan developed by the Rhode Island Department of Insurance provide for an annual open enrollment period, when enrollees may choose a health plan from among all participating plans. In addition, plans may not be medically underwritten and may not limit the number of individuals accepted. However, certain pre-existing condition limitations are permitted.

DESCRIPTION OF BENEFITS

The legislation defines the program as a managed health care system which is exempt from all mandated benefits but which include, at a minimum: inpatient hospital care up to 20 days per year; outpatient hospital care; emergency care; physician care and well baby exams up to six visits in the child's first year; primary care physician office visits up to four visits per year; laboratory, surgery, anesthesia, x-rays and physician care in a hospital inpatient or outpatient setting; maternity care; mammograms and pap tests; psychiatric and substance abuse services up to 20 outpatient visits per year (inpatient psychiatric and substance abuse services are included in the regular inpatient 20 days per year); and home health care up to 20 visits per year.

IMPACT OF THE LEGISLATION

It is expected that Blue Cross and Blue Shield of Rhode Island will have a product in compliance with the new regulations on the market by summer, 1991. In addition, Ocean State Physicians Health Plan, an IPA model HMO, has applied for approval of a product through the Department of Insurance. According to an official at the Department of Insurance, however, it remains to be seen whether people will actually purchase these products because they are not significantly less expensive than other products currently on the market. Although legislators originally intended to create a low cost product through the elimination of mandated benefits, the minimum benefit structure added back several of the
mandates and other requirements, making it difficult for insurers to price the product much lower than products already on the market. Another apparent problem has been the definition of managed health care system used in the legislation. Several cost containment measures are recommended in the legislation but are not required, making the development and enforcement of regulations difficult.
CASE STUDY 13

VIRGINIA
BACKGROUND AND OBJECTIVES

The Joint Subcommittee on Health Care for All Virginians of the Virginia General Assembly began to focus its efforts on improving access to health insurance during 1989. One of the main issues considered was state mandated benefits. A Senate Joint Resolution directed the Bureau of Insurance to study the social and financial impact of all current and proposed mandated benefits and providers. In addition, a series of recommendations were formulated in an effort to make private health insurance more affordable for employed Virginians.

In a December, 1989 report, the Bureau of Insurance concluded that mandated benefits and providers account for nearly 20 percent of the cost of group coverage, although Virginia has comparatively fewer mandates than most states. The Bureau proposed to the General Assembly that insurers provide information on the cost of mandates and establish a mechanism for evaluating the impact of current and proposed mandates. In addition, the Bureau recommended that policies without mandates be authorized. Blue Cross and Blue Shield of Virginia played a major role in the deliberations and suggested the development of a new mandate-free, low cost insurance product for small businesses which had not offered coverage in the past year.

A major goal of the Joint Subcommittee during the 1989 session was to determine how health insurance could be made more affordable for employed persons in Virginia. The fact that the majority of uninsured Virginians are employed and that the costs of health insurance are increasing rapidly for businesses were of major concern. The Legislature was opposed to a "pay or play" policy where employers would be required to either provide coverage to employees or pay a tax. Therefore, it was decided that if a more affordable product could be developed, employers might choose to begin to provide coverage and would not have to be forced to do so.

PROGRAM DESCRIPTION

The legislation authorizes low cost health insurance products which are exempted from state mandated benefits. The exemption applies to all third-party payers. Payers may make the low cost products available to individuals as well as groups and employers, as long as they have not had health insurance during the preceding twelve months. Groups must have fewer than 50 people. The products must have clear managed care provisions for cost containment and be community rated. A minimum benefit level must also be attained and include at least 30 days of covered inpatient hospitalization, prenatal care, maternity services and well child care to age six.
As of June, 1991, Blue Cross and Blue Shield was the only insurer marketing a product in compliance with the legislation. The product, called First Option, is described below.

BLUE CROSS AND BLUE SHIELD OF VIRGINIA
FIRST OPTION

BACKGROUND AND OBJECTIVES

Blue Cross and Blue Shield Plan of Virginia introduced First Option, a low-cost group health insurance product in August, 1990. The product is targeted at the estimated 880,000 working uninsured in Virginia, especially women who head low-income households with children under age 18. Small businesses with 2 to 49 employees which have not offered coverage in the past 12 months are eligible. The Plan's objectives in developing First Option are to reduce the cost barrier to purchasing insurance, provide affordable coverage containing basic benefit options and increase the number of insured Virginians.

PRODUCT DESCRIPTION

Benefit Structure and Premiums

First Option focuses on preventive care. Well baby care, two physician office visits per year and one dental exam/cleaning per year for children through age 19 are each covered after a $10 copayment. Outpatient same-day surgery and home health care are covered at 80 percent. Other outpatient medical services are not covered. Maternity care requires a $250 deductible for each admission to the hospital and then is covered at 80 percent. Accidental injury is also 80 percent covered up to $150 per person per year. A $250 deductible is required for each inpatient hospital admission, after which 80 percent of surgery and other in-hospital care are paid for up to 30 days per calendar year. Services which are not covered under First Option include mental health and substance abuse services, and services rendered by chiropractors, physical therapists, opticians, audiologists and speech pathologists. Prescription drugs, x-ray and laboratory services are also not covered. Enrollees do not have to use a specified network of providers.

Some options are available at additional cost, including mammography screening (80% coinsurance), full well-baby care (no deductibles or copays), dependent maternity care ($250 deductible and 80% coinsurance) and coverage for other family members. There is a 12 month waiting period for pre-existing conditions. In addition, the Plan employs several cost containment mechanisms including hospital preadmission review, case management,
discharge planning and concurrent review. The maximum annual benefit is $50,000 per person and the lifetime maximum benefit is $1 million.

Premiums are rated according to two age categories (39 and under, 40 and over), geographical region, and type of coverage (employee only, employee-one minor, employee-family). First Option is not medically underwritten. The state of Virginia is divided into six regions. Southern VA/Hampton Roads is the most expensive, followed by Northern VA/Richmond, Hampton/Newport News, Charlottesville/E. Central, Far Western VA, and finally Roanoke/W. Central, which is the least expensive. In Roanoke, an individual under age 39 pays $60.55 per month. An employee with one dependent pays $87.13 and family coverage is $140.34 per month. In Hampton Roads, these rates are $79.48, $114.36 and $184.19, respectively. Employers must contribute a minimum of 50 percent of the employee's cost of coverage, although there is no employer contribution requirement for dependents.

The major difference between First Option and standard BCBS packages available to small groups is the inclusion of preventive care and exclusion of mandated benefits. Most BCBS packages do not cover any type of routine or preventive care. Although First Option does cover some preventive services, it has many coverage limitations. A comparable package covers 80 percent of inpatient services as First Option does, but has a $200 deductible per calendar year as opposed to $250 per admission, and does not limit the number of hospital days. Maternity benefits and outpatient surgery benefits under the comparable package are similar to First Option. However, 80 percent of x-ray and lab charges are covered as well while First Option does not cover these services at all. In addition, prescription drugs are covered (with copayments) under the comparable policy and mandated benefits are covered with varying maximums. The comparable package does not have any calendar year maximum benefits and the lifetime maximum benefit is $2 million. The base rates for this package are $97 per individual per month and $278 per family per month for a 30-39 year old in the Richmond area. First Option base rates in this category are $76 per individual and $175 per family.

Product Performance

The product went to market in August, 1990, at which time no enrollment projections were made. A direct mail campaign was used to identify potential enrollees and actual sales were completed through the customary distribution channels: telemarketing, brokers and sales consultants. As of May 31, 1991, there were approximately 25 groups enrolled (less than 100 persons). The average group size is between three and four. Enrollment has been slower than expected but there is some speculation that the recession could be a contributing factor. The Plan is just beginning to evaluate the product to determine its strengths and weaknesses. One problem appears to be the $50,000 annual benefit limit which some persons feel is inadequate. Another problem is the stipulation that a company cannot have offered health insurance for one year prior to enrollment. The Plan's
original intention in formulating this requirement was to target the truly uninsured but it has apparently excluded many potential enrollees.

**Lessons Learned and Future of the Product**

The Plan hopes that sales of First Option will improve as the product becomes more well known. There is an interest in improving the product to make it more attractive to consumers but any changes must receive legislative approval and thus would take time. There is a possibility that a new catastrophic plan with no covered preventive services will be developed and offered at a low cost. In addition, First Option may eventually be medically underwritten rather than community rated, not for the purpose of excluding people but to improve the rating scheme for the product.
CASE STUDY 14

MISSOURI
MISSOURI

BACKGROUND

The Limited Mandate Insurance Act became effective in January, 1991 as part of a larger package of legislation which included the establishment of a state risk pool and a new long-term care program in the Department of Social Services. The bill had been under consideration by the Missouri Legislature for approximately six years before it was passed. The Missouri Hospital Association was in favor of the bill, although it did not participate in efforts to achieve its passage. Members of the health insurance industry adopted a relatively neutral position with regard to the bill while the Medical Association was opposed to it.

PROGRAM DESCRIPTION

Under the Limited Mandate Insurance Act, insurers are authorized to sell insurance policies which meet certain guidelines to individuals, families and employers of no more than 50 workers. The law does not mandate the inclusion of any specific benefits or coverage, but insurers issuing limited mandate health insurance policies must make certain benefits available as optional coverages. These benefits are child health supervision, newborn children coverage, mammograms and mental health services. The policies are also exempt from mandates prohibiting insurers from discriminating by excluding coverage of services by certain types of providers, treating coverage of maternity care differently than other illnesses, offering maternity coverage to certain policy holders and not others, offering maternity coverage based on marital status, and charging different premiums to individuals within the same class.

Limited mandate policies may be offered to any uninsured individuals or groups, or insured individuals or groups who wish to terminate their current coverage in order to obtain a less expensive policy.

The Missouri Health Insurance Pool, also created by the legislation, provides a source coverage for high-risk individuals who cannot acquire coverage elsewhere and for those whose premiums have increased to a level which exceeds 300 percent of the standard risk rate.

PROGRAM STATUS

As of July, 1991, no insurance companies in the State of Missouri have filed with the Insurance Department for approval of new products which comply with the legislation.
CASE STUDY 15

FLORIDA
BACKGROUND AND OBJECTIVES

In 1990, the state of Florida passed legislation authorizing a basic health insurance policy for small groups of fewer than 25 employees. The original intent of the legislation was to reduce the number of mandated benefits in order to develop a lower cost product. However, the legislation preserved several of the mandates, some of which have proven costly. Therefore, the product, which was ultimately authorized, was not significantly different from other policies currently on the market. Certain mandated benefits such as alcohol/substance abuse services and mental health treatment were exempted from new small groups policies. However, other mandates, such as well child care, mammograms and chiropractic care were retained. In addition, several benefits were retained as mandated options, meaning that insurers must make them available to policyholders for an additional premium.

The major players in the bill's passage were small business groups, particularly the National Federation of Independent Business. Originally, the bill called for much more sweeping changes in the structure of small group basic policies but the result was significantly watered down.

As a follow-up to the small group basic policy legislation, a bill was passed which authorized implementation of a National Association of Insurance Commissioners (NAIC) model for small group rating policies in Florida. The objective in its passage was to correct several insurer practices with regard to small groups and restore some measure of predictability of premium increases for these groups over time. According to officials, the legislation sets forth requirements for insurers to aggregate small groups into large groups and link high rated groups to low rated groups. In addition, it limits premium increases to a specific index. It does not, however, address access to health insurance or affordability. The Florida Department of Insurance, the legislature and the NAIC combined efforts to pass this legislation.

IMPACT OF THE LEGISLATION

According to state officials, as of July, 1991, the small group basic policy legislation appears to have had no impact on the insurance market. In fact, no insurance companies have filed with the Insurance Commissioner for approval of new products. Department of Insurance staff believe that the changes set forth by the new legislation are not broad enough to allow new products to be developed at a lower cost to small businesses. Therefore, insurers have not made an effort to develop such products. Several bills were considered in 1991 which would have removed some additional mandated benefits from small group policies, but all failed.
The Legislature is scheduled to address this problem in the future. It will be examining a series of proposals regarding access and regulatory policies related to underwriting. It is hoped that access can be improved by removing barriers for small groups with high risk employees. In addition, the Legislature will address what insurers’ responsibilities to small groups should be with regard to provision of coverage for high risk employees and/or groups. Once the policy is established, a plan to adjust for the costs must be developed.

EFFORTS UNDERTAKEN BY THE FLORIDA HEALTH CARE COST CONTAINMENT BOARD

The Division of Technical Assistance at the Florida Health Care Cost Containment Board (HCCB) has developed an outreach program for small businesses. The program provides information guides and directories to help small businesses better understand health coverage and to assist these businesses in obtaining coverage. In addition, the HCCB also conducts small business health insurance seminars in conjunction with several Florida Small Business Development Centers.

Several publications for small businesses are available through HCCB. Rx For Small Businesses: Health Care Cost Containment Information Manual, provides an overview of health care costs, a discussion of various health care delivery systems, and suggestions for employers to manage health plan costs. The Florida Health Insurer Directory is compilation of insurance carriers in Florida based on a voluntary survey. The Directory identifies insurance companies which market small group products as well as enrollment requirements. In addition, addresses and contact people for all survey respondents are included.

The Florida Directory of Preferred Provided Organizations and Health Maintenance Organizations identifies HMOs and PPOs in Florida, notes those available to small businesses and describes operational characteristics. The fourth publication, Searching for Affordable Health Coverage: A Small Business Guide, provides a detailed strategy for small employers in order to understand the health insurance market, select cost-effective health plans and control plan costs.

In addition to the offering these publications, the HCCB has prepared a comprehensive report on small business activities relating to health insurance in conjunction with the National Federation of Independent Business (NFIB). The report will be available in August, 1991.
CASE STUDY 16
KENTUCKY
The Health Care Reform Act was passed in the state of Kentucky in March, 1990. The Act included new provisions in the areas of family health care, health manpower and education, health insurance, hospital indigent care, long term care and service development. The health insurance provisions were specifically developed to help improve small business' access to health insurance. The legislation creates trusts through multi-county planning regions called Area Development Districts (ADDs) for the purpose of allowing small employers to join and purchase health insurance for their employees. The ADDs negotiate with insurers to obtain group insurance policies for small businesses.

In addition to the creation of the small business trust, the legislation establishes a minimum level of covered hospitalization and requires coverage for physician care in the hospital but exempts policies from all other state mandated benefits. Employers who purchase a product in compliance with the new legislation may receive tax credits for four years following the initiation of coverage. The law was part of a larger legislative effort to address the uninsured problem in Kentucky.

Any ADD in Kentucky may form a health care trust. Each trust encourages employers to participate in the purchase of group health insurance coverage for employees and establishes the amount of premiums to be paid to the trust. In addition, each trust negotiates and contracts with insurers or health care providers for covered services, including basic inpatient hospital services and emergency medical services. Basic inpatient hospital services must include at least 14 days room and board and at least 50 percent of the related charges for physician services.

ADDs collect one percent of the premiums paid into the trusts to cover administrative costs. Employers who contribute at least half of employee premiums receive a 20 percent tax credit the first year, 15 percent the second, 10 percent the third and five percent the fourth. In order to be eligible to purchase insurance through the ADDs, employers must have fewer than 50 employees and cannot have offered coverage for the preceding three years.
IMPACT OF THE LEGISLATION

Three insurance carriers (Blue Cross and Blue Shield, Humana and Travelers) currently offer products in compliance with the new legislation. Blue Cross and Blue Shield of Kentucky offers an HMO product in a limited service area which is described below.

BLUE CROSS AND BLUE SHIELD OF KENTUCKY
OPTION 2000 LIMITED PROTECTION PLAN

In response to the new legislation, Blue Cross and Blue Shield of Kentucky (BCBS Kentucky) developed the Option 2000 Limited Protection Plan, a low-cost limited benefit package. The plan is administered through the Southeastern United Medigroup, a subsidiary of BCBS Kentucky.

PRODUCT DESCRIPTION

Benefit Structure and Premiums

Option 2000 is an inpatient hospital benefit package with a $200 calendar year deductible. After the deductible has been fulfilled, enrollees must pay 20 percent coinsurance up to $5,000 of the allowable amount of eligible charges ($1,000 out-of-pocket maximum per year). The plan pays 100 percent of the allowable amount of eligible charges over $5,000 up to the lifetime maximum of $250,000. Inpatient and emergency room physician services require 50 percent coinsurance (which are not subject to the $1,000 out-of-pocket maximum). Covered services include 31 days room and board per admission (after a 60-day break, the 31 days are renewed), ambulance services up to $100 per incident and other hospital services. Emergency room visits require a $50 copayment.

Enrollees must use the plan's participating hospital network. There is a 50 percent benefit reduction if a participating hospital is not used, except in emergencies. This means that the enrollee must pay 50 percent of the cost of services provided rather than the usual 20 percent. The plan does not provide coverage for outpatient services, including but not limited to outpatient diagnostic and surgical procedures, outpatient office visits, outpatient prescription drugs and ambulatory care. The plan is medically underwritten.
As of March 31, 1991, the rate schedule shown below was in effect.

**OPTION 2000 MONTHLY PREMIUM RATES**

<table>
<thead>
<tr>
<th>Age</th>
<th>Male Employee or Legal Spouse</th>
<th>Female Employee or Legal Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$31.23</td>
<td>$52.78</td>
</tr>
<tr>
<td>30-39</td>
<td>44.95</td>
<td>75.04</td>
</tr>
<tr>
<td>40-44</td>
<td>52.78</td>
<td>87.41</td>
</tr>
<tr>
<td>45-49</td>
<td>71.13</td>
<td>104.41</td>
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<tr>
<td>50-54</td>
<td>85.50</td>
<td>111.68</td>
</tr>
<tr>
<td>55-59</td>
<td>118.14</td>
<td>122.77</td>
</tr>
<tr>
<td>60-64</td>
<td>139.77</td>
<td>139.77</td>
</tr>
<tr>
<td>Over 65</td>
<td>160.68</td>
<td>156.77</td>
</tr>
</tbody>
</table>

For dependent coverage, enrollees pay a flat fee of $39.88 per month, regardless of the number of dependents.

Humana and Travelers have developed products which were approved by the same area district legislation as the Limited Protection Plan. These products are more limited than Blue Cross's product and do not cover any physician services (the Limited Protection Plan has 50 percent coinsurance for physician services). Humana also developed an HMO product available within a limited services area while Travelers' product is available statewide. Enrollment has been very limited thus far.

**PRODUCT PERFORMANCE**

Enrollment

The BCBS product went to market on February 1, 1991. Approximately two months after its introduction, four groups had applied and all had passed underwriting. However, the product does not appear to have tapped its target market yet. There have been a large number of inquiries, but many groups are not eligible because they currently provide coverage. In addition, some small businesses feel the benefit package is too limited. BCBS staff speculate that those who feel the benefits are too limited can afford to be discriminating while those who have been unable to obtain or afford insurance would probably be satisfied with the product. BCBS has projected an enrollment of 3,000 people by the end of the first year but enrollment has been slower than expected.
LESSONS LEARNED AND FUTURE OF THE PRODUCT

Because the Option 2000 Plan is very young, it will take some time to determine whether it is a success or not. BCBS staff plan to determine whether the product needs modifications or marketing plans need to be changed once the product has had an opportunity to reach its target market.

According to the Kentucky Department of Insurance, approximately 12 businesses had purchased policies offered by either Blue Cross, Humana or Travelers by mid-June, 1991 (approximately 400 employees). The Department is currently conducting a study to determine the problems with the program and better methods for reaching the small business population.
CASE STUDY 17

KANSAS
A program to encourage small employers to offer health insurance to their employees was created in July, 1990 by the Kansas State Legislature. The program was the result of efforts by the Commission on Access to Services for the Medically Indigent and Homeless which was created in 1986 to address the state's uninsured problem. The Commission was comprised of four legislators and five members of the general public. It was responsible for identifying the number of medically indigent in Kansas, defined as persons without health insurance, not eligible for government programs and without resources to pay for health care. In addition to its efforts to identify medically indigent persons, the Commission collected data to estimate the number of uninsured in the state. This figure was found to be approximately 400,000 persons.

The Commission studied two ways to improve access to health insurance and devised a two part strategy. The first part of the strategy is the creation of a state-funded adjunct to Medicaid for people who could not obtain employer coverage. This program provides very limited coverage, and premiums are based on income. The second part of the strategy encourages small employers to provide coverage to their employees by offering tax credits based on employer contributions to premiums. In addition, insurance companies are not required to pay premium taxes on policies offered under the new regulations, thereby allowing lower premiums. The legislation developed to address small business coverage was modeled after legislation which was passed in Oregon. The bill was introduced by the legislative members of the Commission.

PROGRAM DESCRIPTION

The legislation allows for businesses to establish a multiple employer health plan comprised of two or more employers. The plan members must adopt a program of operation and appoint a Board of Directors. Once the plan is formed, it may enter into a contract with one or more insurance carriers to administer the plan. The law does not mandate the inclusion of any specific benefits or coverage but requires that mandated benefits which are excluded be made optional to employers. To be eligible for membership in a multiple employer health plan, a business must have 25 or fewer employees who do not have health insurance and are not eligible for Medicaid. In addition, the employer cannot have offered coverage to employees during the preceding two years and must contribute a certain minimum amount to employee premiums.
 Benefit Structure

The benefit structure is comprised of two parts. Part I coverage has a $5,000 individual deductible and a $7,500 family deductible. The legislation states that "all reasonable and customary charges for the necessary care and treatment of any sickness or injury incurred during any calendar year" are covered after the deductible has been met and there are no exclusions for pre-existing conditions. A 6-month waiting period may be required for certain conditions which have been diagnosed or treated within a six-month period preceding the application. Selected services may be excluded from coverage including dental services, optometry, hearing aids and routine foot care. Employers must pay the premium of Part I coverage up to a maximum of $40 for each eligible covered employee unless a higher maximum employer contribution is established in the operating plan. Employee contributions may not exceed 25 percent of the monthly premiums or $15, whichever is less.

Part II coverage provides optional benefits and contains incentives for employees to be cost conscious in their use of health care services. One option under Part II is to reduce the deductible of Part I coverage to as low a level as desired and increase premiums accordingly. Employer contributions to premiums are voluntary under Part II and may be included in the costs used to calculate tax credits.

Tax Credits

Tax credits during the first two years of participation in the health insurance plan are $25 per month per eligible covered employee or 50 percent of the total amount paid by the employer during the taxable year, whichever is less. The available tax credits are reduced during each of the subsequent three years of participation.

IMPACT OF THE LEGISLATION

Currently there are no insurance products on the market in compliance with the new legislation. Blue Cross and Blue Shield of Kansas has submitted provisions for a new product which are pending approval by the Insurance Commissioner. Other carriers are apparently interested in developing products but have not submitted applications to the Insurance Department. In addition, the Department has not received any applications from employers interested in forming multiple employer health plans. The Insurance Commissioner must issue certification to employers who participate in the program in order that they may receive tax credits but the Commissioner has not received any applications for the certification. The Department has mailed applications to several employers, and although there appears to be an interest in participating, none have responded.
BACKGROUND AND OBJECTIVES

In 1989, the Governor of Illinois appointed a study group to assess the availability of health insurance. The participating organizations included Blue Cross and Blue Shield, Health Insurance Association of America, Illinois Life Insurance Council, Illinois Hospital Association, Illinois Medical Society, representatives of labor interests, Illinois Manufacturers Association, legislators and the State Chamber of Commerce. The Illinois Department of Insurance acted as the driving force in assembling the study group and became the forum for its deliberations.

The group determined that the most promising approach to improve access was a program which focuses on the small business sector. The National Association of Small Business felt that affordability was the most significant barrier for small businesses in providing coverage. Insurers claimed that the affordability problem was due in large part to state mandated benefits, which were driving costs up. Therefore, the group developed a plan for a mandate-free policy for groups of 25 or fewer which have not offered coverage for the past year.

IMPACT OF THE LEGISLATION

The new law, which became effective on January 1, 1991, eliminated several mandated coverages for small groups, including mental health services, blood processing and inpatient alcohol treatment, but preserved mandated coverage for adopted children, newborn children and mammograms. Since the law's effective date, several companies have petitioned the Department of Insurance for approval of new products meeting the conditions set forth. These companies include Blue Cross and Blue Shield, Travelers of Hartford, Travelers of Illinois and Country Life Insurance Company. Many other insurance companies are apparently interested in marketing new small group products but are waiting to see how successful the Blue Cross product is first. Because the Department of Insurance is not required to report to the legislature regarding the success of the new products until 1993, the impact of the legislation will not be studied until 1992. A description of the Blue Cross product now available is provided below.
BLUE CROSS AND BLUE SHIELD OF ILLINOIS
BASIC I

BACKGROUND AND OBJECTIVES

By excluding formerly mandated benefits such as psychiatric services, substance abuse services and well baby care, Blue Cross and Blue Shield of Illinois was able to develop a more affordable product for small businesses. The product, called Basic I, is marketed to firms which have 2 to 25 employees and which have not offered health insurance in the last 12 months.

PRODUCT DESCRIPTION

Benefit Structure and Premiums

Basic I is a PPO plan which is medically underwritten and requires a one year waiting period for coverage of pre-existing conditions. Certain industries are also excluded. There is a $1,000 annual deductible per individual with most medical services covered at 70 percent after the deductible has been reached. These include inpatient and outpatient hospital services, surgery, emergency room, maternity care, home health care, skilled nursing and other services. There is a $1 million lifetime maximum benefit and a $7,500 yearly out-of-pocket maximum.

Basic I costs about 40 percent less than BCBS's standard $100 deductible comprehensive major medical product. BCBS staff, however, find it difficult to compare Basic I to other products in terms of benefits.

PROGRAM PERFORMANCE

Enrollment

The product went to market almost immediately after the legislation removing mandated benefits was passed in January, 1991. Since then, BCBS has received approximately 1,500 inquiries but has only processed one case. The low enrollment has been attributed to three major problems: the deductible is too high, one-person groups are not eligible and many groups do not pass underwriting.
LESSONS LEARNED AND FUTURE OF THE PRODUCT

BCBS will continue to offer Basic I as a "shelf product" but it is considering offering a new product called Basic II which has a lower deductible and coinsurance similar to other products (80 percent). BCBS did not offer this product to begin with because it was under pressure from the Legislature to develop a product and put it on the market as soon as the legislation became effective. BCBS staff have now had time to give more thought to developing uninsured small group products, and to consider the benefit structure of Basic II more carefully.
CASE STUDY 19

WASHINGTON STATE
BACKGROUND AND OBJECTIVES

The Washington State Legislation passed the Basic Health Care Act in 1990, allowing groups of fewer than 25 employees to be exempt from certain state mandated health insurance benefits. The relatively brief piece of legislation sets out the mandates which may be excluded and the types of policies which can be issued. Its objective is spelled out clearly in the introductory language which says that "the rising costs of comprehensive group health coverage is exceeding the affordability of many small businesses and their employees...[the legislature] further finds that certain public policies [e.g., mandated benefits] have an adverse impact on the cost of such coverage. It is therefore the intent of the legislature to reduce costs by authorizing the development of basic hospital and medical coverage for small groups." The original bill was drafted in large part by a lobbyist for health care contractors and was supported by the Washington Association of Business.

PROGRAM DESCRIPTION

Washington’s "bare bones" package exempts groups of 25 or fewer from most state mandated benefits, although inpatient hospital coverage and coverage for adopted children must be included. There is no waiting period for businesses which have previously offered insurance.

As of July, 1991, there were 27 approved products offered by 13 companies which were in compliance with the new legislation. The last enrollment count was December, 1990, at which point 240 lives were covered. This figure will be updated in August, 1991. According to legislative testimony, the products are selling very well. Early evidence from an Insurance Commission official suggests that some small employers are replacing their current policies with the new lower cost plans rather than drop their coverage altogether. Four products are currently being offered by Pierce County Medical, a Blue Cross and Blue Shield pilot program. They are described below.

PIERCE COUNTY MEDICAL
PACESETTER AND VALUE PLANS

BACKGROUND AND OBJECTIVES

Pierce County Medical, a Blue Cross and Blue Shield Plan in Tacoma, has developed the Pacesetter and Value plans, targeted at uninsured small businesses. The Pacesetter 500 and 500 Plus plans were developed in January, 1990 to meet a perceived need for less expensive health insurance plans for small businesses. The plans are medically
underwritten and use large deductibles to make premiums more affordable. Value Plans 1 and 2 went to market in October, 1990. Their development was prompted by the state’s request to devise a less expensive plan without state mandated benefits. State lawmakers, out of concern that insurance companies were not reaching small businesses, passed legislation to exempt small business products from mandates. The Pacesetter plans are available to groups of 4 to 10 and the Value plans are offered to groups of 3 to 24 regardless of current or previous health insurance coverage.

PRODUCT DESCRIPTION

Benefit Structure and Premiums

Both the Pacesetter and Value plans are PPO products. Pacesetter 500 and 500 Plus have a $500 annual deductible per individual and $1,000 deductible per family. Most services are covered at a rate of 80 percent. Both Pacesetter plans include coverage for inpatient care, outpatient office visits, x-ray, lab, well child care, mammograms, pregnancy, ambulance, substance abuse services (up to $5,000 every two years), mental health services (up to $3,500), home health care (up to 130 visits per year), hospice care (up to six months) and skilled nursing care (up to 100 days per year). Pacesetter Plus additionally covers routine eye exams, allergy testing, durable medical equipment, physical therapy and prescription drugs (all at 80 percent). Both Pacesetter plans have $1 million lifetime benefit and a $1,500 annual out-of-pocket maximum per person.

Value Plan 1 has no deductible. Inpatient care requires a $300 copayment per admission. Inpatient physician services are paid in full while room and board and ancillary services are 80 percent covered. Outpatient emergency and surgical services are also paid at 80 percent. Outpatient physician office visits require a $15 copayment while x-ray and lab are paid at 80 percent. Well child care is paid in full and routine mammograms and gynecological exams (one each per year) are paid in full after a $15 copayment. Value Plan 2 has a $250 individual annual deductible and $750 family deductible. Inpatient and outpatient services, including lab and x-ray are paid at 80 percent after the deductible has been fulfilled. Well child care is also paid at 80 percent but the deductible requirement is waived. Maternity benefits are paid on the same basis as any medical condition. Both Value plans also include coverage for allergy testing, ambulance services, accidental injury to teeth, diabetes management, durable medical equipment and physical therapy. Substance abuse services, mental health services and prescription drugs are not covered.
Premiums for small groups are rated on several risk levels based on age, sex, employer contribution, industry and other factors. The monthly rates for an average risk level are as follows:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Subscriber</th>
<th>Spouse</th>
<th>Child*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacesetter 500</td>
<td>$67.50</td>
<td>$77.30</td>
<td>$37.65</td>
</tr>
<tr>
<td>Pacesetter 500+</td>
<td>$72.85</td>
<td>$83.45</td>
<td>$40.60</td>
</tr>
<tr>
<td>Value Plan 1</td>
<td>$58.45</td>
<td>$67.05</td>
<td>$35.30</td>
</tr>
<tr>
<td>Value Plan 2</td>
<td>$52.45</td>
<td>$59.85</td>
<td>$29.55</td>
</tr>
</tbody>
</table>

*maximum charge is for two children

In comparison, a standard "off the shelf" preferred plan costs $112.45 per month for an individual subscriber.

PRODUCT PERFORMANCE

The Pacesetter plans have not been very successful. Since the products went to market in January, 1990, Pierce County Medical has written 16 plans, for a total of 119 subscribers and 221 total members (including dependents). The low enrollment has been attributed to several factors. First, the marketplace was not ready for a $500 deductible. Most products at the time of Pacesetter's introduction had deductibles of $100 to $200 and the jump to $500 was apparently too large. The product also went to market at an inopportune time. There had not been any rate increases for quite some time, therefore people really had no incentive to change policies to beat the cost. Recent rate increases may prompt increased sales of Pacesetter products.

On the other hand, the Value plans have been very successful (mostly Value Plan 1), in fact, 16.9 percent of Pierce County Medical's sales since October, 1990 have been Value plans. Since the Value plans' introduction, 59 groups have bought one of the two plans for a total of 269 employees and 429 total members, including dependents. An average of 4.5 employees comprise each group. In addition, the products seem to have hit their target market. Approximately 75 percent of persons enrolled in the plans have not had previous group coverage.

Pierce County Medical's plans do not appear to have much competition. Blue Cross and Blue Shield of Washington developed a new small group product but apparently its market entry was delayed and it has not been well received. Commercial carriers' products, if any exist, have not been visible. Most of the competition from them are standard small group policies. The biggest competitors are John Alden and Principal Mutual.
LESSONS LEARNED AND FUTURE OF THE PRODUCT

Both the Pacesetter and Value plans will continue to be offered. The Value plans will probably not be changed because they appear to be doing well as they are. The Pacesetters will likely be offered with a $250 deductible as an alternative to the $500 deductible. There have already been steps taken to obtain approval for the alternative deductible by the state Insurance Commissioner. The future of these products looks very positive. They have been well received by both the public and insurance agents and brokers, and with the changes in Pacesetter, it is hoped that their reputation will become even better.
CASE STUDY 20

THE CONSTRUCTION INDUSTRY
THE CONSTRUCTION INDUSTRY

BACKGROUND OF THE UNINSURED PROBLEM

According to a 1990 analysis of insurance coverage status of the population conducted by the Employee Benefits Research Institute, of the 12 million persons employed in the construction industry, approximately 26 percent (3.1 million) are uninsured. This high rate of uninsured has been attributed to the fact that construction employees often do not consistently work for the same employer and may instead be employed on a short-term contractual basis for a particular project. Among construction workers who are insured, 7.5 million (62.9 percent) receive their coverage either directly or indirectly through an employer.

Numerous construction trade associations were contacted in an effort to determine what types of health insurance plans are provided to members, and if they were aware of efforts to improve access to health insurance for construction workers. Three organizations, the National Association of Home Builders, Associated General Contractors of America and Associated Builders and Contractors were able to provide useful information.

HEALTH INSURANCE PLANS PROVIDED BY TRADE ASSOCIATIONS

Associated Builders and Contractors, a national trade association located in Washington, D.C., is an organization representing both large and small businesses. Members may obtain a health insurance policy underwritten by John Hancock Insurance Company through the Association. Groups of three or more are eligible for this coverage. A business must cover 75 percent of employees if the employees contribute to premiums. If the employer pays the entire premium, all employees must participate. A separate program for groups of fewer than three is underwritten by Connecticut General. Premiums are higher for these smaller groups. The association has not been involved in any special programs to improve access, other than sponsoring the two insurance plans.

The Associated General Contractors of America (ACGA) has a membership of 32,000 companies in 102 chapters. General construction contractors make up 25 percent of the membership, of which 90 percent are small businesses (many with 10 or fewer employees). Associate members, which are construction-related businesses and large companies make up the remainder of membership. AGCA offers a group health insurance plan through National Employee Benefits Trust, which specializes in providing health care coverage to employees in the construction industry. The program is offered to all members but only general construction contractors have taken advantage of it. Most associate members and larger companies have their own insurance plans.
The plan is a comprehensive health care package with a choice of deductibles and 80-20 coinsurance. Dental and vision benefits are available as options. It is not medically underwritten, although pre-existing conditions diagnosed six months prior to coverage are subject to a one-year waiting period. Premiums are rated according to geographic location only. There are currently about 550 companies and 20 chapters enrolled in the plan (approximately 6,000 covered employee lives plus dependents). The Trust tends to cover small businesses (fewer than 10 employees) because it is often the only choice available for many of these groups and premium prices are competitive. Larger groups tend to have many other insurance options and, therefore, choose not to obtain coverage through the Trust. Because the Trust is a non-profit organization with limited funds, it is constrained in its marketing efforts. Most often, businesses obtain information about the health insurance plan through their local chapter of AGCA or the national office. ACGA has not been involved in any special programs to improve access.

The National Association of Home Builders (NAHB), a federation of 800 state and local chapters with 153,000 members, also offers an insurance program to members. Although it is a national program, the insurance plan must be individually endorsed by each state. The program is currently available in 32 states. This stipulation affects the way in which the health insurance program is organized. An insurance trust was established in 1989 with NAHB members as trustees and a third party administrator. This administrator handles billing, claims and other operational activities. The insurance carrier is Bradford National Life, and is supported by several reinsurers.

The NAHB Trust offers a comprehensive health care product. It includes major medical coverage, dental coverage, life and disability insurance. Members of NAHB may purchase the product for themselves, family, employees and dependents. The program was developed in response to concerns raised by members about health insurance access. Now in its second full year of operation, the program has enrolled approximately 9,000 to 10,000 lives. Its price competitiveness depends upon the environment. Overall, prices are competitive with comparable coverage across the country.
CASE STUDY 21

THE RETAIL TRADE INDUSTRY
BACKGROUND OF THE UNINSURED PROBLEM

According to an analysis of the 1990 Current Population Survey conducted by the Employee Benefits Research Institute, approximately 25 percent of workers (5.1 million persons) in retail trade have no health insurance coverage. Many of these workers are employed in small businesses. Out of concern about the large proportion of uninsured in the industry, some retail trade associations are making an effort to provide coverage through their organizations. In addition, the National Retail Federation (NRF) commissioned a study of health insurance availability for retail businesses which was prepared in August, 1990. The International Mass Retail Association which represents some small businesses is currently developing proposals addressing the health insurance problem and cost containment issues.

In addition to some of the general retail trade associations, some industry-specific associations are also becoming involved in efforts to improve access to health insurance for retail employees. The Jewelers of America began a health insurance program for members in June, 1991, and the National Shoe Retailers Association offers an employee benefits consulting service to its members.

THE NATIONAL RETAIL FEDERATION STUDY

The NRF study emphasizes some common characteristics of retail employees which make them more likely to be uninsured. A large proportion of retail workers are young (18 to 24), work part-time, and change jobs frequently. Many young people choose not to purchase health insurance anticipating that they will not need it. Part-time workers are often not eligible for employer-sponsored plans and transient workers do not work long enough in one place to qualify for insurance. The NRF study also examines the characteristics of employer-sponsored plans for retail employees. The median deductibles for these plans is $250 for individuals and $600 per family; the median coinsurance requirement is 20 percent; the median annual stop-loss limits are $2,000 per individual and $3,000 per family; and the median workweek for eligibility is 30 hours.

The NRF has established a Benefits Committee which is currently examining Congressional proposals. A white paper which outlines responses to these proposals is being considered for publication in the near future.
EFFORTS UNDERTAKEN BY INDUSTRY-SPECIFIC ASSOCIATIONS

The Jewelers of America is a trade association representing approximately 13,000 jewelry stores, 98 percent of which are considered small businesses. The association began a health insurance program for members in June, 1991 called the Association Members Benefit Trust which is underwritten by All American Life Insurance Company. The plan includes $1 million comprehensive major medical coverage, a choice of deductibles, a six month initial rate guarantee and 80/20 coinsurance. Services covered include inpatient care and physician services, emergency room, ambulance, x-ray and lab fees, inpatient alcoholism services, inpatient psychiatric services, prescriptions, some nursing home care, maternity services and home health care. Routine care, dental care, and outpatient psychiatric services are examples of services which are not covered.

Businesses may choose from deductible amounts of $250, $500, $1,000, $2,500 or $5,000 and premiums are adjusted accordingly. Premiums are rated according to age, sex and geographical location. The plan is medically underwritten and pre-existing conditions diagnosed in the previous year may not be covered for a year following coverage. For a female aged 30 to 34 who chooses a $500 deductible, monthly premiums range from $74.58 to $165.23 depending on geographic area. Monthly rates per child range from $41.60 to $91.00 (also with the $500 deductible).

The Jewelers of America sent out a mailing announcing the plan which has generated over 700 inquiries to date. A small number of people have enrolled during the six weeks since the June, 1991 mailing.

Members of the National Shoe Retailers Association (NSRA) may receive the services of W.F. Morneau Employee Benefits Consulting Firm. Companies which do not offer health insurance may use the service to find a competitively priced plan while companies which already offer coverage may use the service to find something more affordable. Consulting services are provided free of charge and a commission is paid by companies which are placed with an insurance carrier.

W.F. Morneau staff have found two major problems in dealing with NSRA members (many of which are small groups). In many cases, the biggest problem is that a company has one or two employees who have a serious medical condition, causing the entire group to be rejected in underwriting. Groups which are rejected by traditional carriers are urged to consider alternative delivery systems such as HMOs or other forms of coverage such as state pool plans or guaranteed issue products. Another barrier to obtaining coverage for shoe stores is a large number of part-time employees. Often there simply aren't enough eligible people on the payroll to obtain group coverage.

Out of approximately 100 NSRA members which have used the consulting service, only 6 companies have actually been placed with an insurance carrier. This low rate of success has not been confined to the NSRA. W.F. Morneau also provides services to several other associations which represent small businesses and the same problems have been
prevalent. They have experienced many of the same difficulties in placing members of the National Propane Gas Association which is comprised mainly of small businesses. They have been more successful in placing members of Associated Equipment Distributors, but their group sizes are larger.
CASE STUDY 22

BLUE CROSS AND BLUE SHIELD OF OREGON
OREGON OPTION
BACKGROUND AND OBJECTIVES

The Oregon Option plan was developed in 1989 at the request of the State Legislature. As part of a new program to help reduce the State's uninsured population, the Oregon legislature authorized tax credits for businesses which have not offered health insurance in the previous two years and begin offering coverage. The credits amount to $18.75 per employee per month or 50 percent of the employee premium, whichever is less, and decrease each successive year of the program until completely eliminated in 1993. In addition, regulations and rate guidelines were established to allow carriers to exclude certain state mandated benefits from small business products. Oregon Option was developed to meet these guidelines and became available to businesses with fewer than 25 employees and have not offered health insurance for the past two years. The product went to market in April, 1989.

PRODUCT DESCRIPTION

Benefit Structure and Premiums

Oregon Option is a PPO plan comprised of two parts. The first is the Core Medical Program which provides coverage for employees only. The second part extends core medical coverage to dependents, offers alternative deductibles and stop loss options as well as options for preventive care, dental services and vision care. Annual deductibles range from $200 to $4000. Most services rendered by preferred providers are covered at 80 percent while non-preferred providers are covered at 70 percent. Covered services include inpatient and outpatient facility and physician charges, maternity services, well baby care, emergency room (after a $25 copayment), routine exams, x-ray and laboratory. Other services such as skilled nursing care, blood products, prescription drugs, ambulance and durable medical equipment are covered at 70 percent regardless of whether the provider is preferred. The monthly premium rate for the Core Medical Program is $53.33 per individual.

The difference between Oregon Option and other BCBS products is the exclusion of several state mandated benefits. A comparable BCBS major medical package costs $79.55 per month but includes mandated benefits. Some commercial carriers offer similar products costing approximately $70 to $75 per month. Kaiser is the Blue Cross Plan's primary competitor. Although its product is similar, it does not require a health statement to screen potentially high risk applicants as the Plan does. However, Kaiser's minimum group size is three while the Plan allows one-person groups. Other competitors are "niche players," who...
offer products in certain local communities at a lower price. Blue Cross products, on the other hand, are rated based on the entire population in the state.

PRODUCT PERFORMANCE

Enrollment

The product has been on the market for about two years. The State ambitiously projected an enrollment of 25,000 by Spring, 1991 but the actual figure is about 8,000. This lower than expected enrollment has been attributed to a very small average group size (about two). One concern to the Plan is the legitimacy of some businesses which apply to purchase the product. Although a business must report its registration to the State, rules outlining the qualifications of businesses are not enforced. Thus, there are worries that some applicants apply to receive the tax breaks and are not legitimate businesses. Regardless, experience with the enrolled population has been good so far. The Plan has experienced a loss ratio of 40 percent with the product. However, there is a 12 month waiting period for pre-existing conditions. There is speculation that the loss ratio could worsen once more people reach the 12 month requirement. There is another fear that sales of the product will decrease as the tax credits are phased out.

LESSONS LEARNED AND FUTURE OF THE PRODUCT

The Plan intends to continue to offer the product but would like the State to authorize a rate increase because the current monthly rate of $53.33 constrains the amount of benefits which can be offered. There have also been problems with the eligibility guidelines. According to regulations, businesses may "waive employees off" a policy or establish "classes" of employees, such as management, and then purchase coverage for a certain class. The Plan feels this "sets up a roadblock" because the plan ends up covering only about 75 percent of employees on average. It is hoped that these difficulties can be remedied in the near future. In general, the Plan is optimistic about the future of the product and its potential to reach many of Oregon’s uninsured.
CASE STUDY 23

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA
BASIC
BACKGROUND AND OBJECTIVES

Blue Cross and Blue Shield of Oklahoma's Basic plan was developed as a "safety net plan" to provide coverage for people who are employed but without health insurance. A study published in 1988 revealed that 54 percent of businesses with fewer than 10 employees in Oklahoma did not offer health insurance coverage. This was due in large part to small businesses' perceived inability to afford such coverage. In an effort to help combat this problem, BCBS of Oklahoma worked with the Governor, businesses, legislators and physicians to design a benefit plan with lower, more affordable premiums which fits the needs of small businesses.

PRODUCT DESCRIPTION

Benefit Structure and Premiums

Persons enrolled in the Basic plan must use a network of 35 hospitals and 3,500 physicians throughout the state. There is a $200 deductible per year. After the deductible has been met, the plan covers 100 percent of inpatient hospital care up to 21 days and hospital maternity and nursery services up to $1,000. Outpatient services are covered at 70 percent and lab and x-ray are paid for up to $100 per year. For prenatal office visits, the plan pays $25. If the visit is more than $25, the enrollee must pay the difference. Well baby exams have the same stipulation and are limited to four per year. The plan does not pay for routine exams, physician office visits or prescriptions.

The average monthly premium is $80. This average is computed based on individual and family policies and all age groups. The product is age rated and medically underwritten. The pre-existing condition waiting period is 12 months.

A popular package sold by BCBS of Oklahoma is the Master Benefits PPO. Once a $200 deductible has been met, the plan covers 100 percent of inpatient hospital care, certain outpatient procedures, office visits, laboratory and x-ray. Prescriptions are covered at 80 percent. The average monthly premium for this plan is $135.

BSBS staff are not aware of any competition in the uninsured small group market in Oklahoma. There was a program funded by the Robert Wood Johnson Foundation in Tulsa which was part of the Health Care for the Uninsured Program. However, the program never reached the enrollment stage.
LESSONS LEARNED AND FUTURE OF THE PRODUCT

Basic was developed in March, 1990 but is awaiting certification by the Oklahoma Basic Health Benefits Board. The Board has recently begun addressing the problem of small business access to health insurance. It is establishing criteria (in terms of benefits, premiums, etc.) to certify products for the uninsured and is devising tax incentives for small businesses which begin offering coverage. Once the product receives certification, BCBS will develop advertising strategies and promotional plans and begin to sell the plan. No enrollment projections had been made as of June, 1991.
BACKGROUND AND OBJECTIVES

Out of concern regarding small employer access to affordable health insurance coverage, the National Association of Insurance Commissioners (NAIC) began developing model legislation in 1990 that would assure availability of private insurance to small businesses and help to stabilize the small business health insurance market. There has been increasing awareness among insurance regulators, members of Congress, state and federal officials and consumers about rating, renewal and underwriting practices of insurers for the small group market which have made it increasingly difficult for small employers to obtain health insurance. Many times coverage is available only at a very high cost. In addition, the rapid inflation in health care costs and insurers' practices in response to these costs have only compounded the problem.

NAIC organized a Health Care Access Working Group comprised of representatives of State Insurance Commissioners to develop the model legislation. The Advisory Committee to the Group, made up of insurance groups, considered a wide range of alternatives for improving access for small groups and reforming insurance carrier practices. The alternatives considered seek to accomplish several key objectives. These include: 1) making private health insurance coverage available for all small employers; 2) addressing the small group access problem through the private sector; 3) requiring insurers to implement the NAIC's small employer rate reform provisions; 4) including all unregulated entities in the reform; 5) incorporating specific market conduct requirements to ensure compliance with carrier requirements; and 6) exempting small employers from state "anti-managed care" and mandate laws.

In making its recommendations based on the objectives stated above, the Committee emphasizes that while they will improve availability of health insurance for high risk small employers, the reforms are not intended to address the underlying problem of high health care costs. In fact, improving access for high risk small groups may add to the cost of coverage for some small employers. However, the NAIC feels that it is important to provide protection to these groups. In addition, the Committee feels the NAIC should recognize that many of the sources of health care cost increases such as Medicaid eligibility restrictions, Medicare and Medicaid reimbursement levels, provider practice patterns, managed care legislative restrictions, and costs associated with excess capital expansion, medical malpractice and new technologies are beyond the scope of the Committee.

The Model Act addresses only premium rates and renewability of coverage, a small part of the small business access problem. Other areas are being studied and approaches are being debated.
DESCRIPTION OF THE MODEL ACT

The NAIC Model Act, which was adopted in January, 1991, has multiple purposes. These include improving access, preventing abusive rating practices, requiring disclosure of rating practices to purchasers, establishing rules for continuity of coverage for employers and covered individuals, and improving the efficiency and fairness in the small group market.

Restrictions Relating to Premium Rates

First, the index rate for rating period for any class of business may not exceed the index rate for any other class of business by more than 20 percent, unless certain provisions are met regarding the class of business. Class of business is defined as "a distinct grouping of small employers as shown on the records of the small employer carrier." Index rate "means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate." Rating period is defined as "the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier." The second provision requires that premium rates charged to employers with similar case characteristics or coverage cannot vary from the index rate by more than 25 percent. In addition, the rates which could be charged under a certain class's rating system also cannot vary from the index rate by more than 25 percent.

Third, a small employer's percentage increase in its premium rate for a new rating period may not exceed a certain level. This is calculated by taking the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period, and adding to it an adjustment of no more than 15 percent and any adjustments due to changes in coverage or case characteristics. There are special provisions for premium increases for policies issued prior to the effective date of the Act.

The rating provisions set forth are only intended to affect insurers use of claim experience, health status or duration of coverage in determining premium rates. All other legitimate rating factors should not be affected. However, insurance carriers may not transfer a small employer into or out of a class of business based on case characteristics, claim experience, health status or duration since issue.
Provisions on Renewability of Coverage

In an attempt to prevent insurers from refusing renewal of small group policies because of large claims, employee health status or other reasons, the Model Act sets forth specific conditions for the termination of a policy. An insurance carrier must allow a health insurance policy to be renewable to all eligible employees and dependents except under the following circumstances: 1) nonpayment of required premiums; 2) fraud or misrepresentation of the employer; 3) noncompliance with plan provisions; 4) inadequate number or percentage of eligible individuals in a group; or 5) the employer is no longer in same business as it was on the effective date of the policy. An insurance carrier may choose not to renew policies in an entire class of business. However, it may not establish a new class of business for five years or without commissioner approval and it may not transfer businesses from the non-renewed class into other classes unless all non-renewed businesses are transferred.

The effects of the above provisions relating to premium rates and renewability of coverage is that small employers cannot be charged higher premiums purely on the basis of high claims cost for a single enrollee or small number of enrollees, nor can the carrier cancel coverage on the basis of high claims cost experience.


The Model Act requires insurance carriers to "make reasonable disclosure" of stipulations and/or changes in rating and renewal provisions. Carriers must explain to small employers how rates are set or adjusted because of claims experience, health status or duration of coverage. In addition, carriers must provide small employers with a description of the class of business in which they are included and provisions on renewal of coverage.

Maintenance of Records

Insurance carriers are required to maintain detailed descriptions of rating, renewal and underwriting practices and must document that practices are based on commonly accepted actuarial assumptions and are accordance with sound actuarial principles. In addition, carriers must file for certification with the commissioner that rating methods are actuarily sound and all documentation of rating and renewal practices must be made available to the commissioner.

While provisions of the NAIC Model Act may not seem to be extraordinary or particularly bold, their adoption by states should help to significantly reduce the number of arbitrary cancellations of coverage and very large premium increases (e.g., 35 percent or more) which have occurred with some frequency in recent years. Within six months of its adoption, at least ten states have enacted legislation which incorporates all or several provisions of the NAIC Model Act.
CASE STUDIES 25 AND 26

NEW YORK STATE PROGRAMS

COMMUNITY HEALTH PLAN AND HEALTH INSURANCE PLAN
BACKGROUND AND PROGRAM OBJECTIVES

During its 1988 session, the New York State Legislature authorized the establishment of the Committee on Expanded Health Care Coverage (CEHCC). The Committee studied ways to improve access to health insurance for the uninsured and underinsured and made recommendations regarding the design and implementation of regional pilot projects to address the problem. The recommendations resulted in legislation called the Expanded Health Care Coverage Act of 1988, which officially established three individual subsidy pilot projects and two employer incentive pilot projects. In addition, the legislation set forth provisions regarding selection of insurers, eligibility criteria, levels and types of subsidies, the role of the Insurance Department and requirements for evaluation of the projects.

Several entities were involved in the pilots' development and implementation, including the Department of Health, insurance companies, economic development representatives, Social Service and Labor representatives, the New York State Assembly and Senate, and the New York State Business Council. These groups agreed on a program which would be a joint public-private venture with the State and individuals and/or employers contributing to premium expenses. The State's share of the funding is provided by the bad debt and charity care pool.

The objective of the employer incentive programs, Community Health Plan (CHP) and Health Insurance Plan (HIP), is to offer firms with 20 or fewer employees incentive payments for the purpose of providing health care coverage to all qualified employees and their families. The State makes a monthly subsidy payment to an approved insurer for the amount of 50 percent of the premium. Employers must contribute the other 50 percent (employees may not contribute to their premiums). Insurers for each of the pilot projects were selected through a Request for Proposal process.

Eligibility criteria for businesses participating in both CHP and HIP include the following:

1) A business must have 20 or fewer full-time employees.

2) Full-time is defined as a minimum of 30 hours per week.

3) A business cannot have provided health insurance to employees as of January 1, 1988.

4) A firm must enroll at least 75 percent of its employees and their dependents.
5) If an employer hires more than 20 employees after joining the program, the employer may continue to participate but premium costs for additional employees are not eligible for subsidy.

There are no income eligibility criteria for employees. The State subsidizes 50 percent of the premium, regardless of income level.

Descriptions of both the Community Health Plan and the Health Insurance Plan are provided in the next section.

COMMUNITY HEALTH PLAN

PROGRAM DESCRIPTION

The Community Health Plan, a staff model HMO, operates in two districts in New York. The Capital District regional plan serves Albany and surrounding counties and the HealthShield regional plan serves counties in the Hudson Valley. CHP has been in existence since 1974. It began enrolling pilot project participants on June 1, 1989. Pilot participants must choose the Share 5 Plan of CHP from among the various plans offered, which includes a comprehensive package of benefits.

Benefit Structure and Premiums

The CHP Share 5 benefit package includes inpatient hospitalization plus related medical services, outpatient physician visits, ambulatory diagnostic and therapeutic services, 20 outpatient mental health visits per year, 30 inpatient days for mental health/psychiatric care per year, 60 alcohol/substance abuse visits per year, second surgical opinions, home health care, and authorized emergency services. A $240 deductible must be fulfilled for inpatient hospitalizations and there is a $100 outpatient deductible for ambulatory surgery. A $5 copayment is required for each outpatient visit. The deductibles and copayments are subject to a sliding scale based on income and family size.

Monthly premiums differ slightly between the two districts. They are shown in the table below.

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<tr>
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<th>Capital Area</th>
<th>HealthShield</th>
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<tr>
<td>Individual</td>
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<td>$128.41</td>
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<tr>
<td>Family</td>
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The State and the employer each contribute 50 percent of employees' monthly premiums. The rates shown reflect a slight increase which was approved in early 1991.

Administration and Marketing

The administrative staff for CHP was already in place before the program's implementation. CHP utilizes its regular staff for the pilot project, led by a project director who formerly worked as a marketing representative before the project began. CHP marketing representatives are responsible for marketing the pilot project as well as all other CHP plans. A full time marketing coordinator is responsible for recruiting and enrolling employers, supported by marketing representatives from the Capital Area and Healthshield district offices of CHP.

All pilot projects in New York State used a variety of marketing strategies, including direct mail campaigns and community outreach activities. CHP began its marketing efforts with a mass mailing (20,000 pieces) to small businesses in the target area. The mailing list was obtained from the Department of Labor. Unfortunately, the mailing generated only a minimal response even though it was accompanied by a rather elaborate promotion. A second mailing which included a prepaid return postcard yielded a three percent response rate. Responses to this mailing were followed-up with phone calls which proved to be the most successful means for recruiting enrollees.

Other marketing efforts included television and radio interviews with the CHP project director, a CHP-sponsored community fair for small businesses, presentations to area Chambers of Commerce and articles in business newsletters. Market research was not conducted prior to program implementation. Instead, decisions regarding benefit structure and marketing strategies were made based on advice and expertise from outside organizations.

PROGRAM PERFORMANCE

CHP began its enrollment phase on June 1, 1989. The program was to run for 18 months and projected to enroll 2,500 persons during that time frame. The program has been extended until December 31, 1993 and as of July 15, 1991 had an enrollment of 1,800 (382 businesses). The original enrollment goal remains and is expected to be met by the program's end date. Enrollment has been slower than anticipated. This could be due to the fact that the majority of the businesses enrolled have five or fewer employees. A survey conducted in 1990 pinpointed several reasons why eligible businesses chose not to enroll in the program. The majority which declined to enroll felt it was too expensive (67.9 percent), 21.4 percent said they did not like the benefits, 7.1 percent did not like HMOs and 3.6 percent said it was inconvenient.
One of the biggest problems with CHP since its inception has been a high rate of disenrollment. It has been suggested that this is due in large part to a volatile small business environment in the State. Many small employers join the program only to find themselves going out of business shortly thereafter. Another possible contributing factor is the transient employee population in small businesses. Employers simply find it too cumbersome a process to insure employees who work for short periods of time.

Another problem has been marketing. CHP marketing representatives have found the small business population to be a "hard sell." Not only do employers have to be convinced to participate, they must be convinced to contribute 50 percent of their employees’ premiums (which may not be payroll deducted). Because employees may not contribute to premiums, their participation (even if they are willing to pay), depends upon their employer’s cooperation and contribution. It has been recommended that the rule preventing employee contributions be eliminated.

A third issue which has come under scrutiny is what enrollees will do when the program ends. The program has established a somewhat unrealistic situation for employees because it requires no premium contribution from them. When the program ends, the State contribution will be discontinued and if an employer chooses not to continue contributing, the employee could potentially be left with his or her entire monthly premium to pay.

LESSONS LEARNED AND FUTURE OF THE PROGRAM

Three primary lessons have been learned during the course of the CHP pilot program. First, the enrollment process is very labor intensive. Staff members can expect to spend as much time and effort enrolling a group of three as they would enrolling a group of 100. Second, many small business owners simply will not take the time to learn about the program and often, marketing representatives never get an opportunity to speak with employees about the program. CHP has conducted open houses and educational sessions but the turnout has typically been poor. Finally, some businesses simply do not care for the HMO concept.

Several recommendations were formulated in attempts to remedy some of the difficulties which have been experienced thus far. Recommendations include permitting self-employed individuals to receive a state subsidy if their income falls below a certain level, allowing employees to contribute up to 20 percent of premium costs, and moving the date for employers not providing health insurance forward from January 1, 1988 to April 1, 1991. The date change and subsidies for the self-employed were approved in July, 1991 but have not been officially implemented.

The program will continue until the end of 1993. At that point enrollees will have the option to remain in CHP and convert to direct pay. It is hoped that a sizeable proportion of enrolled employers will continue to contribute at least 50 percent of premiums and that
employees will pay the remaining portion. CHP plans to work closely with each enrolled business to make arrangements for the changeover.

HEALTH INSURANCE PLAN
OF GREATER NEW YORK

PROGRAM DESCRIPTION

The Health Insurance Plan (HIP) is a group model HMO which enrolls pilot project participants in selected zip code areas of Brooklyn. HIP is assisted in its recruitment and enrollment efforts by the Brooklyn Economic Development Corporation (BEDC), which is a subcontractor for the project. Enrollment began in May, 1989.

Benefit Structure and Premiums

The benefit package includes inpatient hospitalization plus related medical services, outpatient physician visits, ambulatory diagnostic and therapeutic services, skilled nursing facilities, 60 alcoholism and/or substance abuse visits per year, second surgical opinions, home care services, authorized emergency services, ambulance services, eye exams, and 30 days per year for mental or nervous disorders.

There are no deductibles or copayments. Monthly premiums are $109.05 for individual coverage and $283.57 for family coverage. Rates were increased in January, 1991.

Administration and Marketing

The program is administered by HIP staff and BEDC assists in the recruitment and enrollment process. BEDC is an organization which interacts with businesses to provide services which they would otherwise be unable to obtain. HIP was able to use BEDC's reputation among businesses to gain credibility for the program and was able to determine the level of interest in a health insurance program.

The primary focus of marketing efforts has been mass mailings accompanied by telemarketing. The direct mail campaign was based on two mailing lists. One was from the New York State Department of Labor which included 22,000 small businesses with fewer than 20 employees in the targeted area and another which was purchased by BEDC from a list broker and included 10,000 small businesses. In a joint effort, HIP and BEDC followed up the mailings with 17,000 phone calls. In addition, the program has used press announcements, articles in business-related journals and newsletters, community outreach
activities, door-to-door solicitation and public service announcements. Telemarketing has proven to be the most successful strategies while the door-to-door visits proved relatively unsuccessful. While direct mail did generate a moderate response, it was found that the mailing lists became quickly outdated due to the high turnover rate of small businesses. The door-to-door strategy was not successful because many business owners simply did not have the time or were unwilling to speak with HIP/BEDC staff about the program.

Although marketing efforts have been intensive, enrollment has been slow and somewhat discouraging. However, as of July, 1991, eligibility criteria were awaiting revision which are hoped to make more businesses eligible. These revisions would allow the cutoff date for providing health insurance to be moved forward to April 1, 1991 and would allow self-employed persons to be eligible for the state subsidy. Once these become effective, HIP staff expect to repeat the same marketing strategy, with an emphasis on telemarketing.

PROGRAM PERFORMANCE

HIP began enrollment in May, 1989 and as of June 30, 1991 had approximately 1,400 members. The vast majority of firms enrolled (82%) have five or fewer employees and there are no firms enrolled with 16 to 20 employees.

One of the biggest challenges for HIP staff has been generating interest in the program. It is not clear whether the lagging enrollment is due to the sluggish economy, the fact that the program is going to end, the eligibility requirements or a combination of factors, but it is hoped that enrollment will pick when the marketing campaign begins. Another problem has been adjusting the billing schedule to suit small businesses. HIP staff have found that many small businesses do not pay bills on a monthly basis. And while some pay bills quarterly, others simply pay them when they have time. There is a stipulation in the pilot project guidelines that a firm may be forced to disenroll if it does not pay bills on time. However, HIP staff claim that the program would have virtually no enrollment if this regulation were enforced.

Another practical problem with the program has been the service area. For data collection purposes, pilot enrollees are restricted to the Brooklyn area even though HIP serves other areas of New York. It has been speculated that the restricted area may also be contributing to the low enrollment.

Despite its problems, HIP's disenrollment rate has slowed down and very few members were lost due to the January, 1991 rate increase. In addition, many of the persons who dropped out over time did so because they lost their jobs and some who lost their jobs have continued in HIP and pay the premiums themselves.
LESSONS LEARNED AND FUTURE OF THE PROGRAM

According the HIP staff, the primary lesson that should be learned from a voluntary program such as this is that enrollment is expected to be low and administrative expenses are expected to be high. It has proven to be an extremely labor intensive effort for relatively small returns.

Another issue which has come under scrutiny is the restriction prohibiting employee contributions to premiums. Although it is not clear whether allowing employee contributions would boost enrollment significantly, HIP staff would like to at least get employees more involved in the decision to participate in the program. Most often it is the employer who decides.

The program will continue until the end of 1993. Until then, HIP marketing staff are continuing their efforts to generate greater participation.
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COUNCIL OF SMALLER ENTERPRISES
COUNCIL OF SMALLER ENTERPRISES

BACKGROUND AND OBJECTIVES

The Council of Smaller Enterprises (CGSE) was founded in 1972 as the Small Business Division of the Greater Cleveland Growth Association, Cleveland’s Chamber of Commerce. Since then, it has grown to become the largest local small business organization in the United States with 10,000 members as of April, 1991. In order to be eligible for membership, a business must have between one and 150 employees, be located in the state of Ohio and be a for profit organization.

One of COSE’s main objectives is assisting members in obtaining reasonably priced group health care and other employee benefit programs through its group health insurance program which was implemented in 1973. COSE’s health insurance program began with a meeting with executives of Blue Cross and Blue Shield of Ohio, in which Blue Cross agreed to provide a ten percent discount on the cost of its standard package of group health care benefits. In return, COSE’s parent, the Greater Cleveland Growth Association, agreed to help Blue Cross market the program. The program began enrollment with 80 companies and 1,000 employees in 1973 and grew to 1,200 companies by 1978.

The original benefit package featured community rating, no medical exclusions and no age ratings. Over time, however, these features, along with a disproportionately large population of older and sicker people increased claims cost and subsequently, premiums. In addition, data on utilization and demographics was unavailable, which made the program difficult to manage. At this point, in 1978, COSE executives began to focus their efforts on changing COSE’s role in obtaining health insurance for its members. Because COSE was simply acting as a marketing aid for Blue Cross, Blue Cross could conceivably bypass COSE altogether and sell directly to its members. Therefore, in an effort to make COSE a critical link between insurers and COSE members, Group Services, Inc. (GSI) was created in 1983.

Group Services, Inc. (GSI) is simply a purchasing group which administers COSE’s employee benefit plans. It is the intermediary between insurance carriers and COSE and negotiates contracts and premiums and provides administrative services for the program.

PROGRAM DESCRIPTION

COSE offers several medical programs. Some are basic benefit/major medical plans which provide "first dollar" coverage, some are comprehensive plans which provide benefits after an annual deductible has been fulfilled and some are managed health care plans, including two health maintenance organizations (HMOs) and one preferred provider organization (PPO). A total of 12 plans are available through Blue Cross and Blue Shield of Ohio and Kaiser Permanente, as well as a dental plan which is offered by CIGNA.
Benefit Structure and Premiums

First dollar coverage is available through Super Blue 1 and 2 and Plans A and B from Blue Cross and Blue Shield of Ohio. The plans cover inpatient hospital care and a wide range of other expenses at 100 percent coverage. Certain supplemental benefits such as private duty nursing and ambulance services are covered at 80 percent after a $200 annual deductible has been reached ($400 for a family). The annual out-of-pocket maximum is $500 and the lifetime maximum benefit for all four plans is $250,000. Super Blue 1 and Plan A cover 80 percent of prescription drug charges after the annual deductible has been fulfilled while Super Blue 2 and Plan B cover 100 percent of prescriptions after a copayment ($4 for generic and $8 for brand-name drugs). Super Blue 2 and Plan B also cover vision care while Super Blue 1 and Plan A do not. The Super Blue Plans are slightly less expensive but enrollees are restricted to a specified network of hospitals. If a non-network hospital is used, enrollees are responsible for additional copayments and benefits are reduced by 20 percent. The monthly premiums for a single person under age 30 in Cuyahoga County are $79.64 for Super Blue 1, $91.54 for Plan A, $101.55 for Super Blue 2, and $113.45 for Plan B (rates for non-Cuyahoga County residents are slightly less expensive).

Four additional plans offered by Blue Cross provide benefits after a deductible has been satisfied. Super Blue 3 and 4 and Plans C and D offer 80 percent coverage (after deductible) for most services (except routine care) until the out-of-pocket maximum of $1,000 ($2,000 for families) has been reached. Remaining expenses are 100 percent covered up to the lifetime maximum of $1 million. Super Blue 3 and Plan C have a $100 individual deductible and $200 family deductible while Super Blue 4 and Plan D have a $250 individual deductible and $500 family deductible. Enrollees in the Super Blue Plans must use the Super Blue network of hospitals (under the same stipulations as Super Blue 1 and 2). Premium rates for a single person under age 30 in a group with fewer than 10 employees are $64.52 for Super Blue 3, $74.15 for Plan C, $58.94 for Super Blue 4, $67.75 for Plan D (Cuyahoga County resident).

HMO Health Ohio is a health maintenance organization operated by Blue Cross. The plan provides a comprehensive benefit package, including inpatient hospital services, doctor office visits, outpatient services, emergency room services, ambulance services, prescription drugs and out-of-area coverage in emergencies. There is no deductible but emergency services have a $25 copayment and prescription drugs have a $5 copayment. Monthly premiums are $120.85 for single coverage and $332.37 for family coverage. Blue Cross also offers a PPO program to COSE members. The PPO plan has lower premiums and higher copayments than the HMO.

Kaiser Permanente offers its High Level and Low Level Option HMO products to COSE members. Inpatient hospital care, outpatient care, office visits, emergency room services, prescription drugs and well baby care are covered under both options. The High Level Option offers most of these services at no charge while the Low Level Option requires a $5 copayment (except for inpatient care). In addition, the High Level Option requires a $5 copayment for prescription drugs, including refills, while the Low Level Option requires a $5 copayment for each prescription and each refill. The High Level Option also covers the
cost of durable medical equipment and hearing aids while the Low Level Option does not. Single coverage for the High Level Option is $131.63 per month and $128.60 for the Low Level Option. Family rates are $364.51 and $356.12 respectively. Dental coverage is also available for $10.50 per month for an individual and $28.85 per month for a family.

The CIGNA Dental Options plan is also available to COSE members. Enrollees may choose between a traditional indemnity plan and a managed care delivery program. The managed care program has High and Low Options. The indemnity program allows enrollees to choose their own dentist. A $50 deductible must be fulfilled with 100 percent coverage thereafter. Preventive services are covered with no deductible. The managed care High Option rates are $12.56 for single coverage and $32.83 for family coverage. Low Option rates are $8.38 and $21.77. The indemnity program rates are $23.30 and $64.49.

Administration and Marketing

COSE performs the billing and enrollment functions for the health insurance programs offered to its members. It does not handle claims payment, which is instead managed by Blue Cross and Blue Shield. COSE also takes part in the initial stage of the sales process. Personnel at the Chamber of Commerce deliver brochures which describe the health plans to businesses. Interested parties are then referred to either Blue Cross, Kaiser or CIGNA representatives. Businesses must apply for membership through the Chamber of Commerce but all underwriting is done through the insurance carriers. COSE charges a flat fee for administrative costs for all groups. Every group pays $8 per month plus 80 cents per employee. The average premium is $210 per person per month and the average administrative fee is $13 per group per month. Thus, administrative costs amount to less than one percent of premium costs, a significant savings over what would be charged if the insurance carriers assumed all marketing and administrative responsibilities.

The program uses a variety of marketing strategies, including direct mail, newspaper and print ads, radio and television. Print advertising has been the most effective, followed by radio and direct mail. Television has proven to be a good reinforcer of other advertising campaigns but it has not been particularly effective by itself. The insurers also do some advertising in conjunction with COSE’s campaigns. The marketing campaigns have generated sufficient interest that the insurance representatives do not have to do much cold calling and instead, simply follow up on leads.

Eligibility

Blue Cross and Blue Shield of Ohio requires certain minimum levels of enrollment depending on business size. Groups of one to five must enroll all members; groups of six must enroll five, groups of seven to eleven must enroll all but one person, groups of 12 must enroll ten; and groups with over 12 persons must enroll 85 percent. Employees which are covered through a spouse’s policy are not included in the minimum enrollment calculation. Only full-time employees who work a minimum of 30 hours per week are eligible to enroll.
and groups with fewer than 25 employees must submit health statements for underwriting purposes. Employers must contribute a minimum of 25 percent of an employee’s monthly premium.

Kaiser’s eligibility requirements are more liberal than Blue Cross’s in terms of the proportion of employees who must enroll. In addition, employees must only work 20 hours per week in order to be eligible. Employers must contribute 25 percent to monthly premiums. CIGNA requires that employees work a minimum of 30 hours per week to be eligible and all employees in a group must enroll. Employers must pay 100 percent of the monthly premiums.

PROGRAM PERFORMANCE

As of September, 1991, over 8,000 of COSE’s member companies were enrolled in at least one of its health insurance plans. The plans provide coverage to over 60,000 employees and 85,000 dependents. According to COSE staff, approximately 25 percent of the participating companies would be unable to obtain health insurance if COSE did not exist, especially sole-proprietorships, new firms, very small companies, and other businesses that for various reasons, cannot qualify for coverage. Approximately 20 percent of enrollees had never been covered under group health insurance before enrolling in a COSE-sponsored health plan.

The program has been in existence for 18 years and has changed in scope and dimension over time. Originally, the program was community rated, not medically underwritten, and had no age rating. This attracted a large population of older and sicker people which substantially increased claims costs and premium rates. In order to combat these huge increases and ensure more stability and predictability, age rating was adopted as well as medical underwriting. The underwriting practices reject less than 20 percent of applicants. Unfortunately, even though COSE’s underwriting rules are fairly inclusive, very small groups which have individuals who are uninsurable because of pre-existing medical conditions still face difficulties in obtaining coverage.

A key factor in the successful performance of the program has been centralized administration. Before 1982, the program had six carriers which each administered their own plan for COSE members. This proved to be inefficient and costly. Therefore, GSI assumed a central role in the administration of the program by taking over enrollment, billing and reimbursement functions.

From 1984 to 1990, enrollees in COSE-sponsored programs experienced a cumulative increase in health insurance premiums of 34.5 percent, compared with a 154 percent increase experienced by small groups with commercial insurance in the same market area. In 1984, COSE negotiated its first three-year contract with its primary carrier. Its current minimum contract is three years and there is a two-year renewal option for most contracts.
LESONS LEARNED AND FUTURE OF THE PROGRAM

COSÉ learned several important lessons about implementing a small business health insurance program early on in its history. First, a relationship had to be established between insurance carriers and small businesses with COSÉ as the critical link. Members had to be convinced that COSÉ was the best way to obtain health insurance and insurers had to be convinced that COSÉ could be an important source of business. COSÉ has managed to do both. Although COSÉ admits that members may in fact be able to beat its prices for a year or two, it is evident that they get a better deal in the long run than they would on their own. COSÉ also admits that it cannot be everything to everyone and that it simply cannot accept everyone regardless of medical history. COSÉ’s biggest carrier, Blue Cross and Blue Shield of Ohio, considers COSÉ a valuable asset, generating $130 million in premiums annually. As a result, COSÉ has earned negotiating power and is able to participate in product development and pricing as well as secure some stability in premium increases.

The other lessons learned deal with management of information. An information base had to be established which included utilization statistics for COSÉ enrollees. Once it was established, COSÉ had to use that information to develop more cost-effective innovations. Now with over 145,000 enrollees, insurers can more accurately predict utilization rates and, as a result, they charge lower premiums because of the reduced underwriting risk.

COSÉ attributes much of its success to several key factors. The first key factor is size. Because COSÉ has over 145,000 health plan enrollees, it has actuarial credibility like any other large group. Size has also proven to be a good negotiating asset because it gives COSÉ leverage in its interactions with insurers. Another factor is its long-term commitment in contracts. One of COSÉ’s major goals is not to “make the best deal for one year or the best deal for everybody for all time” but instead to ensure stability and predictability. COSÉ’s good working relationship with its major carrier, Blue Cross and Blue Shield of Ohio, has also been a critical factor. Blue Cross has recognized that COSÉ is an important customer and is committed to working with COSÉ to keep the program moving forward. Finally, one of the most important attributes of COSÉ is its Board of Directors. The Board is comprised mostly of COSÉ members. Therefore, they think not only about how decisions affect COSÉ but also how they will affect them and their businesses directly.

The future of COSÉ is very positive. While it is always trying to make improvements, it has established a strong base from which to expand. An expansion to Toledo is under way and there is interest in expanding to other Chambers as well. The program is growing at a rate of about ten percent per year. According to COSÉ staff, there is no reason why the program could not be duplicated elsewhere but there has to be a great deal of support from all sides.