Options for Small Employer Health Insurance in Missouri

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INTRODUCTION

Purchasing pools, reinsurance arrangements and state employee pool buy-ins are initiatives available to states to reduce the costs of providing health insurance coverage in the small employer market. These initiatives may be implemented independently or in combination.

This report outlines the key attributes, respective benefits and challenges of both purchasing pools and reinsurance, provides examples of state initiatives that combine purchasing pools and reinsurance to better meet the needs of uninsured employees of small firms, and describes selected states' experiences with state employee pool buy-ins. An overview of regulations enforced in the small group health insurance market is included to set the context for the design and implementation of these options. The viability of any initiative to expand coverage to small employers depends on the degree to which the initiative matches the needs of the targeted population and complements the insurance regulations in the state.

I. MISSOURI'S WORKING UNINSURED

While the number of uninsured children in Missouri and the U.S. has declined – due in part to the implementation of the State Children's Health Insurance Program (SCHIP) – the number of uninsured working-aged adults continues to rise. This increase in adult uninsured rates can partly be attributed to the decline in employer-based health insurance coverage. It is estimated that employer-based coverage in Missouri declined from 74% to 65% between 2001 and 2004,[1] and an estimated 12-16% of Missouri's working age population was uninsured in 2004.[2]

Uninsured adults typically work for small employers and have low wages.[3] As shown in Table 1, one in four Missourians (24.8%) working for an employer with fewer than 11 employees was uninsured in 2004. As the size of the firm increases, so does the likelihood of having health insurance, with 95% of employees in firms with more than 100 employees having health insurance coverage.

Table 1. Uninsurance Rate by Employer Size, Missouri 2004

Employer Size	Insured	Uninsured	
<11 employees	75.2%	24.8%	***
11-24 employees	86.8%	13.2%	**
25-50 employees	89.8%	10.3%	
51-100 employees	87.8%	12.2%	*
101+ employees (reference group)	95.0%	5.0%	
Total	89.4%	10.6%	

Source: 2004 Missouri Health Care Insurance and Access Survey
*p<0.05, **p<0.01, ***p<.001: Indicates statistically significant difference relative to reference group

Wage levels also play a role in the likelihood of employer-based health insurance coverage, with low-wage employers being less likely to offer health insurance coverage. Table 2 shows that approximately one-third (33.8%) of Missouri employees with incomes below the federal poverty level (FPL) were offered employer-based coverage, compared to 82.4% of workers earning 300% of FPL.[4]

Table 2. Health Insurance Offer Rates by Selected Employer Characteristics, Missouri 2004

	Offer Rate	
Type of Employment		
Permanent (reference group)	73.6%	
Temporary	42.7%	***
Seasonal	40.6%	***
Hours Worked		
0-10	51.4%	
11-20	42.9%	
21-30	37.1%	
31-40	77.0%	
41+ (reference group)	76.4%	
Employee Income (as % of FPL)		
<100%	33.8%	***
100-133%	38.4%	***
134-150%	49.1%	***
151-200%	65.0%	***
201-250%	75.3%	*
251-300%	68.7%	***
>300% (reference group)	82.4%	

Source: 2004 Missouri Health Care Insurance and Access Survey
*p<0.05, **p<0.01, ***p<.001: Indicates statistically significant difference relative to reference group

State policy initiatives to increase employer-based coverage have focused on both small and low-wage employers in efforts to reach the working uninsured and effectively target scarce resources.

Considering worker incomes at or below the poverty level by employer size, Table 3 illustrates that a larger portion of individuals, 9.5%, working for the smallest firms (≤25 employees) earn lower incomes compared to 5.0% of individuals working for large firms (101+ employees). The lower wage levels may restrict employee ability to afford premiums and other out-of-pocket costs associated with health insurance.

Table 3. Employee income (as % FPL) by employer size, Missouri 2004

Employee Income (% FPL)	Number of Employees			
	≤ 25	25 to 50	51 to 100	101+
≤ 100%	9.5%	12.9%	7.2%	5.0%
101 - 200%	18.2%	15.2%	19.1%	13.5%
201 - 300%	21.7%	16.0%	16.9%	17.4%
301%+	50.5%	56.0%	56.8%	64.2%
Total	100.0%	100.0%	100.0%	100.0%

Source: 2004 Missouri Health Care Insurance and Access Survey

II. PURCHASING POOLS

Purchasing pools are used to pool multiple employers and their employees to leverage affordable health insurance rates, share/spread risk, and achieve benefits from administrative cost savings due to volume purchasing.

Recently there has been a renewed interest in purchasing pools as an option to provide affordable insurance to counter low rates of employer-based health insurance coverage, especially among small businesses. Many states have made legislative provisions to establish small employer purchasing pools, including California, Florida, Minnesota, New York, Oregon Texas and Washington. Typical purchasing pools offer standardized benefits through two or more health plans, with centrally-administered enrollment, billing and claims processing.

Attributes of Purchasing Pools

The types of purchasing pools and their negotiated arrangements with health plan providers vary from state to state, and pools may be private or government-run. Table 4 highlights key attributes of purchasing pools including size of employer, number of enrollees, and the type of sponsorship, along with examples of state initiatives to illustrate each attribute.

Table 4. Key Attributes of Purchasing Pools

Definition/Description	Examples of States
Type by size of eligible small employers	
Eligible employers vary in size from state to state, but participation is typically limited to employers with ≤50 employees.	CA: PacAdvantage (2 to 50 employees) CT: Connecticut Business and Industry Association (CBIA) Health Connections (3 to 50 employees)
Enrollment	
The larger the pool, the greater the ability to spread risk.	CA: 8,216 groups; 144,425 lives[5] CT: 3,500 groups; 55,000 lives[5]
Sponsorship	
State subsidies can be used to support the initial financial investment for start-up costs. Other small employer pools have been initiated without state financial support.	*State established:* CA: PacAdvantage *Privately established:* CT: CBIA Health Connections; WA: Association of Washington Businesses *Public-private partnership:* NY: New York City HealthPass

Benefits Offered by Purchasing Pools
Small employer purchasing pools offer value-added benefits that can contribute to premium reductions, such as:

Administrative Ease: Pools serve as a "single point of entry" for employers to easily compare multiple insurers' plans and benefits.[5] For enrollees, pools also simplify selection of coverage by publishing premiums for a set of standardized benefits, thus making it easier to evaluate each plan.

Availability of Multiple Plan Options: Pools may offer a choice of insurance carriers with different benefit levels/costs instead of the single-plan option offered by most small and many large employers. Having a choice of plans, providers and prices can be a plus to consumers.

Spill-over Benefits: Some analysts have observed that the existence of pools provides choice to enrollees, thus enhancing competition.[6] Adopting managed competition principles with other pool attributes may lead to additional reduction in insurance costs in the small group health insurance market.

Challenges of Purchasing Pools
The evidence on the success of purchasing pools in increasing access and affordability of health insurance is mixed. Pools have had limited success in offering premium savings to their members.[5] Some of these challenges include the following:

Limited Ability to Capture Administrative Savings: While reduced paperwork for benefits administration, claims processing and marketing have led to somewhat lower administrative costs, overall the pools have struggled to attain the volume necessary for administrative efficiency. Some insurers report that administrative costs actually increase because products have to be modified to accommodate the informational needs of employees.[5]

Limited Market Share: Purchasing pools represent only a small portion of the small group health insurance market in their states.[5] California, North Carolina and Texas pools accounted for less than 5 percent of each state's market. Florida and Connecticut accounted for 5 and 10 percent, respectively. The small market share constrains the pools' bargaining leverage to reduce premiums.[5]

Risk of Adverse Selection: For insurers, offering lower premiums to enrollees within the pool raises concerns of attracting too many high-risk individuals, also known as adverse selection. With more high-risk individuals the price per enrollee increases. As plans become expensive, low-risk enrollees tend to opt out to look for cheaper plans outside the pool, further driving up the average premiums within the pool. This dynamic is a "death spiral" for pools and threatens their viability.

III. REINSURANCE

Reinsurance is another mechanism used in the small employer market to contain health coverage costs for participants. Essentially, it is insurance for the insurer, or for the entity that assumes the risks of health expenses for the insured. Reinsurance is based on the premise that if an insurance company cedes some of its risk to a reinsurer, the company will require fewer reserves and surpluses to be built into the premiums, thereby lowering premiums and potentially increasing enrollment.[7] The choice of whether to reinsure is based on the insurer's assessment of the enrollees' level of risk. For each insured group, the insurer must determine whether or not the expected cost of health care is likely to exceed the cost of the reinsurance premium. If health care costs are expected to exceed the premium amount, then it is prudent to reinsure the group.

Reinsurance structures vary and should be informed by state health expenditures, state insurance market regulations, estimated enrollment, and projected expenses for several layers of coverage.[7] Reinsurance is available in the private sector but several states have assumed some or all of the reinsured risk.[8] State-funded or public reinsurance programs are offered in Arizona, Minnesota and New York, and conventional/private reinsurance programs funded by insurer premiums and/or assessments are offered in Connecticut, Idaho, Massachusetts, and New Mexico. Reinsurance may be used independently or in combination with purchasing pools to further lower premiums. Section IV provides examples of purchasing pools that use reinsurance for additional premium savings.

Conventional/private reinsurance relies on funding from insurers in the form of premiums or assessments while spreading risk across insurers. Reinsurance premiums and assessments can be costly due to the increased administrative costs of underwriting, which can limit the savings passed on to enrollees. Consequently, the success of private reinsurance depends on careful program design to maximize insurer participation, discourage adverse selection, and encourage premium reductions.[7]

Publicly subsidized reinsurance programs have the capacity to distribute risk among a broader base of participants, reduce adverse selection and underwriting, and hence reduce premiums.[9] Stable funding is likely to be the greatest challenge for public programs; however, data and modeling can be used to demonstrate the long-term benefits of reinsurance in terms of reduced uninsurance rates and increased health status.

Attributes of Reinsurance Programs

Attributes of reinsurance programs, types of reinsurance, funding sources, and insurer participation are summarized in Table 5. Type of reinsurance refers to whether group- or individual-level losses are the activation threshold; funding sources refers to public or private; and insurer participation refers to voluntary versus mandatory.

Table 5. Attributes of Reinsurance Programs

Attributes	Definition/Description	State Examples
Type		
Aggregate stop-loss reinsurance	Covers group-level losses that exceed a specified threshold.	AZ*, NM*
Individual excess-of-loss reinsurance	Covers individual-level losses that exceed a specified threshold. Provides an incentive to manage medical care because insurers retain responsibility for at least a portion of every insured's claims.[7]	CT, ID, MA, MN*, NY*
Funding Sources		
Private reinsurance	Funded by premiums or assessments from insurers for each group or individual to be reinsured. The reinsurer may retain the right to assess participating insurers for additional funds if needed to cover excessive losses.	CT, ID, MA, NM
Public reinsurance	Funded by a subsidy from the state, which assumes responsibility for losses incurred above a specified percentage/threshold.	AZ, MN, NY
Insurer Participation		
Mandatory	States have the option to mandate insurers to participate in the reinsurance pool but we found no examples of states that did so.	---
Voluntary	Insurers participate voluntarily in the reinsurance pool. However, if the funds of the reinsurance pool are depleted, assessments may be levied on all insurers in the state, or on licensed insurers in select markets (e.g., insurers in the small-employer market) to make up for the losses.	AZ, CT, ID, MA, NM, NY

* Reinsured Purchasing Pools; see Section IV for details

Benefits of Reinsurance

Some of the benefits offered by reinsurance include:

Distribution of Risk: Private insurers or the state (in the case of public reinsurance) assume some or all of the risk, thus distributing the risk of high-cost claims.

Less Adverse Selection: Due to the distribution of the risk of high-cost claims, variance in health care expenditure is reduced and premiums are more likely to remain constant and consistent with the rest of the market. Competitive premiums can reduce the possibility of adverse selection.

Reduced Premiums: Reinsurance has the potential to reduce premiums by limiting the high-cost claims for which individual insurers are responsible, thereby reducing the need for reserves to cover unexpected losses. These savings may be passed on to enrollees in the form of lower premiums.

Increased Insurance Coverage: Effective design and implementation of reinsurance programs may increase the affordability and availability of insurance for historically uninsured populations via reduced risk for insurers and reduced premiums for consumers.

Challenges of Reinsurance
Implementing reinsurance to increase the affordability of health insurance is not without its challenges, including:

Challenges in Estimating the Cost of Reinsurance: Estimating the cost of a reinsurance program involves significant data gathering. It involves a derivation of the expenses and health care utilization patterns of insured individuals gathered from local insurers and adjusted for inflation, the threshold level at which reinsurance is activated, and the cost-sharing of reinsurance expenses between the insurer and the reinsurer.[7] Arriving at a reliable estimate of what the insurance program may cost is an iterative process and can be a challenge, given the derivations required from the gathered data.

Disincentive to Manage Care Costs: In aggregate stop-loss reinsurance there are no incentives for insurers to manage/contain care costs of enrollees since aggregate-stop loss reinsurance is activated when group costs exceed an established threshold. In contrast, excess-of-loss reinsurance requires insurers to retain a good deal of risk, as they are responsible for all costs below the activation level of excess-of-loss reinsurance.[7]

Cost/Funding: For private programs, reinsurance premiums are expensive and may result in losses if claims fail to exceed the amount of the premiums paid. In addition, insurers will have to pay the cost of increased underwriting. Publicly subsidized reinsurance programs face the risk of reduced or unstable funding levels over time.

IV. REINSURANCE OF PURCHASING POOLS

The goal of increasing health coverage in the small employer market ensures continuity of coverage, improved health status for employees, and decreased uninsurance rates. To that end, reinsurance combined with purchasing pools can work to lower premiums for enrollees through two means: purchasing pools share/spread risk for premium savings by volume purchasing, and reinsurance distributes the risks of high-cost enrollees among insurers or the state.

Reinsured Purchasing Pools in States
States use purchasing pools with reinsurance as a mechanism to encourage employer-based health insurance. Examples of publicly reinsured purchasing pools include Arizona, Minnesota and New York. New Mexico is an example of a purchasing pool with a conventional/private reinsurance program. An overview of these initiatives, including details on eligibility criteria, financing options, and lives covered is provided below.

Health Care Group of Arizona
Arizona's Health Care Group (HCG) was created in 1985 to purchase primary insurance for a pool of small employers with 2-50 employees and self-employed individuals.[7] For firms with 1-5 employees, 100 percent of eligible employees are required to participate, and at least 80 percent of eligible employees are required to participate among firms with 6 or more employees.[10] HCG does not require employer contribution.[11] Initially HCG did not have a reinsurance mechanism, but adverse selection and high premiums warranted the need.

Public aggregate stop-loss reinsurance became available in 2000. The state subsidizes losses between $20,000 and $100,000 and purchases catastrophic reinsurance for claims greater than $100,000.[12] As of January 2005, HCG had 12,600 enrollees.[7]

Minnesota's Regional Health Care Purchasing Alliances
Since 1997, Minnesota's regional health care purchasing alliances have allowed small businesses with 1 to 10 employees to collectively negotiate benefits with participation requirements varying across alliances. Funds for the initial development of the alliances were appropriated by the legislature. As issues of adverse selection and risk were identified, the legislature in 2001 authorized and appropriated $1.7 million for public reinsurance funds, known as the Purchasing Alliance Stop-Loss Pilot Project. Through this fund, health plans contracting with rural health care purchasing alliances are reimbursed 90 percent of any enrollees' claims between $30,000 and $100,000 per year, thus mitigating the insurer's high medical claims under $100,000.[13]

Healthy New York
Healthy New York (HNY) is a state-sponsored program specifically targeted to meet the health insurance needs of sole proprietors and small employers with 50 or fewer employees. Established in 2001, HNY operates as a purchasing pool contracting exclusively with health maintenance organizations (HMOs) to offer a standardized insurance product. To ensure that HNY truly meets the needs of the low wage earners, 50 percent of the firm's eligible employees are required to participate, 30 percent of the firm's employees must earn less than $32,000, and the firm must not have provided comprehensive coverage to its employees in the last year.[7] Funded through the Tobacco Settlement Fund, HNY assumes the risks of high-cost care through a publicly subsidized excess-of-loss reinsurance program. Initially, HNY paid 90 percent of the claims between $30,000 and $100,000 with the HMO responsible for the remaining 10 percent. The HMO is fully responsible for expenses greater than $100,000. In 2003, reinsurance levels were revised. Plans are currently reimbursed for 90 percent of claims paid between $5,000 and $75,000[14] which has reduced HNY's premiums by 17 percent on average.[7] As of October 2005, HNY had 102,500 enrollees.[14]

The New Mexico Health Insurance Alliance
The New Mexico Health Insurance Alliance (NMHIA) partners with carriers to provide coverage to self employed workers and their families, and to small businesses with 50 or fewer workers (working as few as 20 hours per week). NMHIA does not require employer contribution but mandates 50 percent participation from eligible employees who have lost their group coverage involuntarily.[11] The initiative created in 1994 manages risk through conventional/ private reinsurance premiums and periodic assessments on the 400 carriers in the state.[10] NMHIA withholds 5 percent of the premiums for reinsurance in the first year of coverage for small groups and approximately 10 percent in subsequent renewal years, along with administrative charges. Every year the reinsurance fund is used to reimburse participating health plans the amount by which incurred claims and reinsurance premiums exceed 75 percent of earned premiums. If losses are in excess of reinsurance funds, an assessment on insurers is triggered. Enrollment under this initiative has been as high as 8,800 lives, but recent years have seen this figure decline.[11]

V. MISSOURI'S POLICY OPTIONS TO DECREASE UNINSURANCE AMONG SMALL, PRIVATE EMPLOYERS

In an effort to provide coverage to uninsured employees in small, private firms in Missouri, the Missouri Department of Health and Senior Services (MDHSS) is considering the following options:

1. Extending coverage to small, private businesses to purchase health insurance for their employees by providing an option to buy-in to the Missouri Consolidated Health Care Plan (MCHCP) offered to employees of public entities;
2. Extending coverage to small, private businesses to purchase health insurance for their employees by providing the option to buy-in to the existing MCHCP offered to state employees; and
3. Establishing an independent purchasing pool for small, private business owners to secure coverage for their employees, potentially within the infrastructure of the MCHCP.

These options can be designed with or without a reinsurance component.

Small Employers Buy-in: MCHCP

The MCHCP administers two distinct pools – one for public employers and one for state employees. Although the state serves as the administrator of each pool, they are operated as separate pools for the purposes of purchasing insurance. Each of the two MCHCP pools has its own risk profile and contracts with health plans.

The first option includes the extension of MCHCP for public entities to employees of small, private employers in Missouri. Reinsurance could be used in addition to the buy-in option to offset the costs associated with high-risk enrollees. The second buy-in option includes the extension of the MCHCP for state employees to small private employees in Missouri. Again, reinsurance could be used in addition to the buy-in option to offset the costs associated with high risk enrollees. To implement either of these options, legislative action would be required to enable the existing MCHCP to include small, private employers for purposes of affordable health insurance.

Table 6 outlines potential attributes and structural design and operational issues that Missouri may consider while examining either of the two buy-in options. Attributes include eligibility criteria for employer participation, premium levels, plan participation, administration, sponsorship of pools, and options for funding reinsurance.

Table 6. Potential Attributes and Structural Issues for Missouri to Consider

Attributes	Definition/Description
Eligibility criteria for small, private employers	
Size of firm (3-25 vs. 2-50)	Specify the size of employer eligible to participate. Missouri statute defines small employer as 3-25; HIPAA defines small employers as 2-50.
Proportion of employees eligible	Specify the percentage of employees (who do not have access to health insurance through any other source such as parent/spouse/public programs) required to participate.
Length of time uninsured	Consider the length of time for which the employer has not offered health insurance for eligibility, so as to truly target uninsured employees.
Employer premium contribution	Specify the percentage of premium that the employer needs to contribute, if any, in order to be eligible.
Premiums	
Existing enrollee premium	Address concerns among existing MCHCP enrollees about any perceived potential increase in premium levels, erosion of benefits or quality of service due to new members.
New enrollee premium	Set premiums for new enrollees that are affordable without escalating the potential for adverse selection.
Participation	
Number of groups/lives enrolled	Assess the potential size of the pool. The greater the number of groups/lives enrolled, the greater the potential for spreading risk and achieving cost economies.
Choice of product	Consider options for increasing choice through a greater number of participating plans or by increasing the number of benefit designs within a participating plan. Participation by too many plans may increase the risk of adverse selection.
Administration	
Administrative costs Marketing costs Monitoring/evaluation	Absorbing new enrollees into MCHCP may increase administrative costs in the area of enrolling/disenrolling, premium collection, claims processing, marketing costs to recruit small employers, and plan compliance/evaluation procedures.
Sponsorship of purchasing pool	
State established Privately established Public-private	To ensure political and financial feasibility, buy-in from significant stakeholders, as well as stable sponsorship, is critical. Expertise and interest from public/private sectors will be required to champion this initiative, but decisions will need to be made about the sponsoring entity.
Funding of reinsurance	
Public reinsurance	Reinsurance can be set up and funded through private or public mechanisms. Some states provide public subsidies to help keep premium costs down. The level of subsidy varies by state, type of plan, and size of reinsurance pool.
Conventional/private reinsurance	Reinsurance can be set up and funded completely by the private sector. Private reinsurance pools are typically funded by upfront insurer premiums and/or back-end assessments on participating plans to cover the expenses of high-cost claims.

Benefits of the MCHCP Buy-in Option
The most important benefits offered through the MCHCP buy-in include the following:

Increased Availability of Insurance: The buy-in option (either the public or the state employee pool) would enable small, private employers to receive the advantages of an existing larger pool: its ability to better spread risk and leverage market power with potential for lower premiums for health insurance.

Option for Plan Choice: Small, private employers who participate in the pool option would also have the advantage of choice of health plans and/or benefit designs offered by the MCHCP, thus increasing their current product choices.

Reduced Burden on Safety Net: There is some potential for decreasing the burden on public programs and safety net providers, as more working adults would have access to affordable health insurance coverage.

Risk Selection: Participation and bidding by vendors may be more likely since the public entities and the state are known risks.

Challenges of the MCHCP Buy-in Option
There are several challenges associated with the buy-in, as described below:

Administrative Complexity: The inclusion of small, private employers into the MCHCP will be a complex administrative undertaking. Structural and organizational impediments may not allow for easy inclusion of small employers, and their eligibility criteria would need to be specified. Also crucial to consider is the effect on premium levels for current enrollees due to the inclusion of new enrollees.

Administrative Costs: The state may incur upfront costs for marketing/advertising and enrolling small employers to achieve necessary economies of scale and lower premiums. Missouri state law defines small employers as 3-25 employees[15], compared with the federal HIPAA definition of 2-50 employees.

Crowd-out Provisions: The state will want to ensure that coverage is extended to eligible uninsured employees so that it does not become a replacement for employer-based private health insurance coverage. Anti-crowd-out provisions built into Missouri's policy option may increase administrative complexity and limit enrollment.

Source of Funding: The state may want to explore private and public financing options. Public options could include providing administrative infrastructure as well as state subsidies for reinsurance, tax credits and other options to encourage participation. Private options are typically through premium taxes or provider assessments.

Actual/Perceived Risk: The addition of small employers to the MCHCP pool could raise issues because the risk of the small employers is unknown and could have a negative impact on the existing MCHCP pool.

ERISA: Inclusion of small, private employers into the MCHCP would likely impact the current ERISA exemption of the MCHCP. This impact would need to be examined further.

Reserves: Because most of the state pool is self-insured, necessary reserves to insure additional small employers would have to be built-up.

Perceived Fairness: If small, private employers are added to the existing MCHCP, equity or fairness challenges may be raised by public entities that believe the reinsurance provisions should also apply to them.

Independent Small Employer Pool

Another option is to establish a separate pool for small, private business owners independent of the MCHCP available to state and public entity employees. Similar initiatives have been instituted in other states (e.g., Minnesota and New Mexico) where small employers have established their own pools to negotiate insurance with carriers for reasonable premiums. The state can provide infrastructure to support the development of a pool, or as has been implemented in several states, provide the administrative support for a new pool within the MCHCP infrastructure. The following discussion addresses some of the benefits and challenges associated with an independent small employer pool. However, most of the design and operational issues highlighted in Table 6 will still be relevant when considering this option.

Benefits of the Independent Small Employer Pool vs. MCHCP Buy-in

Some of the benefits of an independent purchasing pool when compared to the MCHCP buy-in option include:

Administrative Ease: A small employer pool independent of the existing MCHCP coverage available to state and public entity employees may be less complex and administratively easier.

Option for Plan Choice*:* Small employers that participate in the independent pool may be able to contract with different carriers, offering more plan options and benefits. Enrollees would not be limited to choosing among options available to existing MCHCP employees. Also, health plans contracting with independent pools may not be subject to the same requirements for those doing business with the state. This freedom may be potentially advantageous to an independent small employer pool.

Challenges of the Independent Small Employer Pool vs. MCHCP Buy-in

Challenges of a small employer pool, independent of MCHCP are:

Size of Pool: With small employers buying into MCHCP, there is a broad base of enrollees to facilitate volume purchasing and affordable premiums. However, an initial, smaller independent pool of private, small employers may not have the same advantages of the larger pools currently associated with MCHCP. This will require education and policies that make the program attractive to potential insurers.

Start-up Costs*:* While there are administrative costs associated with small, private employers joining the existing MCHCP, there may be higher costs associated with building the infrastructure needed to run an independent small employer pool.

VI. Similar Proposals at the State/Federal Level

There have been several proposals considered at the state and federal level for small, private employers to buy-in to the state employee health insurance pool. Unfortunately very few of these proposals have been thoroughly developed and implemented, or have been revised to reflect a variation of the buy-in option. The most common variation is using the state employee plan infrastructure to administer a separate small employer pool. Select examples of state initiatives include:

Connecticut

In 2003, Connecticut approved the expansion of its Municipal Employee Health Insurance Program (MEHIP) to include small employers with fewer than 50 employees to provide coverage through state negotiated health plans, known as the MEHIP Commercial Small Group (CSG) plan.[16] MEHIP was established in 1998 to extend health coverage to municipal and non-profit employees, similar to that offered to state employees. MEHIP is sponsored by the office of State Comptroller and is administered by Mercer, a division of Marsh & McLennan Companies. Mercer is responsible for sales, marketing, enrollment, billing and all customer service issues.[16] By law, MEHIP is separate from the state employee plan in terms of premiums and coverage. Under this initiative, the employer selects the insurer, while the employee chooses from among the 10 point-of-enrollment and point-of-service plan options available.[12] As of February 2006, 69 small groups with 155 lives were enrolled.[17]

Kentucky

In 1994, Kentucky established the Kentucky Health Care Purchasing Alliance as part of a broad health care reform effort. The Alliance was a large state purchasing pool with mandatory participation for state and other public employees and voluntary participation for individuals and employers with 100 or fewer employees. Other market reforms implemented at the same time included: guaranteed issue and renewal; prohibition of rating based on health status, previous claims, or gender; and a standardized benefits package. Amid substantial controversy and prolonged delays in implementation, Kentucky's health reforms spurred a mass exodus of insurers from the individual market and strong opposition from health care providers. In 1998, repeal legislation succeeded in reversing many of the earlier reforms and abolishing the purchasing alliance.[18]

Minnesota

In the early 1990s, Minnesota used the infrastructure of its state employee health plan to organize two voluntary purchasing pools: one for public employers regardless of size, the Public Employer Insurance Pool (PEIP); and one for small private employers (2-50 employees), the Minnesota Employees Purchasing Plan (MEIP). The PEIP provides a brokering function to solicit bids and to provide a choice of plans. Coverage is available to Minnesota's counties, cities, towns, school districts and other public jurisdictions. As of July 2004, PEIP covered 7,825 employees, retirees and dependents representing 123 public sector employer groups with an average employer size of 24. The program is financed by employer and employee premiums, administrative fees charged to public employers and a small general fund contribution to administrative costs.[19]

MEIP was intended to serve small, private employers and operated between 1993 and 1998. The pool was discontinued because MEIP was not financially viable due to: conservative premium ratings and individual group underwriting for MEIP employer groups resulting in higher premiums than market rates; high administrative costs due to multiple choice of health plans; and below-market incentives for brokers who were primarily responsible for recruitment into the program.[20] The public sector purchasing pool (PEIP) is still in operation.

New Mexico

In 2004, a proposal was submitted to establish a buy-in to New Mexico's General Services Department/Risk Management Division (GSD) (the state employee health plan) for small employers, including nonprofits with 50 or fewer employees who had not been offered health insurance for at least 12 months.[21] A variation of this plan, called the State Employer Insurance Program (SEIP), was passed by the legislature and signed into law in March 2005. SEIP is a self-funded pool for small employers. While it is administered by the state, it was set up as a separate pool funded by employer/employee premiums and stop-loss reinsurance. Enrollment is estimated at 3,000 for first year of implementation in 2006 and is targeted at employees with incomes above 200 percent of FPL.[22] While there is no direct general fund appropriation for its operation, the plan is being administered by the state.

Washington

Washington used yet another variation of the buy-in option by allowing low-income employees (below 200 percent of FPL) to buy a managed care plan through its state-subsidized Washington Basic Health Plan (BHP). BHP is a state-sponsored health insurance program for low-income residents provided through private managed care plans. Premiums are based on a sliding fee scale. The program requires employers to contribute $52 for the monthly premium of full-time employees and $32 for part-time employees.[23] There are concerns about low participation and administrative complexities of this program. Currently, employees can enroll as individuals for a cost of only $10 per month, creating an incentive for employers to encourage employees to enroll on their own.

West Virginia

The West Virginia Small Business Plan, passed in 2004, is an illustration of a public-private partnership among private insurers, small employers with 2-50 employees, hospitals/physicians, and the West Virginia Public Employees Insurance Agency (PEIA). The PEIA is a self-insured state program that makes health insurance provisions for state employees, employees of state universities and colleges, and county boards of education.[24] PEIA is divided into three risk pools—one for all the active employees in the organizations mentioned above, the second for local county and municipal employees, and the third for retired employees who participated in PEIA prior to their retirement. Originally, small businesses were to participate in the local agency pool; however, there were concerns about potential increase in costs due to the inclusion of the new group. Following this sentiment, the Legislature chose to allow private market insurers to use PEIA provider reimbursement rates.[24] Under the Small Business Plan, all players assume equal responsibility in providing

affordable health insurance to uninsured employees with up to 25 percent reduction in premium costs. [25] This is achieved through PEIA's buying power and provider reimbursement rates which average 20-25 percent below private market rates. Employers are responsible for at least 50 percent of the premium. Instead of state funds to support the plan, start-up costs have been covered by a multi-year grant from The Robert Wood Johnson Foundation under the State Coverage Initiatives program. [25] Oversight is provided by the West Virginia Insurance Commission. As of fall 2005, 500 individuals representing approximately 100 small businesses were enrolled under this initiative.[24] This initiative remains a viable option for small employers. It has broad support in the state and the business community, and continues to grow.

Federal

At the federal level, there have been proposals to open up the existing Federal Employees Health Benefits Program (FEHBP) to small employers and other individuals not covered through work or public programs. Participating small employers would be required to contribute towards their employees' premiums. With some exceptions, new enrollees would have the same plans available to choose from as current enrollees. One plan, the Extended FEHBP (E-FEHBP) would require insurers to rate new enrollees separately and place high-risk enrollees in a federally-subsidized reinsurance pool to protect insurers against adverse risk selection and insulate existing enrollees from potential increase in premium. E-FEHBP estimated reduction in uninsurance by at least 25 percent. [26] Due to the increased administrative costs involved in including non-federal workers into the existing FEHBP, it was proposed that individual states be given a chance to administer this initiative in close collaboration with the federal government, possibly through some federal grants.

VII. State Regulations Enforced in the Small Group Health Insurance Market

Any state considering small employer pooling options should closely examine its insurance market regulations, state-wide health care utilization data, HIPAA requirements, estimated enrollment, and projected expenses to form pools and offer different layers of reinsurance coverage.[7] Many states have adopted insurance reforms in the small group market to level the playing field, stabilize the insurance market, and enhance options available to small employers. Some of the small group health insurance regulations are detailed in Table 7, including rules of issue, benefits, rating practices, exclusions, and minimum loss ratios.

Table 7. Small Group Health Insurance Market Regulations

Rules of Issue	Definition	Missouri Market
Guaranteed issue	Akin to the "take all comers" rule, insurers are required to sell insurance to any "eligible party" interested in purchasing insurance irrespective of the health status or claims experience of its employees.[27]	Yes[28]
Guaranteed renewal	Insurers cannot refuse renewal of coverage to small employers, if small employers desire to continue coverage. The regulation prevents insurers from cancelling coverage of high claims-cost groups.[27]	Yes[28]
Mandated benefits		
Exemptions from state-mandated benefits	Exemption from providing mandated health benefits (e.g., mammography screening, alcohol treatment) in insurance products offered to small employers.	Yes[28] (variable)
Rating practices		
Restrictions on premium rating practices	Insurer restrictions on factors used to determine premium levels for enrollees. Typical premium regulations include pure community rating, modified community rating, and rating bands. National Association of Insurance Commissioners' model (NAIC) also restricts premium rates when coverage is renewed.	Rating Bands[29] (applicable to 3-25 only)
Exclusions		
Pre-existing condition exclusions	To provide greater coverage to enrollees, HIPAA prohibits insurers from excluding coverage of any condition after a member has been enrolled past the waiting period (6-12 months).	Yes[29] (12 months)
Minimum loss ratio		
Minimum loss ratio	Ratio mandates a proportion of premiums collected to be paid out in claims. Ratios range from 50% in MN to 80% in WA. NY and NJ stipulate that if a carrier paid out less than 75% in the prior year, they must pay out the balance as dividends or credits against subsequent premiums to employers.[30]	Group- 78.1%; Individual 65.5%[31]

VIII. SUMMARY

At first glance, purchasing pools appear to be a valid means of increasing health insurance coverage by increasing availability of an affordable health insurance option for small employers. However, states that have implemented pools have experienced low enrollment, premium increases and higher administrative costs. Without additional enrollment, smaller pools may require additional risk protection which may include a reinsurance pool to keep premium levels affordable. While premium costs for the reinsurance will affect overall cost of the purchasing pool, the benefits are that the health insurance underwriting can be streamlined and participants can be assured that they will not be dropped based on the health care needs of one or a few employees.

Another option that has been discussed in many states and at the national level is to allow small employers to buy-in to the existing state employee health plan program. The state employee plans generally provide the larger pool necessary to spread risk and leverage the market. However, there are additional administrative and political complexities, as well as costs, that have created barriers to effective implementation of the buy-in option at the state level.

As Missouri works through its policy discussions about increasing the availability of affordable health insurance to the working uninsured, policy makers will want to consider these complexities as well as the existing market structures. Careful program design and upfront planning including stakeholder education will be needed to achieve a successful initiative that meets the state's objectives.

NOTES:

[1] For information on employment based insurance rates for other years, refer to http://www.census.gov/hhes/www/hlthins/historic/hihistt6.html

[2] The 2004 Missouri Health Care Insurance and Access Survey estimates uninsurance rates for adults 19-64 years at 12%. Using the 2002-2004 pooled data from the U.S. Census Bureau's Current Population Survey, the estimate for Missouri adults aged 19-64 years is 16%.

[3] The Kaiser Commission on Medicaid and the Uninsured. (2006). The Uninsured: A Primer. Key Facts About Americans Without Health Insurance. Issue Brief. Available at http://www.kff.org/uninsured/upload/7451.pdf

[4] According to the U.S. Department of Health and Human Services, the 2004 federal poverty level for a 1 person household is $9,310; 2 person household is $12,490; 3 person household is $15,970 and for a 4 person household is $18,850 (http://aspe.hhs.gov/poverty/04poverty.shtml)

[5] U.S. General Accounting Office. (2000). Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices. (GAO/HEHS-00-49).

[6] Katz, A., and S. Dominguez-Karasz. (2002). Selecting Policy Options for Strengthening Employer-Based Health Insurance in Washington State. Seattle WA: University of Washington, School of Public Health and Community Medicine.

[7] Swartz, K. (2005). Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers. Paper No. 820. New York NY: The Commonwealth Fund.

[8] Cohn, D., E. Martinez-Vidal, and D. Chollet. (2005). More Answers on Reinsurance. Issue Brief. Vol. (2). Washington DC: State Coverage Initiatives, AcademyHealth.

[9] Blumberg, L.J., and J. Holahan. (2004). Government as Reinsurer: Potential Impacts on Public and Private Spending. *Inquiry* 41:130-143.

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[13] Minnesota Department of Health. (2003). Health Care Purchasing Alliances: A Small Employer Alternative for Minnesota. St. Paul MN: Minnesota Department of Health, Office of Rural Health and Primary Care.

[14] Latest figures cited from http://www.statecoverage.net/matrix/reinsurance.htm

[15] Small Employer Health Insurance Availability Act. (2005). *Missouri Revised Statutes.* Sec. 379.930, August 28, 2005.

[16] For more information, refer to http://www.mehip.org/snoCsgWelc.aspx

[17] Enrollment figures were provided by Ann Fern of Mercer, a division of Marsh & McLennan Companies, on 3/9/06. Ann Fern can be reached at 860-723-5751.

[18] Kirk, A. (2000). Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts. *Journal of Health Policy, Politics and Law* 25(1): 133-173.

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[19] Minnesota Department of Employee Relations. (2005). 2006-2007 Budget Request, January 25, 2005.

[20] Minnesota Department of Employee Relations. (1998). Minnesota Employees Insurance Program (MEIP): Impact and continued viability report. St. Paul MN: Minnesota Department of Employee Relations.

[21] Insure New Mexico! Council. (2004). Summary of Recommendations to Governor Bill Richardson, December 14, 2004. Available at: http://www.insurenewmexico.state.nm.us/documents/INSURENMRecommendations.pdf

[22] Insure New Mexico! Council. (2005). Report to Governor Bill Richardson, December 2005. Available at: http://www.insurenewmexico.state.nm.us/documents/2005_Insure_NM_Report_to_Governor.pdf

[23] See State of Washington, Basic Health Plan http://www.hca.wa.gov/overview.shtml

[24] State Coverage Initiatives, 2005. Profiles in Coverage: West Virginia small business plan. Available at: http://www.statecoverage.net/westvirginiaprofile.htm

[25] For more information on the West Virginia Small Business Plan, refer to http://www.wvsbp.org/index.html

[26] Fuchs, B.C. (2001). Increasing Health Insurance Coverage through an Extended Federal Employees Health Benefits Program. *Inquiry* 38:(177-192).

[27] Blumberg, L., and L. Nichols. (1995). Health Insurance Reforms: What they can and cannot do. Washington DC: The Urban Institute.

[28] Georgetown University Health Policy Institute. (2004) A Consumer's Guide to Getting and Keeping Health Insurance in Missouri. (2004). Available at: http://www.healthinsuranceinfo.net/mo01.html

[29] The Kaiser Family Foundation State Health Facts. Available at: www.statehealthfacts.org

[30] Glover, S., C. Stoskopf, T.E. Brown, F. Wheeler, and Y. Kim. (2000). Small Business and Access to Health Insurers, Particularly HMOs. Prepared for the Office of Advocacy for the U.S. SBA by Consult, Inc., Orangeburg, SC.

[31] These are the latest published loss ratios (2004). These are not specific to small employers.