

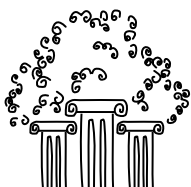
# HELPING SMALL BUSINESS EMPLOYEES ACCESS AFFORDABLE HEALTH CARE:

## Recommendations for a State-Level Response



Appleseed

*Sowing the Seeds of Justice*





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# I. Executive Summary

## A. Background: Small businesses cannot afford to offer health insurance.

Roughly 46 million Americans are uninsured. Over 60 percent of these uninsured are either small business employees or dependents of small business employees.

Small businesses generate 60 to 80 percent of the new jobs annually and account for 99 percent of all American employers. Despite their significant contribution to the workforce, small businesses often lack the resources to offer health insurance to their employees. Rising costs have priced many of them out of the insurance market. Beginning in 2001, rising health benefit costs coupled with a weak economy had a significantly negative effect on health insurance coverage. The cost of providing health benefits increased by more than 13% in 2003, and an 11% increase in 2004 marked the fourth consecutive year of double-digit increases. Employer-sponsored health insurance covered 66% of the non-elderly in 2000, but by 2003, this number had dropped to 62%.



The problem is not that small business owners fail to recognize the importance of providing health insurance to their employees, as many are themselves uninsured. Rather, they often do not have the purchasing power to provide cost-effective coverage through traditional channels.

Solving the healthcare crisis in the United States requires that we address the barriers faced by small businesses and their employees. Policies that improve the options for small businesses will have a dramatic impact on access to health insurance across the country.

## B. Purpose of Report: Appleseed evaluates the state of small business health coverage.

In order to insure their employees, small businesses must develop creative approaches to healthcare coverage. Appleseed has examined the effectiveness, both in terms of cost and reduction in the number of uninsured, of a variety of approaches. Through surveys and focus groups of small business owners and employees, interviews with national stakeholder organizations, reviews of existing literature, and economic analyses, Appleseed has evaluated a breadth of data and knowledge. This report presents our overall findings, as well as attitudinal case studies of small business health insurance coverage in four states: Alabama, Nebraska, New Jersey, and South Carolina.

## C. The Team

Appleseed Centers in Alabama, Nebraska, New Jersey and South Carolina (collectively, "the Target Centers"), the Appleseed Foundation, pro bono lawyers from Porter Wright Morris & Arthur LLP, and professionals from the business and health sectors have joined together to gather the data and develop the policy options presented in this report. Supplemental research was provided by the law firms of Latham & Watkins LLP and Cozen O'Connor LLP. Watson Wyatt Worldwide provided an economic analysis of the Tax Credit, Full S-CHIP Enrollment, Reinsurance, and Federally Qualified Health Centers options for the Target Centers. Dr. Howard Berliner from the New School University provided a cost analysis of the Full-Cost Buy-In options for Alabama, Nebraska, and South Carolina.

## D. Methodology

Under a Federal State Planning Grant from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, state agencies within each of the four target states investigated small business health insurance through surveys and focus groups. These HRSA studies provided extensive quantitative data which is incorporated into this report. Nebraska Appleseed and Alabama Appleseed created and conducted additional surveys to complement their state's HRSA data. Both centers sought to identify why small businesses do or do not offer health insurance to their employees (i.e. employers' preferences, price sensitivities, and barriers) and both used the collected information to facilitate discussion among business leaders and employees in their communities. New Jersey and South Carolina Appleseed did not administer their own surveys as they found the HRSA data collected in their states sufficient. In addition, the Target Centers hosted a number of intensive meetings and forums with various business leaders and stake holders.

## E. Key Findings: Health insurance is a top priority for employees and employers.

- Most employers that offer health insurance agree that the primary reason for offering coverage is the ability to attract and retain high quality employees.
- The high cost of premiums is by far the most common reason cited for lacking coverage among employers who do not offer health insurance.
- When employees in an Appleseed survey were asked to rank overall employment benefits in terms of importance, healthcare was a top priority for all respondents.
- The likelihood that an employer will offer coverage is directly related to the size of the company, with larger businesses more likely to offer coverage.
- The majority of employees would rather have their employers purchase their health insurance than attempt to find their own. Large majorities say purchasing their own coverage would make it more difficult for them to get a good price for insurance (81%), to find or keep insurance if they are sick (79%), to handle administrative issues (73%), and to find a plan that matches their needs well (71%).
- The most common reason given for non-participation by employees in employer-sponsored coverage is that it is too expensive. Employers who have recently cut or reduced health coverage, or plan on doing so in the near future, have most frequently done so due to the high cost of premiums.



- Private family coverage for those in small groups in one target state generally ranges from \$601-840 a month. Most employees there felt they could afford approximately \$116 a month.
- In general, the largest gaps in coverage are among young adults (those in their twenties and early thirties), those with the lowest incomes, and members of racial minority groups.

## F Results: No Single Solution

The multitude of reports on the state of health coverage demonstrates that there is no single or easy solution to the problem. In the absence of some form of mandated coverage, there is unlikely to be a one-size-fits-all solution. Broad change will more likely be the result of numerous incremental solutions, each targeting different aspects of the problem.

In light of these considerations, Appleseed has selected the following nine policy options:

1. Buy-In Options: Full Cost Buy-In to Medicaid/State Health Insurance Pool
2. Full S-CHIP Enrollment
3. Expansion of S-CHIP
4. Expansion of Medicaid
5. Increased Funding for Federally Qualified Health Centers
6. Mandatory Reinsurance
7. Community-Based Plans
8. Targeted Medicaid Waiver/18-65 Year Old Single Adults
9. Tax Credits for Small Businesses

## G. Evaluation Criteria

In evaluating the array of proposed policy solutions, Appleseed applied a uniform set of criteria. The options that are presented here have each been deemed to:

1. Involve the Participation of a Key Stakeholder
  - Government
  - Business
  - Providers (Insurers and Doctors)
  - Consumers (Employers)
2. Maximize Existing Programs
3. Prepare for Long-Term Solutions
4. Be Realistically Achievable
  - Politically
  - Fiscally

5. Expand Coverage
6. Work for and Target Small Businesses
7. Have No Negative Unanticipated Consequences
8. Contribute an Incremental Solution to the Goal of Achieving Universal Coverage

## II. Options Not Chosen

Certainly, it is not possible to advocate for every feasible option, nor is it practical to address each of the options that are not included here. Several options that we have not chosen, however, do merit discussion.

### A. Employer Mandates (Pay-or-Play)

An option that would require employers to offer health insurance to their employees, often structured as a tax (pay) that is waived if the employer offers coverage (play), has proven to be effective in Hawaii, the only state where it is currently in place.

Both federal laws such as ERISA, and many state laws, make implementing such a policy extraordinarily difficult. The political shift and corresponding length of time that would be necessary to make the regulatory culture more open to employer mandates makes this option impractical for our initiative, which aims to combine options to begin covering the uninsured as soon as possible.

### B. State High-Risk Pools

Thirty states have created pools for residents who cannot obtain health coverage in the private market because of health conditions. Some states have also explored adding various segments of the uninsured population to these pools, which are generally funded through assessments on health insurers, taxes on alcohol and tobacco, and tobacco settlement funds.

While we recognize state high-risk pools as viable, we have already incorporated elements of the option in our Reinsurance and State Health Insurance Pool Buy-In recommendations.

### C. Health Savings Accounts (HSAs)

HSAs, also known as Medical Savings Accounts, are becoming increasingly popular with small businesses and have been endorsed by the Bush administration. These tax-free accounts are used in combination with a high-deductible health plan to pay for everyday medical expenses and to cover expenses not covered by the plan.

HSAs, though, must be tied to health insurance. For many small businesses and their employees, even though the premiums tend to be lower, either the employer and/or employee also need to contribute to the HSA in order for there to be sufficient funds in the savings account. Such dual payments often make HSAs as impractical as traditional plans. Additionally, pressed for current liquidity, low-income workers are unlikely to save money in these accounts, and are then unable to pay the high deductibles if serious medical problems arise.

### D. Small Business Association Health Plans (AHPs)

This plan, currently being debated in Congress, allows member businesses of small business associations to pool their employees in order to increase their purchasing power.

This idea of combining the resources of individual small business to be able to better compete for reasonable insurance rates is one of the ideas behind the State Health Insurance Plan Buy-In option that we recommend. The major drawback of the AHPs is that they are not subject to the same regulations as other insurance plans, which could lead to the acceptance of only low-risk candidates and to inadequate coverage.



## III. Brief Overview of Policy Options

### A. Buy-in Programs

Full Cost Buy-In programs (FCBI) allow the uninsured and their employers an opportunity to pay the full premium associated with a state-run insurance program, like Medicaid or a state employee health insurance plan. This option requires recipients to pay the total expense that the state incurs to provide coverage, which is usually more affordable than paying a percentage of an employer based plan. In essence, FCBI programs expand eligibility to public programs, typically by raising or eliminating income ceilings. At least 19 states and the District of Columbia have operated Medicaid Buy-In programs with varying degrees of success, including Arizona, California, Colorado, D.C., Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Rhode Island, Tennessee, Utah, Vermont and Wisconsin. While this is a cost effective way to expand services to the uninsured take up by employers can be limited and is most successful if this option is coupled with a state subsidy. While it is admirable to tie a buy in or premium assistance program with a portion paid by the employer, states should consider individual buy in as an option to increase participation.

### B. Full S-CHIP Enrollment for the Children of Small Business Employees

The State Children's Health Insurance Program (SCHIP) is a jointly funded federal-state program that provides medical insurance coverage for certain low-income children who are not eligible for Medicaid. Full SCHIP enrollment would significantly expand the number of children that are covered by these programs. Moreover, higher SCHIP enrollment would reduce insurance costs for businesses and employees, who could purchase individual coverage, rather than the dramatically more expensive family coverage.

### C. Expansion of S-CHIP

Two proposed State Children's Health Insurance Program expansions would almost certainly have the effect of increasing insurance coverage. One option would be to increase the income eligibility limits for participating children. Once a state increases eligibility to 200% of poverty a state may develop a program that allows the parents of these children to participate in the program. Unfortunately, full utilization of the program in its current state has not yet been achieved. It is estimated that of the 10 million uninsured children in America, 6.2 million are eligible for state-sponsored care, with 2.8 million eligible for S-CHIP. Appleseed applauds efforts to expand coverage and recognizes that some of the states that are profiled in this report have relatively restrictive income eligibility guidelines. Once again, this program is most successful if it can be coupled with a state subsidy.

### D. Medicaid Expansion

The Medicaid program is a jointly funded federal-state program that provides medical and long-term care coverage to low income individuals who meet certain income and categorical eligibility requirements (e.g., aged, blind, disabled, impoverished, members of families with dependent children, etc.). Federal law gives states flexibility to increase income eligibility levels to allow more people to qualify for Medicaid coverage. States can also expand Medicaid coverage by making additional groups eligible for Medicaid. State requests for Medicaid expansion are made by submission of a Medicaid State Plan and/or a State Plan Amendment (SPA). Approval of state requests for expanding Medicaid coverage is by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health & Human Services. CMS has 90 days to approve or deny a SPA. States that have successfully expanded Medicaid coverage include Georgia, New Jersey, Oregon, and Rhode Island.

## E. Increased Funding for Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are private, non-profit or public organizations that receive federal grants from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. The health centers' mission is to improve the health status of underserved populations. FQHCs provide services to the uninsured on a sliding fee scale based on their ability to pay. However, FQHCs do not provide a health insurance solution. These community health centers have been around since the mid-1960s. They experienced rapid growth after the establishment of the federally qualified health center program by Medicare and Medicaid in 1989 and 1990. This program provides cost-based reimbursement for covered services to community and migrant health centers, health care for the homeless, and public housing programs. In state fiscal year 2006, at least 36 states are providing direct funding to health centers for a total of more than \$365 million. As compared to state fiscal year 2005, three states are reducing funding by a total of approximately \$3.5 million, at least 23 states are increasing funding by a total of \$141.5 million, and 10 states have level funded health centers.

## F. Reinsurance

Reinsurance is an alternative mechanism for spreading risk among insurers that does not involve screening out high-risk applicants and referring them to a separate pool. Reinsurance is sometimes achieved through a pool of funds to which a number of insurance companies contribute. The essence of reinsurance is that either the state or a mandatory pooling of carriers would cover the costs for the most expensive cases, making it possible for insurers to offer coverage at lower rates, which should induce more employers to offer coverage. While reinsurance lowers average premiums, it is not targeted to low-income consumers and helps all insureds equally.

## G. Community-Based Plans

Local governments have undertaken initiatives to provide health care directly to low-income individuals. Community-based plans are an example of a health care program for the working poor. It is not health insurance per se, although it functions in many similar capacities. Generally, community-based plans secure primary and specialty care, hospitalization, and other medical services for participants. The Memphis plan is an example of a health care program for the working poor. Local physicians were asked to see ten patients each, without charge, as a community service. The Christian Community Health Fellowship (CCHF), the non-profit organization that administers the Memphis plan, then recruited 2,000 working poor to participate, and negotiated with their employers to contribute a minimum of \$10 a month as "medical insurance." This payment goes both to the physician and the health center where the employee is granted free access, with a \$5 co-pay, to a specific physician for all medical needs.

## H. Targeted Medicaid Waiver

Medicaid waivers are used to "waive" certain Medicaid requirements specified in law. State Medicaid waivers are approved by the federal government and can be used to cover new eligibility groups, such as uninsured individuals with income higher than the state's eligibility threshold. Waivers must be budget neutral over the life of the project (generally 5 years), thus, it cannot be expected to cost the federal government more than it would cost without the waiver. As a result of the budget neutrality requirement, states that use waivers to expand coverage must create offsetting savings or redirect existing federal funds to finance the expansion. If a state finds that its costs are over the amount assured in the waiver, the state will either be faced additional state dollar expenditures or cutting services or eligibility.

The use of Medicaid waivers have become a controversial subject, because while waivers can be used to help expand eligibility and services, they have been used in recent past by some states to justify limitation of services and increased costs to beneficiaries. If this is explored, those states who are advocating the use of waivers should be clear that waivers should be used to bring in additional eligible beneficiaries while it maintain services.

## I. Tax Credits for Small Businesses that Offer Health Insurance

A health insurance tax incentive is a credit or deduction for the purchase of health insurance that reduces an individual's or employer's tax burden. Deductions or credits may be capped, limited to certain categories of tax filers (e.g., small businesses, previously uninsured individuals, etc.) or made available for the purchase of particular types of coverage only (e.g., comprehensive benefit plans). Tax credits may be refundable or non-refundable. Most tax credits are non-refundable, meaning that if a taxpayer's credit exceeds his/her income tax liability, the tax payer does not receive the difference as a refund. With a refundable tax credit, taxpayers whose credits exceed their income tax liabilities receive the difference in the form of a tax refund. Of the tax credit options, including non group tax credits, employee tax credits, and employer tax credits, targeted employer tax credits are the most efficient. These tax credits should be: (a) targeted to the smallest businesses, (b) with the lowest wage employees, and (c) phased out as the size of the business and wages rise. Non group tax credits are almost as effective, but end up covering a healthier population, giving you less bang for the buck in terms of the insurance. However, even the best tax credit costs three times as much per dollar of insurance as public insurance programs. Expanding public insurance is far more efficient than any tax credit policy.





## IV. The Strategy

Appleseed's strategy has been to collaborate with policy makers, grassroots organizations, employers, and low-wage workers through the Target Centers in our four focus states. This report presents Appleseed's overall findings and recommendations, and then profiles small business healthcare attitudes and coverage in the Target Centers' states. From this, Appleseed hopes to increase health insurance coverage by making available lower cost options for small businesses. Appleseed expects that this research and the proposed solutions will help make it easier for businesses to hire and retain quality employees, and for low-wage workers to secure sustainable jobs. It is also Appleseed's hope that given this report, they will empathize with the uninsured and will be empowered to address the issue for their own employees. Better still, Appleseed hopes that small business owners will rely on this report to emerge as advocates for change in the larger business community. Appleseed also seeks to inform the work of advocates and decision-makers at the state, local, and federal levels.



## V. Overall Findings

### A. Who is Uninsured

#### 1. Employment Status

About 81% of the uninsured, including children, come from working families. Of that 81%, 69% have a family member working full-time, and an additional 12% have at least one family member working part-time. However, full time workers in general are much more likely to be insured (15% uninsured) than part-time workers (31% uninsured).

Although most uninsured individuals come from working families, rates vary according to business size and sector, with the smallest businesses having the highest rates of uninsurance. Almost half (48.7 %) of all uninsured workers are either self-employed or work for firms with fewer than 25 workers (26.3% of self-employed workers and 31.2% of all workers in firms with fewer than 25 employees are uninsured). On the other end of the spectrum, only 12.6% of workers in firms with 1,000 or more employees lack insurance. Our findings support analysis by the Employee Benefit Research Institute indicating that the smaller the firm, the higher the probability that workers will be uninsured.

#### 2. Race

Members of racial minority groups experience much higher rates of uninsurance, with high rates for Hispanic (38.7 percent) and black Americans (23.7 percent), compared with relatively low rates among whites (13.2 percent).

#### 3. Age

Excluding the young (under 19) and the elderly (over 65), individuals between the ages of 55-64 are the most likely to be insured (12.9% uninsurance rate) and individuals ages 21-24 are the most likely to be uninsured (33.9% uninsurance rate). In general, there seems to be the largest gap in coverage in the "young adult" phase, the twenties and early thirties.

#### 4. Income Level

About two-thirds of the uninsured are from the lowest-income families (less than 200 percent of the poverty level, or approximately \$29,000 for a family of three). Thirty-three percent of individuals who find themselves within 200% of the federal poverty level are uninsured, as compared with 9% of those at 200% or more of the federal poverty level.

### B. Why the Uninsured Do Not Have Coverage

Research consistently shows that cost is the number one reason people lack health coverage. For example, one survey by the Kaiser Family Foundation showed that among the uninsured, more than half (52%) cite cost as the main reason they don't have insurance: 24% are employed but not offered insurance and say it is too expensive to buy on their own; 17% are unemployed and say it is too expensive to buy insurance on their own; and 11% are offered insurance through their employer but say the amount they would have to pay is still too high. Other reasons given for lack of health insurance include: respondents are employed but ineligible for coverage due to part-time status or a waiting period (11%); respondents do not think they need health insurance (7%); respondents are unable to get coverage because of poor health or age (5%); respondents do not know how to obtain insurance (3%).

The results of the Kaiser survey above are consistent with Appleseed surveys and findings. At least 60% of respondents to each

Appleseed survey in select states demonstrated cost as the number one prohibitive factor for both employers and employees in securing health insurance.

### C. What Business is Looking For and Willing to Do

According to those small business employers who responded to Appleseed surveys the high cost of premiums is the number one reason employers do not offer coverage. With relatively low profit margins, many small businesses simply cannot afford coverage at current market rates.

Because they lack the economies of scale and the management resources of larger firms, small businesses also tend to face high costs when administering plans. Some do not see it as efficient to offer health coverage. According to data collected by the Congressional Budget Office, overhead costs for providing insurance can be over 30 percent of premium costs for firms with fewer than 10 employees, compared with about 12 percent for firms with more than 500 employees.

In addition to simple economies of scale, other things such as higher staff turnover contribute to this difference. Moreover, many small business owners have little desire or, without dedicated human resources staff, capacity to engage in the demanding task of organizing health insurance to meet the often-varied needs of their employees.

Still, the majority of employer-respondents to Appleseed surveys rank health care coverage as either “important” or “very important,” and many recognize it as a disadvantage to not be able to offer coverage. Employers in states such as Nebraska and Alabama have indicated that they would offer health coverage if it was proven to reduce staff turnover, but opinions are split on whether or not it is a decisive factor.

In New Jersey, most of the employers interviewed that did not offer health insurance had never done so, while most of the employers that did offer health insurance had done so for a very long time, even in recent times of premium increases. This suggests that employers that currently offer insurance are committed to doing so, and that they are more likely to reduce coverage or their share of the premium than to stop offering coverage altogether.

### D. What Employees Are Looking For and Willing to Pay

According to the small business employees who responded to Appleseed surveys, healthcare is always ranked as the top priority in terms of available employee benefits.

When given the option, more than half (55%) of those who currently receive employer sponsored insurance, from various sized firms, say they would rather have their employer pay for their coverage, whereas 7% say they would rather receive cash to buy insurance on their own. Large majorities say purchasing their own coverage would make it more difficult for them to get a good price for insurance (81%), to find or keep insurance if they are sick (79%), to handle administrative issues (73%), and to find a plan that matches their needs well (71%).

When asked the highest amount they would accept for a monthly premium if they were shopping for health insurance, about half (49%) name amounts of \$200 or less, just over a quarter (28%) name amounts greater than \$200, and another quarter (24%) say they don't know. Those earning less than \$30,000 a year, and those who are currently uninsured name lower amounts.

Similar to the results above, the highest number of employee-respondents to Appleseed surveys indicated that they would only be willing or able to pay \$100 or less a month for health insurance.

More than half (52%) say they would choose more comprehensive benefits over higher wages, while 36% say they would choose higher wages.

Respondents were asked about a scenario in which the government would offer “a tax credit, tax deduction, or other financial insurance that you could use to purchase health insurance on your own.” The amount of the described tax credit was \$1,000 for an individual, or \$3,000 for a family. Given this option, about three-quarters (76%) of those with employer sponsored coverage say they would still choose to continue receiving insurance through their employer rather than try and purchase it on their own.

Among the uninsured, given three options for expanding their family's access to care, four in ten (40%) say they would prefer to have publicly-sponsored coverage made available to their families, a third (33%) say they would prefer a \$1,000/\$3,000 tax credit, and about one in five (19%) say they would prefer a new public clinic in their community. As for the types of coverage individuals are looking for, most people say they would feel vulnerable without certain aspects of coverage, including coverage for hospital care (93%), specialists (88%), prescription drugs (81%), routine and preventive care (76%), home health care (63%), maternity (58%), and mental health (56%).

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## VI. Practical Options for Increasing Coverage

From this wealth of experience, we have identified the most promising policy options. We do not offer recommendation on levels of funding, groups to be served, or other specific measures which will depend largely upon the demographics, coverage, policy and political landscape in each state.

Identification of these options is part of an ongoing effort to remedy our national healthcare crisis. It is our hope that advocates will use this report as a tool to put the ideas it contains into practice. Legislators and business leaders have the power to turn these proposals into reality, and to begin providing desperately needed care to the small business uninsured today.



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# Appendix A

## Buy-In Programs

### Description

Full Cost Buy-In programs (FCBI) allow the uninsured and/or their employers an opportunity to pay the full premium associated with a state-run insurance program, like Medicaid or a state employee health insurance plan. This option requires recipients to pay the total expense that the state incurs to provide coverage, which is usually more affordable than paying a percentage of an employer based plan. In essence, FCBI programs expand eligibility to public programs, typically by raising or eliminating income ceilings.

The goal of FCBIs is “to increase access to insurance for families with incomes too high to qualify for subsidized public programs, but who may not have access to employer-based coverage and who cannot afford the premiums charged in the individual market.” The creation of a FCBI targeting small-businesses is a natural extension of this goal. Many small business employers cannot afford to provide health care coverage to their employees. Employees are forced to choose between being uninsured or purchasing policies on the private market. A FCBI would provide small-business employees with an alternative means of securing health insurance.

For example, under the Medicaid buy-in option, the program could provide comprehensive medical, dental, and pharmacy benefits to enrollees. Optional benefits, such as emergency transportation, could be excluded due to cost. The state could administer the program through the state’s Medicaid Department.

This option involves the state absorbing most of the administrative cost of the program while the employers and employees would pay the full cost of the PMPM (Per-Member, Per-Month). No state subsidy would be offered for this option, and it is projected that there would be little or no additional cost to the state for administration of the program.

## Buy-In Programs Are a Good Alternative

Through administrative efficiencies and the purchasing power generated from pooling with subsidized programs, FCBIs can offer some families a lower-cost coverage option than what is available on the private market.

State Medicaid programs as a whole have very low administrative overheads. Although there will be some small increases to administrative costs, participants are merely buying into a pre-existing program. The cost to the state is minimal, since the employee and employer are paying what would be the state’s share.

### Concerns

When designing a FCBI program, states can use design features to ensure that implementing an FCBI does not provoke an exodus of covered individuals from the private market, such as inpatient benefit caps, pre-existing exclusions and waiting periods. These design features may also help states ensure that their FCBI will not attract a disproportionately unhealthy population and result in premium increases from adverse selection.

Most FCBIs currently in operation primarily target children and several states are considering adding FCBIs onto their SCHIP programs. Five states that currently operate FCBIs are Minnesota, Washington, Florida, New York and Connecticut. Current evidence from active FCBIs indicates no substantial crowd-out, regardless of whether the programs choose to require minimum spells without insurance for new enrollees. Even though crowd-out does not appear to be a problem with these programs, it is important that states continue to focus on this issue.

While FCBI is the most cost efficient way for a state to provide Medicaid subsidized insurance to small business employees, there are other options to briefly consider. A state can provide a buy in program that is also heavily subsidized. This will address the low take up when employers are unwilling or unable to participate and employees cannot afford the entire state portion. This is a way to still leverage the federal match from the Medicaid program while designing a programmatically simple plan. In addition, some states have had success with Medicaid premium subsidy programs. These programs use Medicaid funds to subsidize private or employer-based insurance for lower wage employees. This form of insurance subsidy can help avoid crowd out as it allows individuals to stay in the private market. Administrative costs can be much higher for this type of program and has low uptake.

**MONTHLY COSTS FOR EMPLOYER, PER INDIVIDUAL EMPLOYEE,  
FOR VARIOUS PLANS WITH DIFFERENT LEVELS OF COST-SHARING**

**ALABAMA**

<b>PLAN</b>	<b>FULL COST ANNUALLY</b>	<b>FULL COST MONTHLY</b>	<b>20% EMPLOYEE MONTHLY</b>	<b>30% EMPLOYEE MONTHLY</b>	<b>40% EMPLOYEE MONTHLY</b>	<b>50% EMPLOYEE MONTHLY</b>
Medicaid w/ Federal Match	\$900.00	\$75 (\$1.47 hour)	\$60 (\$1.38)	\$52.50 (\$1.33)	\$45.00 (\$1.28)	\$37.50 (\$1.23)
BCBS-320	\$2,808.00	\$234.00 (\$1.46)	\$187.20 (\$1.17)	\$163.80 (\$1.02)	\$140.40 (\$1.88)	\$117.00 (\$1.73)
BCBS-350	\$3,000.00	\$250.00 (\$1.56)	\$200.00 (\$1.25)	\$175.00 (\$1.09)	\$150.00 (\$1.94)	\$125.00 (\$1.78)
LGIP	\$3,504.00	\$292.00 (\$1.83)	\$233.60 (\$1.46)	\$204.40 (\$1.28)	\$175.20 (\$1.10)	\$146.00 (\$1.91)

## NEBRASKA

PLAN	FULL COST ANNUALLY	FULL COST MONTHLY	20% EMPLOYEE MONTHLY	30% EMPLOYEE MONTHLY	40% EMPLOYEE MONTHLY	50% EMPLOYEE MONTHLY
Medicaid w/ Federal Match	\$1,578.96	\$131.58/mo (\$.82/hr)	\$105.26 (\$.66)	\$92.11 (\$.58)	\$78.95 (\$.49)	\$65.79 (\$.41)
State- single	\$4,005.12	\$333.76/mo (\$2.09/hr)	\$267.01 (\$1.67)	\$233.63 (\$1.46)	\$200.26 (\$1.25)	\$166.88 (\$1.04)
State- kids		\$834.38/mo	\$667.50	\$584.07	\$500.63	\$417.19
	\$10,012	(\$5.21/hr)	(\$4.17)	(\$3.65)	(\$3.13)	(\$2.61)

## SOUTH CAROLINA

PLAN	FULL COST ANNUALLY	FULL COST MONTHLY	20% EMPLOYEE MONTHLY	30% EMPLOYEE MONTHLY	40% EMPLOYEE MONTHLY	
Medicaid w/ Federal Match	\$1,415.16		\$117.93 (\$0.74/hr)	\$94.34 (\$.59/hr)	\$82.55 (\$.52/hr)	\$70.76 (\$.44/hr)
State- single	\$4,485.96		\$373.83 (\$2.34/hr)	\$299.06 (\$1.87)	\$261.68 (\$1.64)	\$224.30 (\$1.40)
State- kids	\$6,840.00		\$570 (\$3.56/hr)	\$456. (\$2.85)	\$399 (\$2.49)	\$342 (\$2.14)



## Full SCHIP Enrollment For Children of Small Business Employees

### Description

The State Children's Health Insurance Program (SCHIP) is a jointly funded federal-state program that provides medical insurance coverage for certain low-income children who are not eligible for Medicaid. Full SCHIP Program enrollment for the children of small business employees would have similar results as increasing SCHIP income eligibility levels. The program would significantly expand the number of children that are covered by these programs.

Unfortunately, full utilization of the program in its current state has not yet been achieved. It is estimated that of the 10 million uninsured children in America, 2.8 million are eligible for SCHIP.

## Why Full SCHIP Enrollment for Children of Small Business Employees Is a Good Alternative

Unlike many other alternatives, increased SCHIP enrollment primarily involves spending money that is already allocated, and bears no healthcare cost for employers. It does not require any additional legislation, and, like Medicaid, the state pays only a portion of the cost (with the federal government funding the rest).

Higher SCHIP enrollment would reduce insurance costs for businesses and employees, who could purchase individual coverage, rather than the dramatically more expensive family coverage.

## Implementation of Full SCHIP Enrollment for Children of Small Business Employees

Increased SCHIP enrollment is largely a matter of information and outreach. While there have been efforts, many successful, by government and non-profit outreach campaigns, the small business community has yet to become actively involved. Small businesses have unique access to eligible children through their parents who are small business employees. SCHIP presents small businesses the opportunity to offer a benefit at no cost to the business; educating parents about SCHIP enrolling children as a regular human resources function benefits both employer and employee. Small businesses should also work with state SCHIP officials to help remove barriers to enrollment.

## Current Eligibility for Medicaid and S-CHIP

### Alabama (Has a Separate SCHIP called ALL Kids)

Alabama's SCHIP, the ALL Kids program, is separate from the Medicaid program. If a child qualifies for Medicaid, he or she is ineligible for ALL Kids participation.

#### A. Medicaid Program

##### (1) Eligibility

##### (a) Income Limits

- (i) Medicaid income limit for children ages 0-1 in family of three: \$22,078/year (2006) (133% of FPL)
- (ii) Medicaid income limit for children ages 1-5 in family of three: \$22,078/year (2006) (133% of FPL)

- (iii) Medicaid income limit for children ages 6-18 in family of three: \$16,600/year (2006) (100% of FPL)
- (iv) Medicaid income limit for working parents in family of three: \$ 3,154/year (2006) (19% of FPL)
- (v) Medicaid income limit for pregnant women in family of three: \$22,078/year (2006) (133% of FPL)

### **Nebraska** (Has Medicaid-expansion SCHIP called Kids Connection)

#### A. Medicaid/SCHIP Eligibility

##### (1) Income Limits

- (i) Medicaid income limit for children ages 0-1 in family of three: \$30,710/year (2006) (185% of FPL)
- (ii) Medicaid income limit for children ages 1-5 in family of three: \$30,710/year (2006) (185% of FPL)
- (iii) Medicaid income limit for children ages 6-18 in family of three: \$30,710/year (2006) (185% of FPL)
- (iv) Medicaid income limit for working parents in family of three: \$7,716/year (2006) (46% of FPL)
- (v) Medicaid income limit for pregnant women in family of three: \$30,710/year (2006) (185% of FPL)

### **New Jersey**

As of 2006, New Jersey has opened its program to children above 350% of poverty level.

### **South Carolina** (Has Medicaid-expansion SCHIP called Partners for Healthy Children)

#### A. Medicaid/SCHIP Eligibility

##### (1) Income Limits - Up to 150% of FPL, with limited exceptions

- (i) Medicaid income limit for children ages 0-1 in family of three: \$30,710/year (2006) (185% of FPL)
- (ii) Medicaid income limit for children ages 1-5 in family of three: \$24,900/year (2006) (150% of FPL)
- (iii) Medicaid income limit for children ages 6-18 in family of three: \$24,900/year (2006) (150% of FPL)
- (iv) Medicaid income limit for working parents in family of three: \$16,102/year (2006) (97% of FPL)
- (v) Medicaid income limit for pregnant women in family of three: \$30,710/year (2006) (185% of FPL)

## **Cost Estimates of Full SCHIP Enrollment**

### **Alabama**

- 25,000 uninsured children eligible for SCHIP
- federal matching rate 78.66%
- cost of program \$1500 per year (2003)

therefore  $25,000 \times 1500 \times .2134 = \$8,000,000$

the cost to Alabama for enrolling the uninsured SCHIP eligible children would be \$8,000,000 per year

### **Nebraska**

- Eligible children: 18,755 (uninsured children <200% of FPL)
- Cost of SCHIP: \$1292/enrollee total costs
- Federal Share of SCHIP: 71.78
- Cost per child x number of eligibles x 28.22% (state share of S-CHIP) = \$6,838,000

It would cost Nebraska \$6,838,000 to enroll all eligible children in S-Chip.

### **South Carolina**

- Eligible children: (65,178 eligible children <200% of FPL)
- Cost of SCHIP: \$1239/enrollee total costs
- Federal Share of SCHIP: 80%
- Cost per child x number of eligibles x20% (state share of S-CIP)

It would cost South Carolina \$17,250,134 to enroll all eligible children up to 200% of poverty.

## **Medicaid Expansion**

### **Description**

The Medicaid program is a jointly funded federal-state program that provides medical and long-term care coverage to low income individuals who meet certain income and categorical eligibility requirements (e.g., aged, blind, disabled, impoverished, members of families with dependent children, etc.). Federal law gives states flexibility to increase income eligibility levels to allow more people to qualify for Medicaid coverage. States can also expand Medicaid coverage by making additional groups eligible for Medicaid.

### **Medicaid Expansion Is a Good Alternative**

Making additional groups eligible for Medicaid appears to be a particularly effective way to expand insurance coverage. This option offers the state flexibility. The state can use a phased-in expansion, and gradually expand its income limits. The state can determine the income level based on a percentage of the Federal Poverty Level (FPL) or use a flat income level such as \$1000/month to determine eligibility.

### **Concerns**

Potential consequences exist to expanding Medicaid coverage, however. First, some individuals who currently have private health insurance coverage will become eligible for free comprehensive insurance coverage under a Medicaid expansion. Some of these individuals may choose to drop their private coverage. This is known as crowding out the private system. Another issue is that people may not enroll in Medicaid because of concern that it is a welfare related program. Lastly, any expansion of the Medicaid program would necessitate the use of additional state general funds, even with a federal match for the program.

### **The Implementation of Medicaid Expansion**

While each state must comply with minimum federal requirements to serve mandatory groups under certain income guidelines, those guidelines are a floor, not a ceiling. Many states have taken advantage of Medicaid's flexibility and increased income levels to provide coverage beyond the minimum set by the federal government.

Federal law requires States to enroll certain groups. In addition to these groups, the law allows states to cover certain optional groups, with the same financial contribution from the federal government. The mandatory groups (also known as "categorically eligible" groups) include certain low-income children, pregnant women, adults in families with depend children, elderly people and people with disabilities. Examples of optional groups include additional children and pregnant women, childless adults under age 65, certain women diagnosed with breast or cervical cancer, people diagnosed with HIV/AIDS and people with tuberculosis. Federal approval is necessary in order to extend Medicaid coverage to these additional groups.

## Increased Funding For Federally Qualified Health Centers

### Description

Federally Qualified Health Centers (FQHCs) are private, non-profit or public organizations that receive federal grants from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. The health centers' mission is to improve the health status of underserved populations.

Community health centers have been around since the mid-1960s. They experienced rapid growth after the establishment of the federally qualified health center program by Medicare and Medicaid in 1989 and 1990. This program provides cost-based reimbursement for covered services to community and migrant health centers, health care for the homeless and public housing programs. According to a recent study by the Ohio Primary Care Association, there are currently 890 health centers operating 4,990 sites nationwide. They also report health centers served over 12 million patients and provided over 49 million patient visits in 2003.

Use of the FQHC program could be better utilized in three general ways: 1) making sure community health clinic that qualify as FQHCs apply and receive federal funding; 2) increasing the funding for centers that currently qualify; and 3) establishing more FQHCs in of need.

### Increased Funding For FQHCs Is a Good Alternative

FQHCs greatly benefit the communities they serve. FQHCs also have been shown to be effective in lowering hospital admission rates, shortening lengths of hospital stays and helping curb unnecessary use of hospital emergency rooms. Health center patients are more likely to receive counseling on diet, physical activity, smoking, drinking, drug use and STDs than the uninsured patients who seek care elsewhere, and FQHC have been credited with reducing infant mortality rates. It has been reported that health center patients do not delay seeking care as long as other uninsured people. Finally, FQHCs are engines for economic development. Health centers provide jobs for more than 70,000 people nationwide and generate at least \$2.1 billion in spending through the economic multiplier effect.

### Implementation of Increased Funding for FQHCs

In order to qualify as a FQHC and receive federal grants, a health center must:

- Serve all the residents in their service area without regard to income or insurance status.
- Provide services on a sliding fee scale basis.
- Be located in a designated medically underserved area or serve a medically underserved population.
- Maximize all sources of patient and third party payment.
- Ensure that the board of directors reflects the demographics of the services area and that a majority of the board are consumers of services provided by the center.
- Provide basic primary health services.
- Provide services that improve utilization and access such as case management, referrals for substance abuse and mental health services, outreach, transportation, translation services and patient education including nutrition counseling.

### Cost Estimates

The potential savings from expanded FQHC availability can be estimated by comparing average per-visit costs in emergency rooms and FQHCs, a nationally representative claim database, while health center charges will come from published federal data. The Health Resources and Services Administration (HRSA) estimates the following charges for health center users:

**Table 7. Medical encounters per user and charges per encounter in federally qualified health centers, 2006**  
(trended from 2004)

Incurring charges per user	<b>\$456</b>
Incurring charges per encounter	<b>\$145</b>
Encounters per user	<b>3.15</b>

Source: Health Resources and Services Administration and John Snow, Inc. Bureau of Primary Health Care Section 330 Grantees Uniform Data System (UDS): Calendar Year 2004 Data – National Rollup Report (2005). Nursing visits are excluded from these estimates.

Emergency rooms and health centers provide different mixes of services. It is not feasible for Appleseed to perform a thorough case-mix adjustment on health center and ER charges. With that caveat, Appleseed estimates that average covered charges for emergency room visits that do not result in a hospital admission are \$441/visit, or \$296 more than an average FQHC visit. The actual savings per avoided ER visit would probably be less than \$296 for several reasons:

1. Most avoided ER visits would probably be non-urgent. These visits tend to be less expensive than urgent visits. One study suggests that charges per non-urgent ER visit are about one-third of the average for all ER visits. Several studies estimate that 16% to 37% of ER visits are non-urgent in nature.

<sup>1</sup> *Watson Wyatt Worldwide analysis of employer claim data from 2004.*

2. The average cost per ER visit includes both fixed and variable costs. Reducing the number of non-urgent ER visits would reduce the variable costs but not the fixed costs of ER operation. One study finds that marginal costs comprise about 40% of the total cost of a typical non-urgent ER visit. However, a more recent study finds that the marginal cost of an average ER visit is not significantly lower than the total per-visit cost, suggesting that most ER costs are variable.
3. There is evidence that some non-urgent ER visits should not be moved to clinics. Some non-urgent ER visits might be clinically appropriate. One study finds that 86% of walk-in ER visits are appropriate, and that about 5% of patients who are initially assessed as having non-urgent conditions are admitted to the hospital. Many clinics also have limited hours of operation.

Appleseed has not estimated the net cost or benefit resulting from expanded access to FQHCs. Appleseed's per-visit cost estimates do not take construction and operating costs into account, nor do they include the effect of federal subsidies.

Additionally, Appleseed does not have information regarding how many ER and clinic visits take place in each state. The savings

would depend on which ER visits are avoided and whether visits are relatively expensive or inexpensive. Without doing case-mix adjustment, Appleseed can only provide maximum possible savings.

<sup>2</sup> Williams, Robert M. "The Costs of Visits to Emergency Departments." *The New England Journal of Medicine*, 334(10):642-646 (March 7, 1996).

<sup>3</sup> *Ibid.*

<sup>4</sup> McCaig, Linda F. and Catharine W. Burt. "National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary." Hyattsville, Maryland: National Center for Health Statistics (2005).

<sup>5</sup> Young, Gary P. et al. "Ambulatory Visits to Hospital Emergency Departments: Patterns and Reasons for Use: 24 Hours in the ED Study Group." *Journal of the American Medical Association*, 276(6):493-494 (August 14, 1996).

<sup>6</sup> Williams, Robert M., *op. cit.*

<sup>7</sup> Bamezai, Anil; Glenn Melnick; and Amar Nawathe. "The Cost of an Emergency Department Visit and Its Relationship to Emergency Department Volume." *Annals of Emergency Medicine*, 45(5):483-490 (May 2005).

<sup>8</sup> Young, Gary P. et al., *op. cit.*

## Reinsurance

### Description

Reinsurance is an alternative mechanism for spreading risk among insurers that does not involve screening out high-risk applicants and referring them to a distinct pool. Reinsurance is sometimes achieved through a pool of funds to which a number of insurance companies contribute. The essence of reinsurance is that either the state or a mandatory pooling of carriers would cover the costs for the most expensive cases, making it possible for insurers to offer coverage at lower rates, which should induce more employers to offer coverage.

The reinsurance approach limits a given insurer's losses on any individual enrollee or aggregate losses on all enrollees, because part of the insurance risk is transferred to other insurers (or the state). Reducing the risk of very high costs for carriers tends to create an environment where there are more incentives to participate in the market and reduce the occurrence of insurers employing mechanisms that either (1) rate enrollees based on their perceived risk, or (2) avoid covering certain populations (e.g., small employers and the self employed). Even with reinsurance, carriers would retain an incentive to manage every enrollee's care and costs since they would still bear the responsibility for most medical expenses, excluding the most catastrophic expenses associated with serious accidents or life threatening illnesses.

### Why Reinsurance Is a Good Alternative

The advantages of reinsurance are as follows:

- **Positive Effect on Premium and Access:** Providing reinsurance can reduce premiums. Individual carriers would not need to purchase as much reinsurance as they currently do. Their costs would be lowered so that premiums could be reduced and more uninsured people would be able to purchase coverage.
- **Increased Competition:** A reinsurance mechanism could serve to maintain or increase insurer participation in the small group market, thus enhancing the price competition. Since insurers' risk of paying for very high costs would be reduced, smaller carriers could more easily afford to enter and stay in the market.

- **Cost Control Incentive Maintained:** Reinsurance can include additional incentives for carriers to restrain health care costs since carriers would still be responsible for covering a certain proportion of costs after reinsurance starts. The proportion covered by a carrier could also be structured using a sliding scale that decreases as expenses increase (e.g., 50% for claims between \$30-\$50,000; 25% for claims between \$50-\$150,000; and 0% for claims above \$150,000).

**Concerns**

There are several issues raised by the reinsurance option, some of which are:

- **Carrier Risk:** In most reinsurance programs, such as the Healthy New York program, carriers are not totally protected if claims for high-cost enrollees exceed the available reinsurance funds. In addition, reinsurance does not eliminate the risk that an individual carrier may have a disproportionate share of claims above the maximum attachment point. In the event that this occurs, carriers might request higher premiums to recoup their losses.
- **State Subsidy:** To lower costs of coverage significantly – which is necessary to induce a substantial number of uninsured small employers to offer coverage – could require a large state subsidy, assuming the state took on the costs of reinsurance.

**Implementation of a Reinsurance Program**

Reinsurance is traditionally defined as a contract by which an insurer procures a third party to protect itself against part of all the losses incurred in the process of honoring the claims of policy holders. In this case, the third party would be either the state or a mandatory pooling of carriers. The state or pool of carriers would take on most of the risk (cost) of paying for the most expensive cases, making it possible for insurers to offer coverage at lower rates, which should induce more employers to offer coverage.

One reinsurance plan that has shown some success is Healthy New York. The Healthy New York reinsurance plan covers 90% of charges between \$5,000 and \$75,000. Above \$75,000, the member's primary carrier takes over again.

Healthy New York is open to individual enrollees as well as small-business employees. About 8,600 small-business workers and about 5,500 of their spouses and kids enrolled in 2004. This accounted for about 22% of the total enrollment. Certain services are not covered by the plan, however, including mental health.

**Table 6: Estimated premiums per adult for reinsurance and primary health plan, 2006**

State	AVERAGE PREMIUM FOR PRIMARY COVERAGE (below attachment point), 2006		AVERAGE REINSURANCE PREMIUM, 2006	
	\$50,000 attachment point	\$100,000 attachment point	\$50,000 attachment point	\$100,000 attachment point
Alabama	\$3,570	\$3,996	\$961	\$535
Nebraska	\$3,902	\$4,368	\$1,050	\$584
New Jersey	\$4,354	\$4,873	\$1,171	\$652
South Carolina	\$3,793	\$4,246	\$1,021	\$568

The reinsurance premiums represent the maximum possible savings to employers. Actual savings would depend on the following factors:

1. Potential adverse selection. Appleseed's analysis does not account for adverse selection. Selection into these reinsurance pools might increase the proportion of expense above the threshold. Firms with employees who are likely to have very high expenses might be disproportionately likely to choose carriers that participate in the reinsurance program. Employees who expect to have very high medical expenses might also be more likely to accept coverage than individuals who expect to use little or no medical services.

The effects of adverse selection might be mitigated by regression to the mean, however. Many individuals with very high expenses in one year will have significantly lower expenses the following year.

The experience of COBRA enrollees provides a point of reference for evaluating potential adverse selection. Per-capita claim expense for individuals electing COBRA continuation coverage is about 1.56 times the average for all adults. This difference likely reflects the extent of adverse selection under COBRA.

2. The state's share of the reinsurance premium. Employers will only save on total premium expense to the extent that reinsurance is subsidized by the state.
3. The design of the reinsurance program. Appleseed's analysis assumes a single attachment point above which the reinsurer will be responsible for all claim expense. Reinsurance programs can also have multiple attachment points. In this case, the reinsurer's risk would be phased in gradually until it reaches 100%.

<sup>9</sup> *Watson Wyatt Worldwide analysis of employer claim data from 2004.*

## Community-Based Plans

### Description

On a local level, initiatives have been undertaken to provide health care directly to low-income individuals. The Memphis Plan is an example of a health care program for the working poor. It is not health insurance, although in some ways it functions similarly.

Local physicians were asked to see ten patients each, without charge, as a community service. The Christian Community Health Fellowship (CCHF), the non-profit organization that administers the Memphis Plan, then recruited 2,000 working poor to participate, and negotiated with their employers to contribute a minimum of \$10 a month as “medical insurance.” This payment goes both to the physician and the health center where the employee is granted free access, with a \$5 co-pay, to a specific physician for all medical needs. Generally, the Memphis Plan secures primary and specialty care, hospitalization, and other medical services for participants. Each employee is assigned to a specific primary care physician and participating local hospital.

The plan is employer-sponsored and the sponsor agrees to:

- Pay at least \$10 of the monthly fee
- Remit 100% of the monthly fee to Memphis Plan
- Make certain employees meet Memphis Plan eligibility requirements

Employees who are not currently covered by their employer's insurance or who cannot afford their employer's insurance are eligible. The Memphis Plan costs \$35 per month per employee (with at least \$10 paid by the employer and \$25 by the employee), \$20 per dependent 12 or older, \$15 per dependent under 12, with a maximum limit of \$95 monthly per family.

The Memphis Plan covers preventative health care, including routine physical exams, vision and hearing screenings, immunizations, sick care including office visits to primary care physicians and recommended specialists, laboratory and diagnostic testing procedures, prescription drug discounts up to 40% at specific pharmacies, and access to all Church Health Center Programs.

### The CCHF reports:

The Memphis Plan is self-sustaining at this point with revenues generated from the monthly fees and co-pays. In earlier years, grant funding was obtained and used for the development of materials used to market the program. Since all healthcare services are donated, the costs that need to be covered consist of the sales/marketing and administrative costs of running the program. Costs vary depending on the number of staff members hired at any time and the number of participants that need to be served. This program could be replicated given that someone spearheads the collaborative effort. One important issue is making sure that the plan has sufficient providers to meet the need, especially primary care physicians.

As indicated in the text from the CCHF, the Memphis Plan requires a non-profit administrator, in this case a church group, as well as providers. Any organization that touches a large number of people – churches, chambers of commerce, other civic associations, health clinics, etc. – could be the vehicle for implementing this option.

### **Community-Based Plans Are a Good Alternative**

By engaging the various participants in the health care market, the Memphis Plan provides the model for a broad-based reform that could be replicated elsewhere. However, this model may be too novel or too new to assess its extrapolation elsewhere. That caveat notwithstanding, this approach responds to the fragmented character of the health care market by forging a consensus and a plan that includes all the relevant players – consumers, payers (employers, insurers and insured) and providers. This consortium promotes a consensus concerning the obstacles to coverage and a vehicle through which an agreed upon solution can be pursued.

### **Implementation of the Memphis Plan**

The Memphis Plan required a special statute, passed in 1991 by the Tennessee Legislature that allowed the state to offer donated health services to the community.

## **Targeted Medicaid Waiver**

### **Description**

Medicaid waivers are used to "waive" certain Medicaid requirements specified in law. State Medicaid waivers are approved by the federal government and are primarily used to:

- Implement contracts with managed care organizations for the provision of services to the state's Medicaid population;
- Implement additional services not usually covered by Medicaid, such as respite care, environmental modifications and peer support services;
- Cover new eligibility groups, such as uninsured individuals with income higher than the state's thresholds for eligibility, or individuals that meet medical criteria for institutional services but who are enrolled in a Home and Community-Based Services (HCBS) Waiver as an alternative to institutional care;
- Implement changes in service and participation requirements, such as imposing higher cost-sharing requirements under specific circumstances; or
- Provide services in new ways, such as providing a voucher or a cash payment to Medicaid beneficiaries to purchase supports and services of their own choosing (subject to certain state and federal specifications).

### **Why is a Targeted Medicaid Waiver a Good Alternative?**

States are increasingly interested in premium assistance programs for several reasons:

- A substantial number of low-income families may have access to employer-sponsored insurance but cannot afford their share of the premium. For example, 44 percent of uninsured parents with incomes between 200 percent and 399 percent of federal poverty guidelines have access to insurance through their employer.
- Premium assistance programs allow the state to expand access to health insurance by leveraging private health coverage funds.

- Premium assistance programs may help stabilize the private health insurance market.
- New flexibility from the federal government makes it easier to create programs and apply for the necessary waivers.

This is not to say that this cannot be a risky proposition if states adopt this option. It is a strategy that can be used in states where there is a commitment to not cut back on eligibility and services or to increase costs to beneficiaries, but to expand services.

### **Implementation of a Targeted Medicaid Waiver**

Demonstration waivers are frequently used by states to expand Medicaid coverage to different populations. Section 1115 of the Social Security Act allows states to request waivers of many other Medicaid requirements in order to implement demonstration projects designed to promote the objectives of the Medicaid program. Section 1115 gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions under the Social Security Act, including Medicaid and SCHIP, without a statutory change. States can obtain “comprehensive” Section 1115 waivers to make very broad changes in eligibility, benefits, or cost sharing in Medicaid.

Waivers must be budget neutral over the life of the project, which is generally 5 years. Thus, it cannot be expected to cost the federal government more than it would cost without the waiver. As a result of the budget neutrality requirement, states that use waivers to expand coverage must create offsetting savings or redirect existing federal funds to finance the expansion. To assure budget neutrality, under the terms of a waiver, federal funds for services financed under the waiver are capped for the period of the waiver. States, therefore, must keep their spending below the caps or assume the full cost of services above the caps. With unsure budgets at a state level it can become problematic for a state if their Medicaid expenditures substantially increase during the waiver period. This can result in changes in eligibility or decrease in benefits to address state budget concerns.

States, through the 1115 Medicaid waiver option, may expand Medicaid coverage by creating premium assistance programs, sometimes through public-private partnerships with employers. Through these programs, states can subsidize employer-sponsored coverage for workers who are eligible for Medicaid or who have eligible family members. Research shows that a significant number of low-income workers have access to employer-sponsored insurance.

More recently, the federal government has encouraged states to use the Health Insurance Flexibility and Accountability (HIFA) waiver initiative to coordinate public and private coverage for low-income, uninsured populations through premium assistance programs. HIFA waivers allow states increased flexibility, reduced administrative requirements, and a streamlined application process in return for expanding coverage to more people. Prior to this, states have pursued premium assistance programs through traditional Section 1115 research and demonstration waivers or Medicaid’s Health Insurance Premium Payment (HIPP) program. Few states, however, participated in these programs in a significant way because of the administrative burden to develop and run the programs. It must be reminded that some states are using waivers to limit benefits, increase co-pays or change how Medicaid is delivered. While there are many opportunities to use waivers for expansion, states should not be encouraged to use the waiver to limit benefits or eligibility.

Generally, there are five steps in the life cycle of the 1115 demonstration waiver:

1. **Concept Phase:** States present a general outline of their proposal and get feedback from Centers for Medicare and Medicaid Services (CMS).
2. **Proposal Review Phase:** a formal proposal is prepared and submitted to CMS for discussion and review. Federal agencies, including CMS, identify issues and discuss them with the state in depth. After the state has responded, negotiations take place. CMS usually develops terms and conditions which outline the operation of the proposed § 1115 waiver.
3. **Pre-Implementation Phase:** this is a time period between federal approval and actual state start-up of the new program. It usually involves a site visit by CMS Central Office and/or Regional Office staff to ascertain the state's degree of readiness to proceed with the proposed demonstration.
4. **Operational Phase:** this is the period the demonstration is live and delivering services.
5. **Evaluation Phase:** the research and public policy value of the demonstration is evaluated.

The most important phase in the above cycle deals with the states' proposal to CMS. Because each § 1115 proposal is a unique research and demonstration effort designed to allow states flexibility to test new ideas of policy merit, there is no single standardized application format. States generally contact the appropriate CMS Regional Office for assistance. In general, however, a § 1115 proposal would present and discuss the following issues: the environment, administration, eligibility, coverage and benefits, delivery system, access, quality, financing issues, systems support, implementation time frames, and evaluation and reporting.

## Tax Credits For Small Businesses That Offer Health Insurance

### Description

A health insurance tax incentive is a credit or deduction for the purchase of health insurance that reduces an individual's or employer's tax burden. Deductions or credits may be capped, limited to certain categories of tax filers (e.g., small businesses, previously uninsured individuals, etc.) or made available for the purchase of particular types of coverage only (e.g., comprehensive benefit plans). Tax credits may be refundable or non-refundable. Most tax credits are non-refundable, meaning that if a taxpayer's credit exceeds his/her income tax liability, the tax payer does not receive the difference as a refund. However, with a refundable tax credit, taxpayers whose credits exceed their income tax liabilities receive the difference in the form of a tax refund.

### Why Tax Credits Are a Good Alternative

If tax credits were extended to small employers, coverage would be more affordable for both employers and employees so that more small employers would be expected to offer health insurance to their employees. To make this approach cost-effective for the state, the subsidy would need to be limited to certain employers, such as those employing low-wage workers, operating in certain industries, newly offering health coverage, or having a certain level of firm size (e.g., 10 or fewer employees). Employers would also be required to pay some reasonable portion of the premium and to offer a specified package of minimum benefits.

### Concerns

The success of a tax credit, however, depends on the size of the credit. Many employers who do not offer coverage are small firms that hire primarily low-wage employees. Since these businesses may not generate significant profits, they may not incur much of a tax liability. These employers might not experience sufficient benefits from a tax credit and might not participate unless the tax credit was refundable and quite large.

Studies indicate that, in order to bring down the cost of coverage to a level most of the currently uninsured can afford, premium subsidies, including tax incentives, must be substantial (e.g. 60% or more.) An additional problem associated with tax incentives is that even after receiving tax credits, small employers who help subsidize their employee's coverage would still have to pay a significant portion of health insurance premiums from their own funds; this amount might be more than firms on the margin can afford. Moreover, low-wage employees might prefer to have any increased compensation in the form of higher wages. As a closing point, it is important to note that the National Council of State Legislators Report found that state tax incentives has not increased the number of people with health insurance, thus, the report concluded that tax incentives are ineffective for expanding access to health care.

### Implementation of Tax Credits For Small Businesses That Offer Health Insurance

In order to implement a tax credit for small businesses that offer health insurance, state legislatures would need to amend tax legislation to provide for such credit.

**Table 1. Annual average number of full-time workers in establishments with fewer than 50 employees, 2002-04**

Source of coverage	NUMBER OF WORKERS BY STATE			
	Alabama	Nebraska	New Jersey	South Carolina
Covered by employer-sponsored insurance (ESI) in own name	247,501	98,743	556,960	174,620
Covered by other private plan, including ESI in other person's name	23,978	35,190	43,456	27,136
Covered by public plan	31,189	18,872	57,091	47,625
Uninsured, offered ESI	33,935	11,339	72,777	34,034
Uninsured, not offered ESI	68,735	22,968	147,407	67,069
<b>Total</b>	<b>405,338</b>	<b>187,112</b>	<b>877,691</b>	<b>350,484</b>

Sources: Watson Wyatt Worldwide analyses of 2002-04 data from the Current Population Survey, U.S. Bureau of the Census (2002, 2003, 2004) and the Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality (2003).

**Table 2. Estimated per-capita premiums for firms with fewer than 50 employees, all plan types, 2006 (trended from 2003)**

Coverage status	Alabama	Nebraska	New Jersey	South Carolina	U.S.
Single adult	\$4,531	\$4,952	\$5,525	\$4,814	\$5,040
Child only	\$2,315	\$2,530	\$2,823	\$2,460	\$2,575

Source: Watson Wyatt analysis of 2003 data from the Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality (2005) and Employer Health Benefits annual surveys, Kaiser Family Foundation and Health Research and Educational Trust (2004, 2005).

36	<b>Helping Small Business Employees Access Affordable Health Care: <i>Recommendations for a State-Level Response</i></b>

## Endnotes

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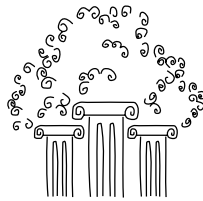
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