United States General Accounting Office

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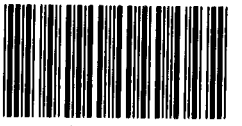
Report to Congressional Requesters

May 1992

ACCESS TO HEALTH INSURANCE

State Efforts to Assist Small Businesses



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Human Resources Division

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May 14, 1992

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Ron Wyden
Chairman, Subcommittee on Regulation,
Business Opportunities and Energy
Committee on Small Business
House of Representatives

Many small business employees are unable to obtain health insurance through their employers, and they and their dependents constitute a substantial portion of the uninsured population. The Congress is considering a range of proposals to address this problem, and many states have already implemented programs aimed at expanding small business employees' access to coverage. Therefore, as you requested, we have examined states' efforts to improve the availability and affordability of health insurance obtained through small business employers. A companion GAO study that you requested explores the broad range of state health care reforms, including efforts to achieve universal access to coverage.[1]

Results in Brief

Nearly all states have recently adopted or proposed measures aimed at improving access to affordable health insurance for small firms and their employees.[2] To do so, they have both imposed restrictions on insurers and relaxed mandates regarding the provision of specific health benefits through employers. In particular, states have restricted insurance company practices that have made obtaining health insurance difficult or impossible under several conditions: if an insured worker, coworker, or family dependent developed an expensive medical condition, if a worker changed jobs, or if the firm changed insurance carriers. By the same token, states have eased certain financial burdens on employers to provide them incentives for offering their workers health benefits: some states have eliminated mandated benefits; others have experimented with subsidizing premiums or offering premium tax credits. Finally, states have developed risk-pool programs that redistribute the high health risks of certain employees across a greater number, or pool, of employees through certain marketing combinations.

[1]Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 1992).

[2]See appendix VI for listings of state activities.

Many of the state initiatives have been adopted within the past 2 years, but early indications are that they have led to only modest gains in the number of firms offering health insurance. This outcome is likely because the elimination of mandated benefits has not lowered premiums enough to make a significant difference in affordability and because reduced-mandate plans generally include other restrictions that limit a plan's attractiveness to employers. Subsidies and tax credits, likewise, have not been sizable enough to encourage firms to offer health insurance.

Certain insurance market reforms may result in much lower premiums for a few firms with high-risk employees, but at the same time these reforms may result in slightly higher premiums for other small firms that have largely low-risk employees. Moreover, states' proposed and adopted measures can do little to address the problems underlying rapidly growing health care costs.

Scope and Methodology

Our analysis was based in part on a review of the literature on health insurance problems faced by small firms and on proposed and adopted solutions. We conducted a telephone survey of all states to gather information about the current status of specific small business insurance initiatives that had either been adopted or formally proposed as of September 30, 1991. Our sources for this survey were legislative liaisons in state insurance commissioners' offices and other state officials to whom we were referred.[3] We compared portions of our data with studies by others, and verified our data when there were differences.

We met with state legislative and agency officials in 10 states, which we selected to gain a broad cross section of views and experiences with health care initiatives: Colorado, Connecticut, Florida, Kentucky, Maine, Massachusetts, Michigan, Ohio, Oklahoma, and Virginia. We examined existing and draft state legislation and reviewed testimony by federal and state officials, experts on health insurance and insurance regulation, and private citizens affected by the denial or prohibitive cost of health insurance. Additionally, we obtained information from representatives of national legislative and insurance regulatory councils, academicians and health policy consultants, and insurance industry officials.

We conducted our review from November 1990 through April 1992, in accordance with generally accepted government auditing standards.

[3]Data about proposed legislation or private sector initiatives may be less comprehensive than information about adopted legislation because some sources may not have had full knowledge of all proposals in their states.

Background

About three-quarters of Americans who lack health insurance are workers or their dependents, and just over half of uninsured workers are employed by firms with fewer than 25 employees. Small business owners consistently cite cost as the chief reason they do not provide health insurance to their employees.

The problem of escalating health care costs is especially acute for small businesses, where employer profits and employee wages may be low (see app. I). Because of their disadvantaged position in a highly competitive health insurance market, small businesses are more likely than larger firms to face higher premium costs, as well as denial or cancellation of coverage. A recent national survey found that 30 percent of small firms surveyed are considering dropping health insurance benefits because of the cost.[4] Thirteen percent of respondents to the same survey indicated they had dropped coverage within the preceding 3 years. Another factor contributing to lack of coverage for small business employees is that some employers do not regard the provision of health benefits as their responsibility.

A firm's small size impairs its ability to obtain low-premium costs due to economies of scale. That is, premiums reflect high insurance marketing and administrative costs, and small employers lack the time and skilled personnel to negotiate suitable, affordable coverage. Firms big enough to self-insure—those that assume all or part of the risk for paying claims under their health care plans—are exempt from state health insurance regulation under the Employee Retirement Income Security Act of 1974. This freedom from state regulation allows self-insured firms to avoid premium taxes and the costs of state-mandated health benefits. Small businesses are typically unable to afford to self-insure, must therefore operate under state regulation, and must bear the associated costs.

Regulatory Reforms May Improve Availability of Insurance but Raise Average Premiums

States have been particularly active in the past 2 years in limiting the extent to which insurance companies can deny coverage or price high-risk firms or individuals out of the insurance market (see app. II). Forty-three states have adopted one or more insurance regulatory reforms that affect the small-group market. Reforms include measures to help ensure that (1) employees who want health insurance will be accepted and renewed by insurers; (2) waiting periods for coverage of preexisting conditions will be short, will occur only once, and will be based only on recent medical

[4]J. Edwards and others, "Small Business and the National Health Care Reform Debate," Health Affairs, Vol. 11 (Spring 1992).

history; (3) coverage will be continuous; and (4) extremes in premium costs will be narrowed to fall within ranges specified by the states.

These reforms are aimed at correcting a growing sense of unfairness in the insurance market, in which individuals who change jobs or experience costly medical conditions can be excluded from coverage. However, while these reforms may improve the availability of health insurance for some, insurers may pass on the resulting costs to all beneficiaries, thereby raising the average level of premiums for others. Time for these state initiatives to develop fully and more information about their effects will be needed before a conclusive assessment can be made of whether the net outcome is an increase or decrease in the number of small-business employees with health insurance coverage.

The Incentive Effect of Waiving Mandated Benefits Appears to Be Modest

To encourage insurance companies to design less costly insurance packages for small businesses, nearly half of the states have passed legislation reducing or eliminating health insurance coverage requirements—"mandated benefits"—and now permit insurance companies to offer lower cost, bare bones health insurance policies to small firms (see app. III). In response, insurers in most of those states have offered plans to the small-group market with premiums up to 40 percent lower than existing small-group policies. In addition to excluding previously mandated benefits, these plans also often incorporate higher cost sharing and preexisting-condition clauses.

The number of additional firms induced to offer health benefits has been small, however, partly because elimination of mandated benefits does not yield large enough premium reductions and partly because the other policy limitations do not make these policies attractive enough for the firm and its employees. This early experience with waiving mandated benefits suggests that it is not the cost of the mandated benefits that prevents small businesses from providing health benefits, but more likely the high and rising cost of all health care services.

Subsidies Have Had Limited Inducement Success

Several states have also addressed the cost issue facing small firms in the insurance market by subsidizing insurance premiums (see app. IV). Twenty-one states have tried to use direct and indirect subsidies, including tax credits and premium tax waivers, to make it easier for employers to provide, and for employees to purchase, health insurance.

Few firms responded to the inducement of even substantial premium subsidies. A New York pilot program offering a 50 percent premium subsidy resulted in a 3.5 percent increase in the number of small firms offering health insurance; analysts estimate that if the program was better targeted to the small business market, it would increase the number of firms providing coverage by up to 16.5 percent. The Robert Wood Johnson Foundation's Health Care for the Uninsured Program (see app. VII), which piloted experiments including subsidies, small-employer pooling, and lower cost health plans, reported that in November 1991, even the most successful of its operating programs had enrolled less than 17 percent of the small business market.

Subsidies are costly, causing some states to restrict the scope of subsidy programs in light of their current budget problems. Most states have limited subsidies to firms that had not offered health insurance during the previous 2 or 3 years. Small firms already offering such coverage feel that this has placed them at a competitive disadvantage. Because of budget constraints, some states have abandoned or limited the geographic scope of programs that require state funds. Michigan, for example, discontinued its subsidized small-employer project, and Maine limited the geographic areas in which it offered its subsidy.

Early evidence suggests that firms need greater assurance from the subsidy programs before committing to providing health insurance. Subsidies must be substantial (subsidies of 30 to 50 percent of premiums did not generate significant responses), and subsidies must be shown to be more than a short-term program that could end once small firms sign up.

Pooling of Risks Helps Some Small Firms

In cooperation with insurance carriers, some states have used risk-pooling mechanisms to address the inability of small firms to spread risks across a large number of employees and to exert buying power in the market for health services (see app. V). These mechanisms include (1) high-risk pools for individuals who are denied health insurance or can obtain it only at prohibitive cost because of expensive medical conditions; (2) reinsurance pools to help insurers mitigate expected high losses caused by insuring high-risk enrollees; and (3) small-employer pools, in which small businesses band together to purchase health insurance.

High-risk pools have made health insurance available for individual high-risk members of small-employer groups. The pools enable individuals who can afford the expensive pool premiums to obtain coverage, while at

the same time enabling their healthier coworkers to obtain less costly group coverage. Some states, however, prohibit this enrollee selection practice, known as carving out; they want to avoid shifting costs from employers to the high-risk individuals and to avoid the pass-through costs small groups can incur when insurers are assessed to cover part of pool costs.

Reinsurance pools help insurers accept entire small-employer groups regardless of the health status of individual members, by spreading pool costs across several insurers. Experience with reinsurance pools has been limited because they were adopted in Connecticut, North Carolina, and Oregon within the past 2 years.

Privately sponsored and state-facilitated small-employer pools have improved affordability and access for some small firms. Their success has been somewhat tarnished, however, by a number of private small-employer pools that have gone out of business or failed to pay claims, leaving groups and individuals with millions of dollars of unpaid bills. An additional problem has been a concentration of high-risk small-employer groups in pools, while low-risk groups obtain less costly insurance elsewhere.

Conclusions

The growing state commitment to improve the affordability and accessibility of health insurance for small businesses reflects recognition that employees of small firms have been poorly served by the existing market structure. Given the difficulties in reaching small firms to market new insurance policies and the introduction of most of the reforms during a recession, more time is needed to assess conclusively whether the reforms will further increase insurance coverage.

State budget problems limit the fiscal capacity of states to adopt reform measures that require substantial state subsidy or funding. As a result, states tended to focus on insurance market reforms, which generate little or no cost to the state treasury. These reforms aim at correcting a number of serious problems in the market, but have yet to produce significant increases in the numbers of small business employees with health insurance. Initiatives requiring state funding to subsidize the small business market are less common, tend to be limited in scope or duration, and have produced limited results. Attempts to lower the cost of insurance by waiving state-mandated benefits have also yielded a modest response from employers.

Ultimately, small business market reforms may have only a limited effect on the affordability of health insurance because they can do little to address the factors underlying growing health costs. Advanced medical technology, the cost of uncompensated care to hospitals and other providers, medical malpractice insurance costs, and consumer trends in buying medical services are among the major factors driving the cost of health care.

We are sending copies of this report to the Director, Office of Management and Budget, and interested congressional committees. Copies will also be made available to others on request. Please call me on (202) 512-7119 if you or your staff have any questions about this report. Major contributors are listed in appendix VIII.

Janet L. Shikles
Director, Health Financing
and Policy Issues

Contents

Figures

Abbreviations

AIDS	acquired immunodeficiency syndrome
BCBS	Blue Cross/Blue Shield Association
COSE	Council of Smaller Employers
ERISA	Employee Retirement Income Security Act of 1974
FHAC	Florida Health Access Corporation
HCAP	Health Care Account Project
HCUP	Health Care for the Uninsured Program
HIAA	Health Insurance Association of America
HMO	health maintenance organization
MEWA	Multiple Employer Welfare Arrangement
NAIC	National Association of Insurance Commissioners
RWJF	Robert Wood Johnson Foundation
SCOPE	Shared Cost Option for Small Employers

Problems for Small Business in the Health Insurance Market

Though most Americans obtain health insurance through their employers, many small businesses do not offer health benefits to their workers. Over three-fourths of the uninsured in this country are workers or their dependents. Over half of uninsured workers are employed by firms with fewer than 25 employees.

High Cost Is Major Reason Small Firms Do Not Offer Health Insurance

Studies consistently cite the high cost of health insurance premiums relative to employee wages and firm profitability as the dominant reason that small firms do not offer health insurance. Unique work force characteristics of small firms and problems they confront in the health insurance marketplace can also contribute to low levels of coverage. The importance of several reasons small employers cite for not offering health insurance are ranked based on the experience of a number of initiatives to improve the small business insurance market sponsored by the Robert Wood Johnson Foundation (RWJF) (see table I.1). (See app. VII for a description of RWJF activities.)

Table I.1: Small Employers' Ranking of Reasons for Not Offering Health Insurance

Cost	Rank
Too expensive	1
Firms not sufficiently profitable	4
Work force considerations	
Many employees insured elsewhere	2
Employees can be hired without offering insurance	3
Employees don't want it	5
High employee turnover	8
Insurance market	
Cannot find an acceptable plan	6
Company turned down: too small	7
Lack of information/difficulty judging plans	9
Employees cannot qualify: preexisting conditions	10
Company turned down: type of business	11

Source: Alpha Center (1990).

Small Firms Face High Insurance Costs

Small firms generally face higher costs for employee health insurance coverage than larger firms. Moreover, a large share of small firms employ low-wage workers,[1] for whom health insurance coverage represents a

[1]An Ohio survey found, for example, that the average wage of a small business employee in 1990 was between $6.00 and $6.50 an hour.

substantial share of total employee compensation. Surveys have repeatedly found that small employers cited high premiums and low profits as major reasons for not offering health insurance to their employees.[2]

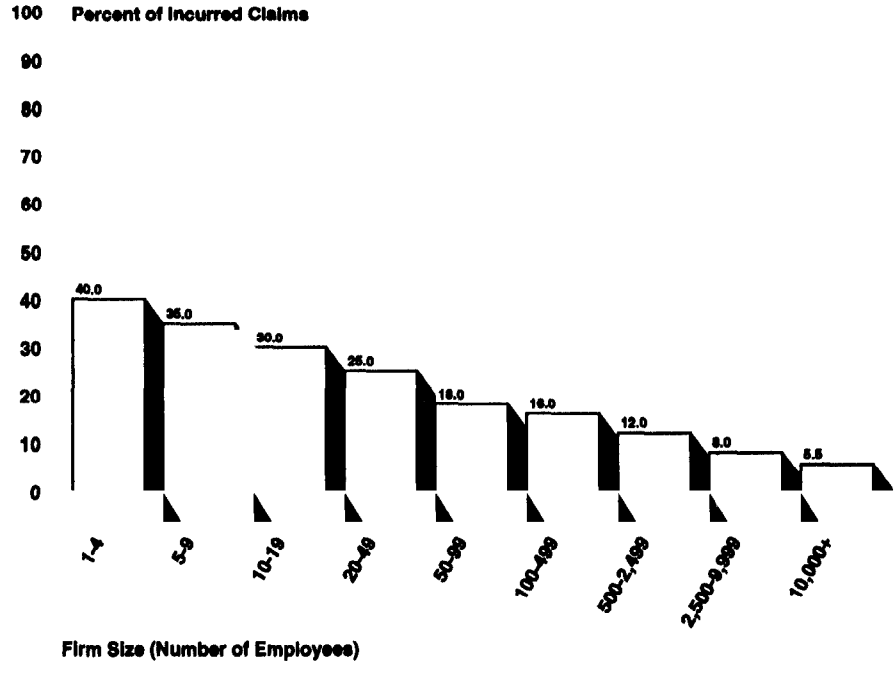
One reason small firms pay higher health insurance premiums is that insurers incur higher administrative costs for small firms than for larger firms. In addition, small employers may lack the bargaining power, time, or skilled personnel to seek and negotiate suitable, affordable coverage.

Administrative costs are higher in the small-group market because of such factors as (1) fixed costs and risk spread among fewer enrollees, (2) the expense of individual medical underwriting, (3) commissions paid to insurance agents, and (4) higher marketing costs. Marketing costs reflect the greater effort required to reach small employers and persuade them to offer health insurance.

The total administrative expenses incurred by major insurance companies for firms of different sizes is shown in figure I.1.

[2]See, for example, C.P. Hall, Jr., and J.M. Kuder, Small Business and Health Care: Results of a Survey (Washington, D.C.: The National Federation of Independent Business Foundation, 1990).

Figure I.1: Insurance Company Administrative Expenses by Size of Firm



Source: Hay/Huggins Company as reported by the Congressional Research Service, 1988.

Many Small Business Owners Decline Responsibility for Employee Coverage

Employer and employee attitudes affect small employers' decisions to offer health insurance and employees' decisions to accept coverage. Surveys of small business owners not offering health insurance have found that many believe that the primary responsibility for health insurance coverage lies with the individual employee, not with employers or the government. The smaller the employee group, the less likely the owner was to feel responsible for offering health insurance.

Many employers assert that employees are covered elsewhere (generally under family members' policies), that insurance is not needed to attract employees, and that there is a lack of employee interest or demand. Because there is little research reporting employees' views directly, it is difficult to verify and evaluate information employers provide about employees.

Many small firms employ low-wage workers for whom health insurance coverage would represent a substantial share of total employee

compensation. Employers report that low-wage workers are more unable or unwilling to forgo part of their cash compensation for health insurance than are more highly paid employees. In addition, young workers, seeing little need for health insurance, may either elect to work for firms without insurance to preserve larger amounts of their wages or reject coverage if it is offered.

Insurance Market Conditions and Practices Place Small Firms at a Disadvantage

The evolution of a highly competitive health insurance industry has led to industry practices that further diminish the ability of some small firms to gain access to the health insurance market. In the past, companies selling health insurance ensured that premiums they collected covered claims they paid by placing all their beneficiaries into a very large group and actuarially projecting their claims. Premiums, then, would be an equalized charge across the entire group to cover the future claims costs and administration. This process is called community rating. Under community rating, the premium is based on the average cost of the anticipated health care used by all subscribers in a particular geographic area, industry, or other broad grouping.

As insurers turned from community rating, they instituted a number of underwriting practices intended to attract businesses with relatively low-risk employees and to exclude potentially high-cost groups. These practices, which GAO has previously reported,[3] include the following:

Medical underwriting: This process determines the health characteristics of individuals and groups and how those characteristics affect potential health care costs and the risk of insuring. Based on those determinations, insurers decide whether and under what circumstances they will accept groups or individuals within groups. For example, insurers may establish exclusions or waiting periods for coverage of preexisting medical conditions.[4] Underwriting is also used to classify applicants by levels of risk in order to guide premium pricing, or "rating" decisions. Medical underwriting may occur both at initial enrollment and when the plans come up for renewal.

Preexisting-condition exclusion: This insurance practice precludes coverage for a condition that predated purchase of the policy. The

[3]Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 1990).

[4]In 1990, 65 percent of all health plans carried preexisting-condition clauses, which excluded or imposed restrictions on coverage for health problems that employees had at the time of enrollment.

exclusion may last for several months or an indefinite period of time. Conditions often subject to exclusion include cancer, arthritis, and asthma.

Industry screening: Through this practice insurers avoid medical underwriting by either rejecting entire groups or charging higher premiums—sometimes as much as 50 percent higher than standard rates—solely on the basis of the type or characteristics of business or industry in which the applicant is employed.

Durational rating: This pricing practice (1) discounts early premiums to reflect savings to the insurer from underwriting and preexisting-condition clauses and (2) raises subsequent premiums sharply as policies age and insurers expect to pay more in benefits. This practice can lead to rapid turnover—or "churning"—of insurance policies by small firms, subjecting employees to repeated limitations on coverage.

These types of market practices continually add people to the ranks of the uninsured. When insurers were surveyed about their responses to adverse medical underwriting,[5] over half reported that their most common action is to reject the entire group. Other responses were to increase the rate for the group, to reject the high-risk individuals but accept the rest of the group, or to limit the coverage of the high-risk individuals. Employer surveys indicate that between 8 and 24 percent of firms were denied coverage by insurance companies because of the health characteristics of their workers. The type of business was reported by 3 to 13 percent of small firms as a reason why they were denied coverage by insurers.

Federal Regulations Limit State Flexibility to Aid Small Business

Both federal regulation and state budget constraints have a strong influence on state approaches to address the problems small firms face in the health insurance market. Some states believe that the federal Employee Retirement Income Security Act of 1974 (ERISA),[6] which preempts state authority to impose certain requirements on self-insured employer health plans,[7] constrains state ability to deal effectively with the small business insurance market. ERISA established standards for employee

[5]B. Yondorf, Health Insurance Availability and Affordability in Colorado: A Report on Underwriting and Pricing Practices (Denver: Colorado Department of Regulatory Agencies, Division of Insurance, Sept. 1990).

[6]P.L. 93-406.

[7]Self-insured companies elect to assume all or part of the risk for paying claims under their health care plans.

benefit plans, including health benefits, and preempted state regulation. Many large firms self-insure, which enables them to avoid state regulation, state mandates for health insurance coverage, and state premium taxes. Small businesses typically purchase their employee health insurance from insurance companies that are subject to state regulation and taxation.

With 56 percent of employees working for firms that self-insure, states are limited in their ability to develop health insurance reforms. States cannot tax or place other levies on the health benefits provided by self-insured firms. Therefore, the financing of subsidies or reforms must come largely from funds generated through the small business portions of the market. States also cannot define uniform benefit structures or underwriting criteria for all health benefits packages offered by employers; nor can states mandate that all employers provide health insurance to their employees.

States Adopt Regulatory Reforms to Improve Availability of Health Insurance for Small Businesses

In an effort to improve the overall availability and affordability of insurance coverage, while at the same time minimizing direct expenditures of state funds, most states have adopted regulatory reforms that directly constrain insurance company practices. These underwriting and rating reforms ease restrictive insurance industry practices by limiting the extent to which insurers can use information about the characteristics of individuals or groups to determine eligibility, extent of coverage, and premiums charged for health insurance.[1] As of September 1991, 43 states had adopted at least one of the regulatory reforms—the majority during 1990 and 1991.

There are two broad types of regulatory reforms—those designed to improve availability and those designed to improve affordability. Availability reforms guarantee that health insurance will be available to all members of small-employee groups in the following circumstances:

- guaranteed issue of policies to all small-employer groups or to all eligible members of small-employer groups;
- guaranteed renewal of policies that limit the capacity of insurers to cancel policies because of medical history or to introduce new policy exclusions at time of renewal; and
- guaranteed continuity of coverage of policies when employers change insurers, employees change jobs, insurers withdraw coverage, or insurers leave the market.

Because insurance may be available but still be priced out of the reach of small businesses, many states have also addressed the issue of affordability through the following restrictions on pricing:

- limiting prices within prescribed ranges,
- limiting price increases, and
- restricting factors used in setting rates, such as health status and previous claims experience.

The number of states that have adopted different regulatory reforms is shown in table II.1. See appendix VI for detailed information on the specific types of underwriting and rating reforms adopted in each state. The remainder of appendix II discusses these reforms and their potential impact in greater detail.

[1]Not all insurers medically underwrite; those who do apply it selectively. The smaller the firm, the more likely it is to be medically underwritten.

Table II.1: States That Have Adopted or Proposed Various Insurance Market Reforms (Sept. 1991)

Types of reform	Adopted	Proposed but not adopted
Reforms affecting availability		
Guaranteed issue	4	9
Restrictions on:		
Exclusion of occupation categories	8	6
Exclusion of preexisting conditions	11	5
Waiting periods for preexisting conditions	24	6
Medical history that can be considered	9	3
Guaranteed renewal:		
Prohibiting cancellation due to medical history	18	6
Prohibiting new exclusions	11	3
Prohibiting new waiting periods	13	3
Guaranteed continuity of coverage:		
When employers change insurers	29	5
If employees change employers	15	6
If insurers withdraw coverage	17	4
Reforms affecting affordability		
Restrictions on:		
Premium ranges	17	10
Premium rate increases	22	7
Medical history that can be considered	4	3
Reforms requiring disclosure by insurers of certain methods and exclusions	20	6

Reforms Affecting Availability

States Ensure Initial Coverage Through "Guaranteed Issue" Provisions

Although most state reforms stop short of ensuring coverage for all employees of all small businesses for all medical conditions, four states have adopted measures requiring that insurers accept all small-employer groups. Other proposals require that they enroll all eligible employees within the small groups that they accept. These measures aim to prevent problems small businesses have in becoming insured because of denial of coverage or because of exclusions or waiting periods for coverage of employees' preexisting medical conditions. Such measures are known by

several terms, including "guaranteed issue" and "guaranteed acceptance." In some cases, entire groups may still be rejected.

Even if insurance coverage is guaranteed, it does not necessarily mean that the insured individual will have all preexisting medical conditions covered. Thus, states have also introduced legislation or regulation that either prohibits such exclusions or, more commonly, limits insurers to specified waiting periods (most commonly 12 months) during which they may exclude coverage for preexisting conditions that manifested themselves within a specified time (most commonly 12 months) prior to enrollment. Nine states limit the age of medical history information (such as 5 years) that insurers may use in the enrollment process.

Extent to Which Coverage Is Guaranteed Varies by State

The provisions for guaranteed issue coverage vary between states. For example, a state may require acceptance of all small-employer groups or may permit rejection of entire groups, but require acceptance of nearly all individuals within groups that are to be insured.

Connecticut requires that all insurers operating within the state's small-group market offer state-specified plans and that insurers accept all small-employer groups, regardless of the health experiences of members of the groups. The state prohibits all exclusions, including those by occupation category, and restricts the waiting period for coverage of preexisting conditions to 12 months. The state established a reinsurance pool, operated by the insurance industry, which coincided with guaranteed issue and pricing reforms.

In Maine, insurers may still reject entire groups. The state requires, however, that if an insurer accepts a group it must accept all individuals within the group, except for new employees that did not have health insurance previously. Maine has considered, but not yet adopted, a proposal that all insurers accept all people in all groups at all times. The state has also proposed a reinsurance pool, which would help to spread the risk of covering more high-risk people under guaranteed issue plans.

Some States Ensure "Guaranteed Renewal" and Continued Coverage

"Guaranteed renewal" reform protects small-employer groups or individual group members from policy cancellation as a result of their medical conditions or potential claims during the policy period. In addition, the reform restricts insurers from extending waiting periods for

preexisting medical conditions or from imposing new exclusions or waiting periods for conditions that arose during the prior year of coverage.

Continuity of coverage reform ensures that employees can retain coverage if (1) their employers change insurers, (2) employees change employers, or (3) insurers leave the market.[2] In addition, employees are assured—as with guaranteed renewal—that they will not be subjected to new exclusions or extended waiting periods because of current conditions or medical history. Continuity of coverage is the most frequently adopted market reform measure to date.

Laws in Maine and Colorado are examples of typical provisions for renewed and continued coverage. Maine requires that when employers change insurers, new insurers provide continuity of coverage to all group members who had been covered any time within 90 days prior to the discontinuance of replaced policies. Only those covered for fewer than 90 continuous days may be subject to preexisting-condition exclusions or waiting periods for a maximum of 90 days. In such cases, insurers must give credit for the portion of the 90-day period already met under similar provisions in the replaced plans. Maine additionally mandates that insurers must accept employees, without new exclusions or waiting periods, who change jobs and who had coverage within 90 days of enrolling (or being eligible to enroll) with their new employers' groups.

Colorado's legislation illustrates the limited situations under which insurers in the state may deny renewal: when the employer (1) does not pay premiums, (2) commits fraud, (3) fails to comply with plan provisions or participation-level requirements, or (4) ceases to do business. Colorado also mandates that insurers cannot discontinue classes of business without the penalty of 5-year restrictions on establishing new classes.

Reforms Affecting Affordability

Recognizing that affordability of health insurance is a major barrier to small business coverage, 22 states have adopted measures that control premium ranges and increases and restrict insurers' rating practices. The majority of these states did so within the same year that they passed legislation to improve the availability of health insurance for small businesses, thus helping to contain increases resulting from expanded

[2]Another type of continuity-of-coverage legislation, which enables former employees and other dependents to continue coverage under a former employer's group health plan, is not part of our discussion of market reform. Some states, however, are extending such guarantees to small business employees—provisions similar to those that already exist for employees of larger firms (20 or more employees) under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (P. L. 99-509).

coverage under guaranteed issue, guaranteed renewal, and continuity of coverage requirements. Rating and pricing reforms are expected to improve affordability for some enrollees, but they are likely to reduce affordability for others.

States Require That Premium Prices Be Within Prescribed Ranges

Seventeen states have enacted legislation to limit the ranges of premium prices insurers may charge small businesses, so that costs may be more predictable and spread more broadly, and coverage may be more affordable to higher risk, higher use groups. States restrict insurers from charging any firm within a class of business a premium that is more than some percentage above average premium rates for that type of firm—usually 20 to 33 percent, even if the firm characteristics suggest substantially higher benefit costs.

Similarly, insurers cannot use premiums that are more than 20 to 33 percent below average rates to attract small firms with potentially low-benefit health costs. Moreover, if insurers have grouped firms into more than one premium classification, states limit the extent to which premiums vary for different classes. Some experts believe the floors of ranges will rise, perhaps to levels so high that low-income people will require subsidies to remain enrolled.

States Require Insurers to Limit Annual Premium Increases

In order to help small business employees remain insured and to protect them from unpredictable and precipitous increases in premium costs, 22 states have mandated limits on the amounts by which insurers can increase premium costs when policies come up for renewal. Most of these states limit annual premium increases for an individual firm to the increase the insurer applies to newly insured groups, plus 15 percent. A further increase may be made to compensate for demographic changes in the covered group.

State Reforms Require Disclosure of Insurance Practices

Small firms generally lack the health insurance expertise that larger firms have through in-house benefits specialists. In an effort to help small employers better understand and assess their insurance options, 20 states require some form of disclosure by insurers. Insurers must, for example, reveal in their sales materials when state-mandated benefits are excluded and disclose some of the criteria they use for classifying, charging, and renewing coverage for small businesses.

Iowa and Florida require that when insurers provide solicitation and sales materials to small employers, they describe

- the class of business in which the specific employer is or will be included;
- the extent to which premiums for the employer are established or adjusted due to claims experience, health status, or duration of coverage;
- provisions concerning the insurer's right to change premium rates and factors that affect such changes; and
- provisions relating to renewability of coverage.

North Carolina's disclosure legislation requires explanation of

- the extent to which actual or expected variations in claims costs or health condition enter into rate setting and change and
- provisions relating to policy and contract renewal and preexisting-condition limitations.

Reforms Expected to Improve Availability but Raise Average Premiums

Since most market reforms have been recently introduced, evidence on their effectiveness in assisting small businesses is limited. Insurance industry experts foresee, however, that these types of reforms will improve availability, but will also raise average premium prices. The positive effects the reforms are expected to generate include

- improved continuous availability of health insurance regardless of health status and experience;
- reduced frequent changes of insurers by insured firms;
- improved adequacy of coverage by reducing exclusions and waiting periods;
- more predictable premium rates; and
- narrower differences in rates between high- and low-risk enrollees, with lower premium prices for high-risk groups.

An expected disadvantage is that these gains will come at the expense of increases in average premium prices. Rating reforms will narrow the range of health insurance premium costs among firms; these reforms do not reduce premiums overall. By requiring the inclusion of high-cost individuals into group plans, the reforms will cause those currently paying the lowest premiums to pay more in order to cover the high-cost individuals. Narrowing the range of premiums means that some firms may be charged more than they otherwise would. What is not clear is the extent of the change in the distribution of costs. The experience of

guaranteed issue plans demonstrates that firms excluded from the market may be brought in with only modest costs to others. These distributional consequences are seen in the following examples from Ohio and from RWJF data.

Without laws requiring that insurers have a guaranteed issue plan, it can be difficult to find insurers that will do so, and the premium cost is far higher than other plans. The Health Care Account Project (HCAP) in southwestern Ohio, for example, found that only one insurer would provide a guaranteed issue plan, and would only do so at prohibitively high cost.

In 1989, Ohio funded HCAP to expand health care coverage among the working uninsured by offering a previously untested alternative benefit design. Since HCAP staff found that unfavorable medical underwriting results contribute to small employers' difficulties in obtaining insurance, the staff attempted to secure a benefits plan that avoided underwriting.

Only one insurer submitted a formal proposal that offered a benefits design that substantially met project specifications; the insurer indicated that rates for guaranteed issue would be approximately 40 to 50 percent higher than for a medically underwritten plan. On the basis of survey data, HCAP staff determined that a guaranteed issue plan would not be affordable for most of HCAP's target market. A compromise was struck; the insurer agreed to relax its practices by excluding only high-use or high-risk individuals, rather than excluding entire groups because of the health status or health experience of individual group members.[3]

Although insurers expect that guaranteed issue and other mandated coverage of high-risk people will cause claims to rise, stimulating higher average premium costs for enrollees, early RWJF small business project data indicate that guaranteed issue may not have as strong a negative financial impact as insurers fear. In programs that are underwriting few, if any, enrollees, insurers' costs have not exceeded their costs for groups that have been subject to medical underwriting. This finding, however, is based on early data from a small number of cases.

[3]J.A. Begala and others, Final Report of the Health Care Account Project, Inc. (Ohio Department of Health, June 1991).

Mandated-Benefit Waivers and Other Premium-Cutting Measures Have Had Modest Effects

Many small firms believe that state-mandated health benefits—state requirements that insurance policies cover specified health services—drive up the cost of health insurance.[1] In response, states and private organizations have developed a variety of measures that adjust the benefit structure of health insurance plans sold to small businesses in order to lower their cost. Twenty-one states have waived all or portions of their state-mandated health benefits, and states and private organizations have developed new plans that lower premiums through limited benefits or increased cost sharing.

Although these measures have reduced premiums to some extent, small-employer response has been modest. Several reasons have been offered to explain why so few small businesses offer these plans to their employees:[2]

- The premium reductions are insufficient to make the plans affordable.
- The reduced-benefit plans are not viewed as adequate coverage by purchasers because these plans do not provide comprehensive coverage or provide only catastrophic coverage.
- The plans' large copayments and deductibles are unappealing to low-income workers because heavy cost sharing keeps health care unaffordable.
- The plans still suffer from many of the problems in the insurance market for small businesses. (See app. II.)

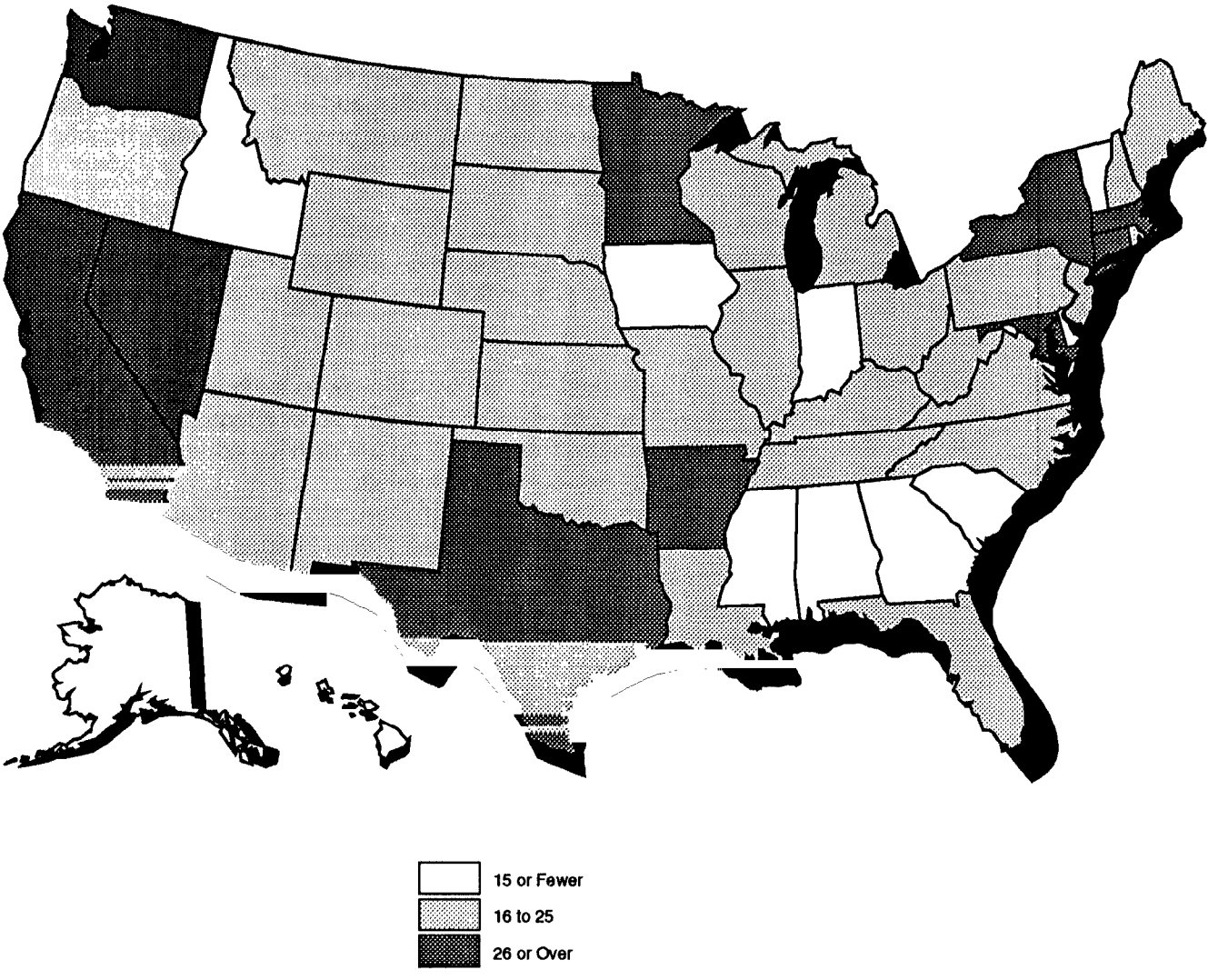
States Tried to Improve Access to Health Care Through Mandated Benefits

Until reduced-mandate plans were allowed, all state governments required, or mandated, that companies selling health insurance cover specific health problems or services. State governments mandated coverage in an attempt to ensure that a broad range of services were available to those with health insurance. The number of mandates, however, required by each state varies: Alaska, Delaware, Idaho, and South Carolina each have only 9 mandates, while Maryland has 35. The approximate number of mandates required by each state is shown in fig. III.1.

[1]Employer health plans for firms that self-insure are exempt from state mandated health benefit requirements because they are deemed to be employee welfare benefit plans that are exempt from state insurance laws under ERISA.

[2]Health Care for the Uninsured, special edition, Alpha Center (Washington, D.C.: Dec. 1991).

Figure III.1: Approximate Number of Mandated Benefits



Source: Health Benefits Letter, "New Study Shows 992 Mandated Benefits in the States," Vol. 1 (Alexandria, Va.: Aug. 29, 1991), based on data from Blue Cross and Blue Shield Association, Health Insurance Association of America, Intergovernmental Health Policy Project, and others.

Mandates can be classified as treatment mandates, provider mandates, and special-population mandates. Treatment mandates require insurance companies to cover treatment for specific conditions, such as alcoholism and mental health problems, or for specific procedures, such as in-vitro fertilization services. Provider mandates require payment for covered services obtained from specific types of providers, such as chiropractors, psychologists, or optometrists. Special-population mandates require insurance coverage for defined groups, such as newborns, adopted children, or the handicapped. The most common state mandates and the number of states requiring them are listed by category in table III.1.

Table III.1: States With Mandates

Treatment mandates	
Alcoholism	40
Mammography screening	39
Mental health	29
Drug abuse	27
Maternity	25
Home health	20
Ambulatory surgery	12
Temporomandibular joint disease	12
Breast reconstruction	11
Optional coverage for abortions	8
Pap tests	8
Hospice	7
In vitro fertilization	7
Cleft palate	7
Ambulance transportation	7
Orthotic/prosthetic devices	6
Provider mandates	
Optometrists	46
Chiropractors	45
Dentists	40
Podiatrists	37
Psychologists	36
Nurse midwives	24
Social workers	22
Osteopaths	20
Physical therapists	16

(continued)

Nurse practitioners	15
Nurse anesthetists	11
Nurses	10
Psychiatric nurses	9
Speech therapists	8
Licensed health professionals	7
Professional counselors	7
Special populations	
Newborns	50
Handicapped dependents	40
Continuation for employees	38
Continuation for dependents	37
Conversion to nongroup	37
Adopted children	25
Preventive care for children	14
Noncustodial children	13
Dependent students	6

Source: Health Benefits Letter, "New Study Shows 992 Mandated Benefits in the States." Vol. 1 (Alexandria, Va.: Aug. 29, 1991), based on data from Blue Cross and Blue Shield Association, Health Insurance Association of America, Intergovernmental Health Policy Project, and others.

All states do not mandate the same health benefits. Most states mandate coverage for special populations like newborns and the handicapped, for procedures like treatment for alcoholism and mammograms, and for more common alternative providers like chiropractors. Other mandates cited as driving up the cost of premiums, but mandated in only a few states, include Chinese medicine (naturopaths), hairpieces for hair loss due to specific medical conditions or treatment, and acupuncture.

The types of mandates required by each state will have an effect on premium cost. But the effect on premiums of a specific health insurance mandate can be ambiguous. Treatment and population mandates generally increase premiums. When a state mandates coverage for alcoholism, for example, insured people with this condition can obtain care that is paid by their insurers, and premiums for everyone rise to cover treatment costs.

Provider mandates, however, could either raise or lower premiums. If, as a result of a chiropractor mandate, insured people begin to utilize this service for a problem that was previously untreated, new costs would be

added to insurers' health care bills and premiums would rise. On the other hand, it is possible that beneficiaries could substitute potentially less expensive chiropractic treatments for other medical treatment. In that case, premiums could fall.

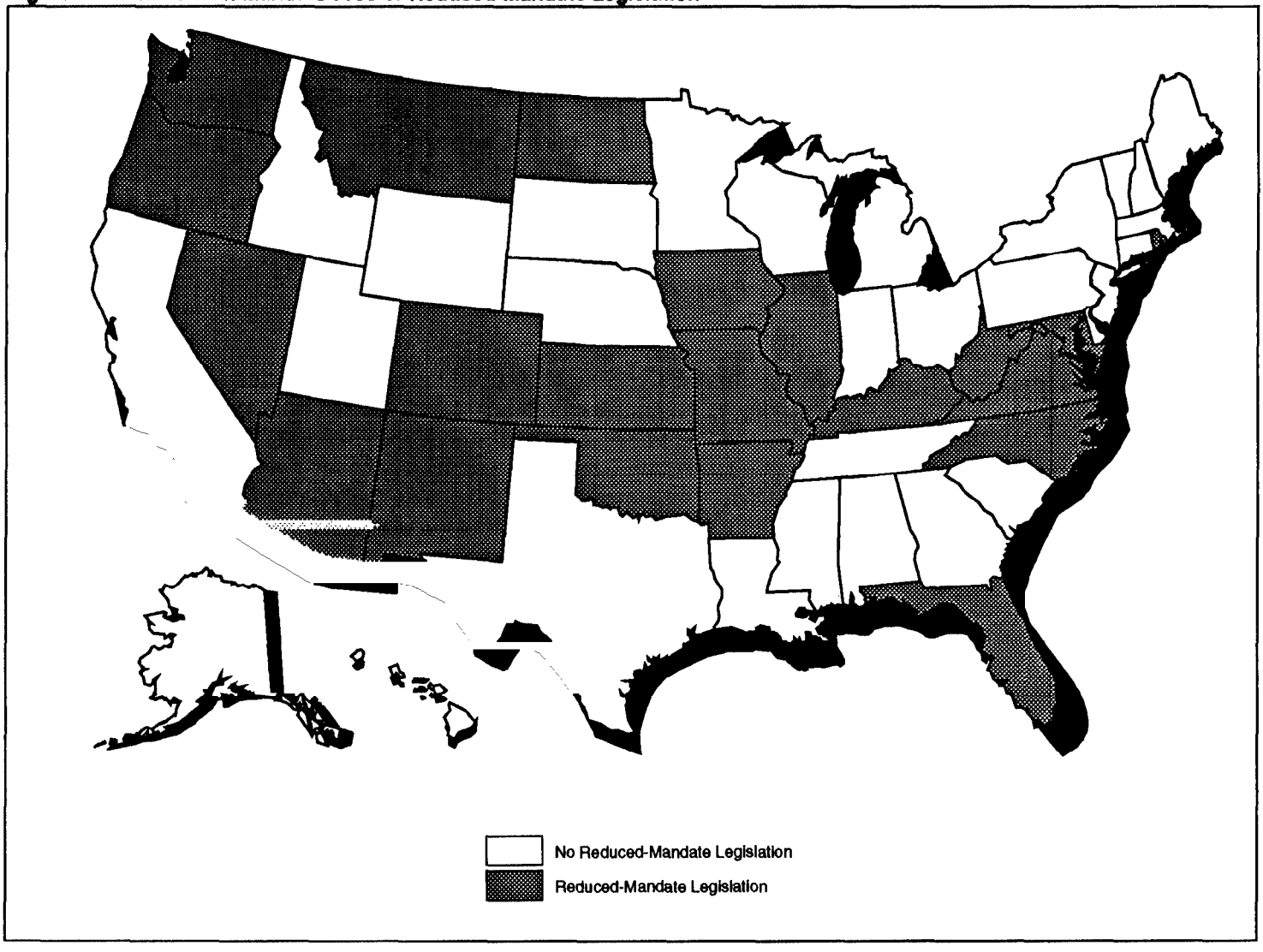
Despite the cost of mandates, however, state governments, insurers, and others acknowledge that many of the mandates that do increase premiums provide coverage for necessary services. For example, neonatal care and substance abuse are considered by many to be expensive but necessary benefits. Thus, some insurance plans do not offer packages without such benefits, even if these benefits are not required.

States Now Dropping Mandates to Reduce Insurance Premiums for Small Businesses

Beginning in July 1990, 21 states[3] began implementing legislation allowing insurance companies to sell health insurance policies to small businesses without some or all of the state-mandated benefits. These states hope that the price of health insurance will drop because they do not require insurance companies to insure benefits that some employers believe drive up premiums. This type of legislation also attempts to address the problem of inadequate access to insurance without spending new state money or expanding the state bureaucracy. The states with mandate-free or reduced-mandate legislation are shown in fig. III.2.

[3]As of September 1991.

Figure III.2: States With Mandate-Free or Reduced-Mandate Legislation



Source: Derived from information provided by state officials.

Some states, like Kentucky and Washington, allow insurance companies to offer insurance without any mandates; other states, such as Rhode Island, still require some mandates, such as children's health or mental health services. Many states prevent employers from offering their employees

this type of insurance if they offered health insurance in the recent past, generally during the previous 12 months. The majority of these plans are available only to companies employing 25 or fewer people.

When a state legislates limited-mandate insurance, the mandates frequently excluded are provider mandates, while the mandates most likely to be retained are special population and treatment mandates. States keep treatment and special population mandates generally for primary and preventive services that are considered to save money if provided early. Iowa's legislation includes a clause stating that if a procedure can be shown to reduce health care costs in the long run, that mandate will be added back to the reduced-mandate plans. The states with reduced-mandate laws and the limitations placed on these plans are shown in table III.2.

Table III.2: Characteristics of Laws Waiving Mandated Benefits

State	Business size[a]	Mandates retained[b]	Limit on previous coverage[c]
Arizona (1991)	39	Prenatal and obstetrical well-child	3 months
Arkansas (1991)	No limit	Prenatal and obstetrical options	12 months
Colorado (1991)	25	Mental health options	None
Florida (1991)	24	Mandates offered as options	None
Georgia[d] (1991)		To be developed by insurance commissioner	
Illinois (1990)	24	Adopted children Newborn children Mammograms	12 months
Iowa (1991)	25	Prenatal and obstetrical	12 months
Kansas (1992)	25	Catastrophic coverage	24 months
Kentucky (1991)	50	None	36 months
Maryland (1991)	25	Prenatal and obstetrical Emergency care	12 months for individuals, 24 months for groups
Missouri (1990)	50	None	None
Montana (1991)	20	Prenatal and obstetrical Mental health Substance abuse Well-child	None
Nevada (1992)	25	Mandates offered as options	6 months
New Mexico (1991)	19	Prenatal and obstetrical Mammograms	6 months

(continued)

State	Business size[a]	Mandates retained[b]	Limit on previous coverage[c]
N. Carolina (1992)	25	To be developed by insurance commissioner	None
N. Dakota (1991)	24	None	12 months
Oklahoma (1990)	No limit	To be developed by insurance commissioner	15 months
Oregon (1992)	25	To be developed by insurance commissioner	None
Rhode Island (1990)	25	Emergency medical Prenatal and obstetrical Mental health Screening services Well-child	3 months for individuals, 24 months for groups
Virginia (1990)	49	Prenatal and obstetrical Well-child	12 months
Washington (1990)	49	None	None
West Virginia (1991)	No limit	Prenatal and obstetrical PAP tests Mammograms	None

Note: Date indicates the year legislation became effective.

[a]Maximum number of employees a business can have to be able to purchase insurance without mandated benefits.

[b]Mandates still required under the state's legislation.

[c]Period during which a company could not have offered health insurance benefits to employees eligible to purchase these plans.

[d]The insurance commissioner must develop a plan for people below 250 percent of poverty with coverage for "primary health care services" and "significantly lower premiums."

Source: Intergovernmental Health Policy Project.

Mandates Add Modest Amount to Health Insurance Premiums, but Often Cover Important Services

Mandates could deter small business from offering health insurance if they appreciably increase health insurance premiums. Studies of the costs of mandates, however, have shown that mandates increase premiums by, at most, 20 percent. And the mandates adding the most to premiums require coverage for services such as mental health, substance abuse, and children's care.

Several studies have measured the effect on premiums of state mandates (see table III.3). The Health Insurance Association of America estimated that mandates caused premiums to increase 12 to 20 percent in

Maryland—the state with the highest number of mandated benefits. The Washington State Insurance Commissioner's Office estimated that in Washington, the price of state mandates added 3 to 12 percent to health insurance premiums. This amount, according to the insurance commissioner's office, is not large—especially in view of overall medical inflation.

Table III.3: Estimates of the Impact of Mandated Benefits on Premiums

State	Estimated percentage increase in premiums due to mandates
Maryland: 35 mandates[a]	11.0 to 21.0
Massachusetts: 26 mandates[a]	8.5
Oregon: 22 mandates[b]	8.1
Washington: 28 mandates[c]	3.0 to 12.0
Washington: 28 mandates[d]	8.0 to 16.0
Wisconsin: 24 mandates[e]	7.1

[a]G. Jensen and J. Gabel, "Price of State Mandated Benefits," Inquiry, Vol. 21 (Winter 1989), pp. 419-31.

[b]The Impact of State-Mandated Health Care Benefits in Oregon, Associated Oregon Industries Foundation (Salem, Oregon: Feb. 1991).

[c]Washington State Insurance Commissioner's Office, unpublished data.

[d]Blue Cross of Washington and Alaska, unpublished data.

[e]G. Krohm and M. Grossman, "Mandated Benefits in Health Insurance Policies," Benefits Quarterly, Vol. VI, No. 4 (1990).

The total cost of health insurance mandates is tied not only to the number of mandates, but also to the specific types of mandated benefits. Mental health and substance abuse mandates are among the most expensive. Other relatively expensive mandates include dental care benefits and neonatal treatment benefits. Mental health benefits are estimated to add between 8 and 12 percent to health insurance premiums, substance abuse benefits between 4 and 9 percent, and neonatal benefits less than 3 percent.

Mandates determined not to add significantly to the cost of health insurance include services for in-vitro fertilization, acupuncture, and cleft palate, as well as services provided by chiropractors and home health nurses. It is these low-cost mandates, however, that are often cited by the business community as examples of the added wasteful expense mandates cause for businesses.

Early Results of Reduced-Mandate Plans Show Marginal Success

By eliminating mandated benefits, state legislators hoped that premiums for health insurance plans sold to small businesses would drop by up to 40 percent. Insurance companies in many of these states responded to this legislation and developed plans with premium prices reduced by 15 to 40 percent. The lower premiums were due, however, not only to mandate exemptions, but also to higher beneficiary cost sharing and exclusions of preexisting conditions. The response to these plans, after the first several months of sales, has been limited. Few small businesses have as yet made these plans available to their employees.

Insurance companies in many states responded to the reduced-mandate legislation and developed plans for the small-group market. In many cases, insurers offered policies with premiums between $50 and $100 a month per covered individual. These plans, however, may also exclude coverage of preexisting conditions for up to 1 year, require higher copayments and deductibles (sometimes as high as $5,000), or involve other benefit limitations (such as benefit caps). Therefore, it is difficult to determine how much of the lower premium price is a result of reduced mandate requirements and how much is a result of other benefit exclusions or limitations. A consumer advocacy group estimated that premiums were reduced far more by increased cost sharing than by the elimination of mandates.[4]

It must be stressed that it is too early to determine definitively the success of this type of legislation. Because outreach to small businesses for any reason is difficult and because the economy has been undergoing a recession, it may take more time to determine how interested small businesses are in this type of plan. Even with these problems acknowledged, however, the number of newly insured small business employees has been low.

The recent experience of Illinois, Virginia, and Washington illustrates the effect reduced-mandate legislation has on improving access to insurance for small business employees. These states allow insurance companies to offer small businesses bare bones insurance plans without, or with few, state benefit mandates. Blue Cross and Blue Shield Associations in each of these states have developed plans with a reduced number of mandated benefits. Premiums for these plans were priced between 10 and 40 percent lower than premiums for the plans previously available to the small-group market.

[4]"State Mandated Benefits Are Neither the Cause of, Nor the Solution to, Rising Health Insurance Costs," States of Health, Families USA (Washington, D.C.: 1991).

Blue Cross of Virginia has been reevaluating the plan it developed because so few policies have sold; by December 1991, 85 policies covering 165 participants were in effect. It plans to remove the plan's $50,000 per annum benefit cap in order to attract new small business customers. An official at Blue Cross felt that this cap limited sales of this product because it did not provide beneficiaries financial security—catastrophic care over that limit would not be covered.

In Washington, the insurance commissioner's office said, as of December 1991, plans had been sold covering over 2,500 persons. Various Blue Shield companies in Washington, however, indicated that demand for their plans had been increasing. By December 1991, the two largest Blue Shield plans operating in the state said that combined, they had sold approximately 1,600 policies, of which over 80 percent were sold to small businesses that did not offer insurance before. The plans believe that the success is due, in part, to (1) the plans they developed that have no deductibles, only higher copayments, and (2) the marketing methods they use to reach small businesses.

In Illinois, since July 1991, Illinois Blue Cross and Blue Shield Association had sold only five group plans, covering fewer than 100 individuals. A company official believes that small businesses operate with such small profit margins that they often cannot purchase health insurance. Moreover, the probability of these businesses' buying insurance is even lower now because of the recession.

Given the experience of these three states, it appears that the cost of mandates is not the key factor preventing small businesses from purchasing health insurance. In most cases, the premium reductions resulting from mandate waivers have been too little to induce small businesses to purchase insurance.

A more significant problem preventing small businesses from offering health insurance is its high and rising cost. Even if mandates are removed from insurance plans, premiums drop only enough to pay for the previous year's medical cost inflation, leaving health insurance unaffordable to many small businesses.

States and Private Organizations Develop Other Lower Cost Plans

In addition to waiving mandated benefits, states and private organizations have implemented a variety of other methods, which may or may not include eliminating mandated benefits, to develop low-cost health insurance plans. To reduce premiums, these plans also use increased beneficiary cost sharing, preventive care, and subsidies.

The Shared Cost Option for Private Employers (SCOPE) program in Colorado is an RWJF pilot project that is neither sponsored nor subsidized by the state. It is a lower cost plan that covers all the state's mandated benefits, emphasizes preventive care, and uses high-cost sharing by the beneficiary to reduce premium cost. To keep premiums low, services are provided through a provider organization with which SCOPE has contracted lower payment rates for physician and hospital services. Further premium savings are achieved through high deductibles and copayments. Preventive care, however, is covered without beneficiary cost sharing. The program does not require that participating small groups be previously uninsured.

With enrollment at nearly 7,000 by June 1991, SCOPE has been one of the most successful RWJF low-cost insurance pilot programs. The director and evaluators of the program believe that SCOPE's heavy media exposure and strong marketing and public relations efforts played a significant role in reaching small businesses.

Provider Discounts Improve Affordability With Few or No State Funds

As of September 1991, health care provider discounts helped some state and private sector programs provide less costly coverage to small-employer groups in at least 16 states. Lower prices are achieved by pooling a large number of small firms in a larger buying group and by limiting the group's choice of providers to those willing to provide discounted pricing. Organizing an insurance program in which small firms can obtain discounts from health care providers requires substantial front-end planning and costs. Provider discounts have enabled several health care programs to offer premiums as much as 45 percent lower than market rates for comparable plans in the same areas.

In December 1991, the Tennessee MedTrust program in Memphis insured about 860 persons. It received no public subsidies, but discounts from the three participating hospitals enabled it to offer premium rates on an average of 45 percent lower than market rates.

Some projects faced open opposition from local insurance groups, however, who charged that the projects had an unfair competitive

advantage due to the discounts that projects received from providers. For example, a local Blue Cross affiliate in Maine asserted, at a hearing for hospital rate approvals, that the state-sponsored and subsidized MaineCare program should not receive such a large (30 percent) discount from participating hospitals[5] because the plan was not restricted to low-income people. The insurer appeared to be concerned that the provider discounts represented unfair competition.

The Utah Community Health Plan, with 1,600 enrollees working for 280 small businesses, was nearly terminated because of opposition from private insurers who filed a formal complaint with the state's attorney general to prevent the plan from becoming certified to enter the insurance market. Insurers claimed that the provider discounts represented unfair competition. The private plan—which receives no state subsidies—estimates that its premiums are 40 percent lower than those of comparable plans in the area, primarily from provider discounts for both inpatient and outpatient care. The projects in Maine and Utah ultimately prevailed by demonstrating that their special purpose was to provide coverage to a market segment unable or unwilling to obtain coverage under the existing system.

[5]MaineCare's 30 percent discount applies to an enrollee's first $20,000 in annual hospital costs.

Subsidies Adopted to Improve Access

Small business owners consistently cite the high cost of health insurance as the chief reason they do not offer coverage to their employees. A number of states have tried using subsidies to induce small businesses to provide insurance. By September 1991, 21 states had subsidized health insurance premiums for small businesses either directly or through income tax credits or premium tax waivers. Many of the initiatives have been in effect for less than 2 years, and there have been few formal evaluations of their effectiveness. Early results, however, indicate that modest-sized subsidies have limited impact on increased insurance coverage.

The number of states that adopted or proposed subsidies as of September 1991 are shown in table IV.I. These data are listed by state in appendix VI.

Table IV.1: States That Have Adopted or Proposed Subsidies (Sept. 1991)

	Adopted	Proposed
Subsidies to employers and employees	7[a]	3
Income tax credits	8	11
Premium tax waivers	9	3
Subsidies to insurers	3	1

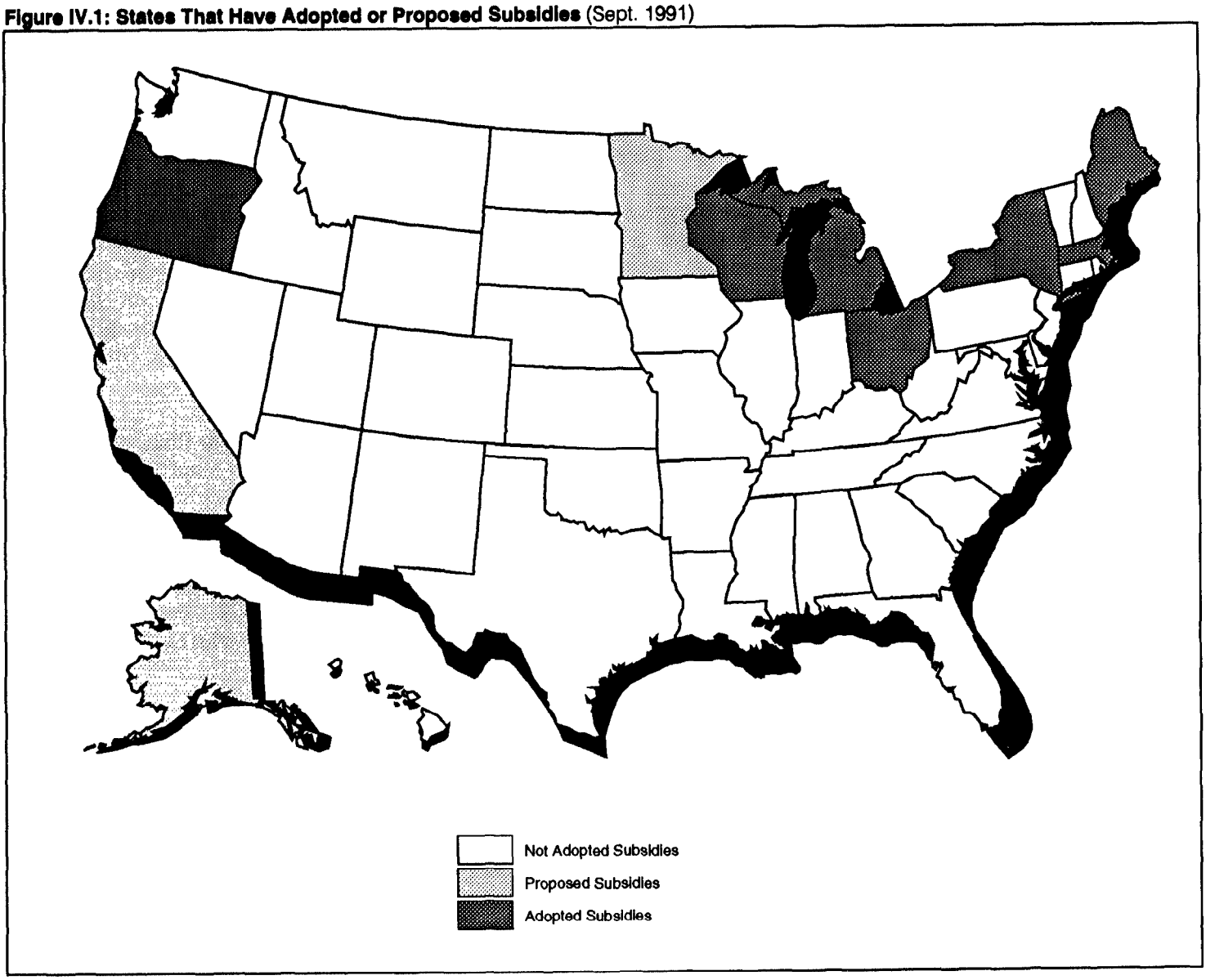
Note: Some states have adopted or proposed more than one type of subsidy.

[a]Of the 7 states that adopted subsidies to employers and employees, Michigan, Ohio, and Wisconsin offered them for a limited period and discontinued them. Massachusetts terminated its subsidy programs in March 1992.

Few Employers Have Begun Offering Insurance as a Result of Subsidies

Seven states had provided direct subsidies for small business employers and employees as of September 1991; however, four of these states have since discontinued these subsidies (see fig. IV.1). Given the potential effect on state budgets, most of these subsidy programs cover a limited geographic area or are pilot programs. Subsidies have been successful in encouraging some employers to provide insurance and some employees to purchase it, but employers' low rate of participation in a number of subsidized pilot projects suggests that many employers will not provide coverage even with substantial premium subsidies. States are thwarted in their efforts to assist small business employees when employers do not take advantage of programs offering subsidies.

Figure IV.1: States That Have Adopted or Proposed Subsidies (Sept. 1991)



Source: Information provided by states.

Privately and state-funded projects, such as the RWJF Health Care for the Uninsured Program, have reduced premiums by as much as 50 percent. Despite the lower premiums, even the most successful of the RWJF pilot

subsidy programs had enrolled less than 17 percent of its uninsured small business market. In most of these pilot projects, the programs enrolled 2 to 7 percent of the uninsured small firms in the area. RWJF program officials estimate that even with insurance premiums 25 to 50 percent below market levels, less than 20 percent of uninsured small business groups will purchase health insurance voluntarily.

A recent evaluation of a pilot study in New York State supports this assessment.[1] A state subsidy that reduced the price of health insurance by 50 percent resulted in an approximately 3.5 percent increase in the number of small firms offering health insurance. If the program was fully implemented and all eligible employers were aware of it, analysts estimate the subsidy would increase the proportion of firms providing coverage by up to 16.5 percent.[2]

Michigan's subsidy program, called the One-Third Share Plan, provided a mixture of public and private funds to employers and employees.[3] Although Michigan had decided to provide subsidies because they were perceived to be a more direct incentive to employers than tax credits, its project enrolled only a small share of the uninsured in the small business market. A Michigan official said, one lesson the state learned from the project is that under a voluntary system, employers can act as an obstacle to providing health insurance to uninsured employees, who cannot purchase coverage if their employers do not offer it.

State and RWJF surveys indicate that lack of participation in subsidy programs is due in part to (1) the low incomes of many small employers, preventing the purchase of even lower cost insurance and (2) the reluctance of employers to participate in short-term pilot programs that would leave them responsible for more costly insurance once the program ends. Lack of participation may also stem from small employers' views that they do not have a responsibility to offer health insurance or that their

[1]Kenneth E. Thorpe, PhD, and others, "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results From a Pilot Study," Journal of the American Medical Association, Vol. 267 (Feb. 19, 1992), pp. 945-48.

[2]One potential qualification for the results of this study is that certain constraints in the subsidy program may have contributed to low participation. For example, employees were not permitted to share in premium payments.

[3]The RWJF provided $350,000 for administrative and start-up costs; the Charles S. Mott Foundation contributed $1 million for premium subsidies and an evaluation of the project's effect; and provider discounts at the Flint site reduced premiums to 16 percent below comparable plans in the area. General tax funds provided the remainder of the subsidies. Rather than provide funds up front to employers, the state reimbursed them for the subsidized amounts after they paid premiums and provided copies of policies to the state.

employees either do not desire coverage or have access to it through a family member.

Budget Constraints Limit State Subsidy Programs

Premium subsidies allow states to control their level of fiscal commitment and to target benefits specifically to uninsured small employers, but they are costly. Private foundations' participation in subsidized pilot projects has been limited primarily to providing funds for start-up and development costs and for project evaluation. Foundations have not been a source of long-term premium subsidies. Because of budgetary constraints, some states, such as Connecticut and Kentucky, determined that subsidies were not an option. Other states abandoned or limited the scope of state-funded programs because adverse economic conditions diminished available funds.

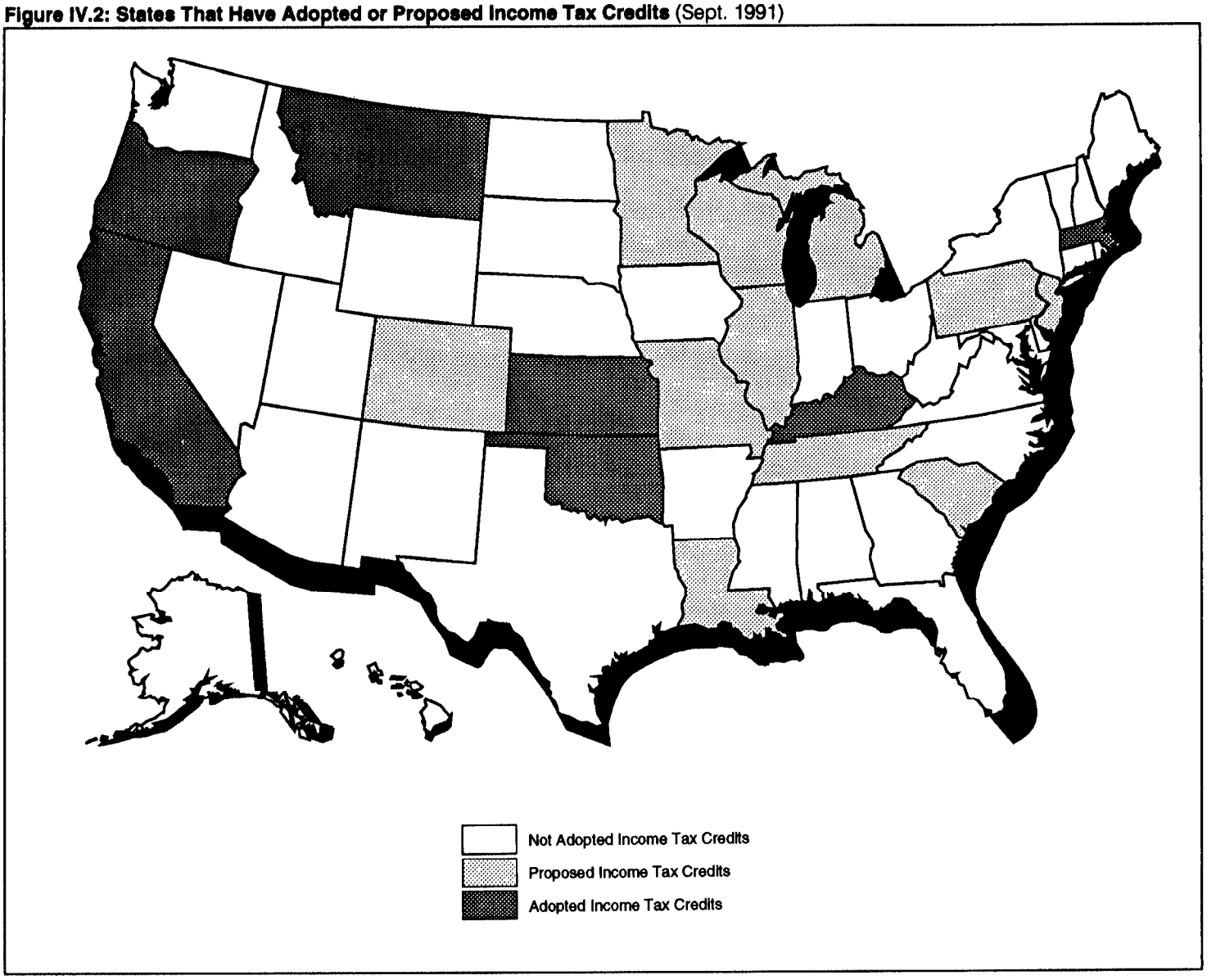
Michigan discontinued its state-subsidized program for employers and employees as of March 1991 due to a state budget deficit. Wisconsin's subsidy programs for low-income employees ended in June 1991 because of state budget constraints and a low number of program enrollees.

Maine's project, MaineCare, attempts to target employers and employees who can least afford to pay for coverage. MaineCare provides 2-year subsidies for newly insured small employers (15 or fewer full-time employees) who have not offered insurance within the previous 12 months; it also subsidizes premiums for low-income (under 200 percent of the poverty level) small business employees. Because of state budget constraints, Maine has been unable to expand the program's geographic area or raise enrollment to the level that had been planned.

Limited Effect From Income Tax Credits

Some states choose to subsidize the cost of insurance indirectly through tax credits. As of September 1991, seven states had adopted income tax credits for certain small employers who offer health insurance to their employees (see fig. IV.2).

Figure IV.2: States That Have Adopted or Proposed Income Tax Credits (Sept. 1991)



Source: Information provided by states.

Income tax credits have induced some small employers to offer health insurance. Such credits, however, do not attract participation by employers who are unlikely to have reportable income unless the credits

are refundable—that is, paid to the firm regardless of whether the firm pays any taxes. In addition, in order to target benefits toward the uninsured, some states limit participation to firms newly offering insurance. Small businesses already offering health insurance may view such limitations as disparate treatment that places them at a competitive disadvantage.

Credits are administratively less costly than subsidies, but nevertheless have an impact on state treasuries through reduced tax revenue. Colorado, Connecticut, and North Carolina, for example, decided against tax credits because of their expected adverse effect on state funds.

States Restrict the Availability of Tax Credits for Small Firms

States have established various restrictions on the use of tax credits by small businesses, some of which may limit their ability to induce employers to offer new coverage. Firms obtaining tax credits must generally meet specific firm-size criteria and must not have offered health insurance for a specified period of time. In addition, most states have authorized tax credits for a limited period of time only. Some states have additional requirements, such as contributions by employers to employees' premiums or state certification of insurance plans.

Kentucky's tax credit program illustrates some of the restrictions states have applied. In 1990, Kentucky approved a 4-year income tax credit for small employers offering any one of three state-approved, lower cost plans. Qualifying employers must employ 50 or fewer people, not have offered insurance for at least 3 years, and pay at least 50 percent of their employees' premiums. The 4-year program gives a first-year tax credit of 20 percent of the premiums paid by employers on behalf of their employees and for the premiums paid by employees. The credit decreases by 5 percent in each of the following 3 years. By decreasing the tax credit gradually over the 4 years, the state hopes to encourage early enrollment in the program, yet prevent firms from developing a dependence on state support. The 4-year tax credit is estimated to cost the state over $2.8 million, assuming participation by 10 percent of the uninsured health insurance market for small businesses, a state official said.

Kansas's experience suggests how program restrictions can inhibit participation by employers. The state approved an income tax credit for uninsured small employers and a premium tax waiver for insurers in 1990. The tax credit equals the lesser of $25 a month for an eligible covered employee or 50 percent of total annual premiums for the first 2 years, and

decreases gradually over the following 3 years. As of September 1991, Kansas had no eligible applicants for its small business health care tax credit, despite extensive marketing efforts by the state. A state official attributed this lack of interest, in part, to a requirement that eligible firms must not have offered insurance for the 2 years preceding application.

Oklahoma's 2-year tax credit is available to specified employers who begin offering state-approved lower cost plans. The state chose a refundable tax credit in an effort to encourage all eligible employers to participate, including those who would not receive a conventional tax credit because of a lack of taxable income. Participating firms receive a tax credit amounting to $15 a month for each covered employee.

California Provides Tax Credits to All Small Businesses

California differs from most states in that its income tax credit, which will become effective in 1993, is not limited to firms offering insurance for the first time. Any small employer may claim the credit, regardless of when coverage begins. This forestalled criticism by small employers who were already providing health insurance coverage that the state gave preferential treatment to newly insured small groups.

Premium Tax Waivers Have Minimal Effect

One of the factors that raises health insurance premium costs for small employers is the pass-through of the 1 to 3 percent premium tax that the majority of states impose on insurers. In an effort to reduce premium costs for small employers, 11 states have passed or proposed premium tax waivers for plans offered to small businesses.

States have typically introduced premium tax waivers along with other insurance reform measures. For example, in North Carolina, insurers are required to offer state-specified basic and standard health care plans. The state offers a partial premium tax waiver for such plans, provided that the insurers participate in the state's reinsurance pool. In 1991, Connecticut waived premium taxes for special health care plans designed to provide lower cost health insurance for low-income employees of previously uninsured small employers.

Small firms could benefit from savings passed through to them, but eliminating a 1 to 3 percent tax would have little effect on total premium cost. Furthermore, because premium tax waivers have generally been in effect for less than 2 years, there is no information on the extent to which insurers have passed savings on to small businesses in the form of lower

premiums. Indiana considered a premium tax waiver, but rejected the proposal because a survey of licensed insurers showed that savings from the waiver would not be passed along to small employers through premium reductions.

States Subsidize Administrative Costs to Help Insurers Lower Premiums

In order to encourage insurers to participate in the small-group market, a few states have used mechanisms to reduce the higher marketing and administrative costs that insurers experience in this market. The Florida Health Access Corporation (FHAC), a state-sponsored nonprofit organization, for example, assumes various administrative and marketing services and pays a portion of its providers' stop-loss insurance premiums.[4] These subsidies enabled the corporation to reduce the rates for its program 25 to 30 percent below the market rate for comparable coverage.

The Florida plan is currently operating in 16 counties. As of January 1992, the project had enrolled over 2,200 firms, representing over 9,500 people. However, the president of FHAC said that further growth is currently stymied by the state's billion-dollar budget shortfall. As a result, the project plans to slow its marketing campaign and postpone further site expansion.

Arizona's Health Care Group subsidizes insurers by performing a number of administrative functions, such as in-kind actuarial, financial, and legal services; collecting premiums; and making changes to enrollees' policies. These services that reduce the administrative responsibilities of insurers could serve as an incentive for insurers to serve the small business market The project had enrolled 939 firms, representing over 3,000 individuals, as of June 1991.

[4]Stop-loss insurance limits the maximum costs a primary insurer must pay if claims costs are very high. Stop-loss insurance covers up to 100 percent of costs above a predetermined threshold.

Pools Designed to Facilitate Small-Group Access to Health Insurance

An important factor that drives up the cost of health insurance for some small groups and makes it unpredictable for all is the inability to spread risk over a large number of people. States have established three types of pools, which help small business employees obtain health insurance by spreading risks more widely through groups of individuals or businesses: high-risk, reinsurance, and small-employer pools.

The following definitions briefly describe the pooling approaches discussed in this appendix.

- High-risk pool: A state-sponsored program for individuals who, because of current health status, poor health history, or hazardous employment, (1) are termed medically uninsurable and have been refused coverage by insurers, (2) are considered high risk and must pay high insurance premiums, or (3) can qualify for only limited coverage.[1]
- Reinsurance pool: A state-sponsored mechanism that reduces the risk associated with providing coverage to high-risk individuals or groups by allowing individual insurers to group the high-risk people and their excess medical costs in a separate pool in which the risks are spread across a larger pool of insurers.
- Small-employer pool: A private or state-facilitated organization in which two or more small employers join together and obtain group health insurance. Some private small-employer pools developed without state support.

The numbers of states that had adopted or proposed the various pooling approaches, as of September 1991, are shown in table V.1. These data are listed by state in appendix VI.

Table V.1: States That Have Adopted or Proposed Various Pooling Mechanisms (Sept. 1991)

	Adopted	Proposed
High-risk pools	26	11
Reinsurance pools	3[a]	11
State-facilitated small-employer pools[b]	5	9

[a]In addition, Vermont has enacted legislation permitting a state reinsurance pool. The pool has not yet been established.

[b]Private employer pools without state support operated in 45 states as of September 1991.

Source: Information provides by states.

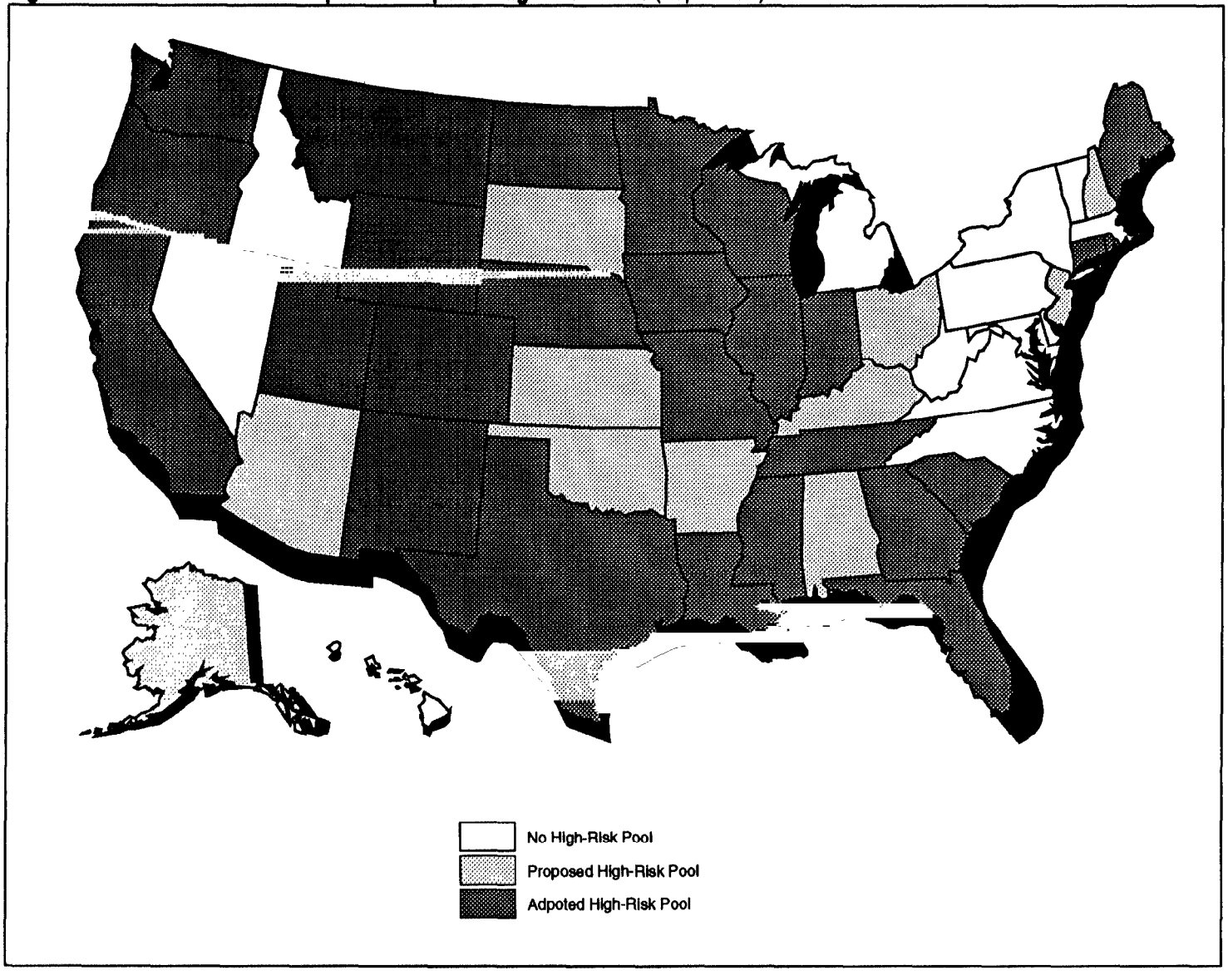
[1]Although "uninsurable" and "high risk" are not synonymous, most pools include both categories of enrollees under the term "high-risk pool."

High-Risk Pools Adopted by Half of States

High-risk pools for those who have been denied health insurance or cannot obtain it at a reasonable price have been adopted in 26 states and have been proposed in another 11 states (see fig. V.1). Although established to provide health coverage to high-risk individuals outside the employer-based system, some small firms use the high-risk pools to "carve out" high-risk employees from their health insurance plans.[2] Exclusion of high-risk employees enables remaining members of employer groups to obtain more affordable insurance.

[2]A more complete discussion of how high-risk pools facilitate individual coverage is contained in Health Insurance: Risk Pools for the Medically Uninsurable (GAO/HRD-88-66BR, Apr. 1988).

Figure V.1: States That Have Adopted or Proposed High-Risk Pools (Sept. 1991)



Source: Information provided by states.

High-risk pools have been successful in providing coverage to almost 77,000 people. But they have a number of problems and, in most states, only a small percentage of those eligible have participated. Individuals

may be unable to afford premiums for high-risk pools, which range from 125 to 400 percent of the cost of standard-risk policies. In addition, individuals may have to wait to be accepted into pools or to gain full coverage.

States Have Various Approaches to Financing High-Risk Pools

On average, the premiums paid by risk-pool beneficiaries cover about 60 percent of total pool claims paid, although this proportion ranges from 40 to 100 percent in individual states. The remaining costs are typically covered by insurers through assessments based on their share of the private market.[3] Although no state is typical, the situations in Florida and California illustrate the range of financing mechanisms taken by states.

Florida's high-risk pool, which began operating in 1983, is funded by assessments on the state's private insurers, HMOs, and Multiple Employer Welfare Arrangements (MEWAs).[4] The state has temporarily suspended new enrollments because of budget forecasts for 1991 that predicted deficits for high-risk pools between $45 million and $150 million. The state has raised premium rates 80 percent, modified benefits offered, strengthened cost containment and oversight of the program, and hopes to reopen enrollment. Membership in the pool, however, dropped from about 7,800 in June 1991 to fewer than 4,700 in December 1991. A preliminary survey showed that the primary reason enrollees left the program was the increase in premium costs.

In contrast, California funds its high-risk pool through an appropriation of tobacco tax revenue. The state established its risk pool in 1990 and limited enrollment in the pool to keep costs within authorized limits. The pool's authorized membership limit of 10,000 has already been reached. Although it is too soon to determine the level of pool losses, risk-pool officials estimate that $1.10 in claims will be paid for each $1.00 paid in premiums. The state specifically prohibits carving out employees to place them in the state's high-risk pool.

When states permit a business to exclude high-risk people from an insured group so that the business can get a lower premium for its other employees, responsibility for high-cost employees is shifted initially from

[3]California, Illinois, and Maine make up the difference between claims and premiums through state appropriations; Colorado uses a special state income tax surcharge; and Tennessee partially funds its risk pool through general revenues.

[4]MEWAs are established to provide health or other benefit coverage to employees of two or more employers. MEWAs allow businesses to provide benefit coverage for employees by pooling funds to pay for benefits or to buy group insurance.

the individual small firm to the high-risk pools. The initial burden is shared by the high-risk individuals to the extent they pay higher premiums and by insurers or state governments to the extent they subsidize the insurance premiums for these high-risk people. If insurers pass on the cost of assessments through higher premiums, all firms purchasing insurance ultimately share in the cost.

ERISA May Limit Potential Funding Base for High-Risk Pools

High-risk pools in most states depend on assessments paid by private insurers to cover claims in excess of premiums collected. Some state officials contend that ERISA's exemption of self-insured firms from requirements to contribute to pools severely limits states' ability to adequately fund their high-risk pools. The result of the ERISA preemption is to place the burden of assessments to cover risk-pool losses on private insurers, which nationwide constitute only 60 to 65 percent of the health insurance market. Moreover, as the number of firms opting to self-insure grows, the funding base for risk pools may continue to shrink.

Reinsurance Pools Accompany Market Reform in Three States

Reinsurance pools are emerging as a mechanism to reduce the risk faced by insurers in providing coverage for high-risk enrollees. The pools thus indirectly permit some firms to retain such employees in their group health insurance plans at lower cost than would otherwise be possible.

The reinsurance pool works by having all insurers, or at least a large number of insurers, contribute a small amount for each worker covered to be set aside to cover the potentially high costs associated with any high-risk person insured in one of their plans. Several mechanisms have evolved to accomplish this. Stop-loss plans, for example, limit the insurer's liability for coverage of a single person to a fixed amount. If a high-risk person has medical costs that exceed this stop-loss threshold, the reinsurance plan picks up all remaining costs. The reinsurance process, in effect, insures a single insurer against the possibility of a large loss if the insurer takes on a high-risk client by sharing the potentially high loss with a large group of insurers. All of the currently operating reinsurance pools were established in conjunction with insurance market reform legislation requiring insurers to provide greater accessibility and coverage to high-risk small business employees.

Reinsurance pools were established in Connecticut, Oregon, and North Carolina in 1991. Another 11 states are considering proposals for reinsurance pools. Since reinsurance pools are so recently adopted, there

is little information yet about their effects. The current pools, however, differ in structure, reflecting in part differences of opinion regarding which insurers should be required to participate, whether participation should be mandatory, and whether states should provide some form of support for the pools.

States Adopted Reinsurance Along With Market Reform

Many small business market reforms (see app. II) restrict the ability of insurers to carve out high-risk individuals from small-group plans or charge premiums reflecting potential claims costs. Each of the three states discussed below established reinsurance pools in conjunction with guaranteed issue legislation, exclusion and pricing restrictions, and other market reform legislation.

Connecticut authorized the creation of a two-tier mandatory reinsurance pool effective May 1991. Insurers that write small business policies in the state must contribute to the pool through a 5 percent assessment on their small business premiums. If this assessment fails to cover losses, an assessment may be made on all health benefit premiums in the state. Budgetary constraints prevent the state from contributing to the pool. As of August 1991, the reinsurance pool covered 97 persons; 66 of those persons were part of 17 plans reinsured as whole groups. The remainder were from plans that reinsured individuals within groups.

Oregon adopted a voluntary two-tier reinsurance pool, authorized in August 1991. The state requires membership of all state insurers and MEWAs, except for small business insurers who elect to assume their own risk. Members are assessed an amount not to exceed 4 percent of their small business premiums. If this amount is not enough to cover pool losses, members are assessed an amount not to exceed 1 percent of any health benefit coverage they issue. The state does not contribute to the pool.

North Carolina approved the creation of a voluntary state reinsurance pool in July 1991. Members of the pool are assessed up to 4 percent of their small business premiums, and receive a partial premium tax waiver from the state for specific small-group policies.

Insurers Favor Reinsurance Pools, but Disagree on Required Participation

Officials with a number of the nation's largest insurance companies have indicated that reinsurance could ease acceptance of small business market reforms. In a survey of 21 of the nation's largest health insurance companies, respondents indicated that if a reinsurance mechanism was in place, they would accept market reform requirements such as elimination of current underwriting practices, issuance of health insurance to all individuals requesting it, and renewal of small-group policies, regardless of claims experience.

Insurance associations cannot agree, however, on whether participation in reinsurance should be mandatory. The Health Insurance Association of America (HIAA) doubts that voluntary participation by insurers in the reinsurance pools would be effective because companies with less risk could decide not to participate in reinsurance, and thus fewer firms would share the risk for reinsurance. HIAA has proposed a mandatory two-tier assessment system like the one used in Connecticut. In contrast, the Blue Cross/Blue Shield Association (BCBS) and the Group Health Association of America support the establishment of a voluntary, private reinsurance mechanism. BCBS asserts that firms that can assume their own risk—as some BCBS organizations are able to do—should not be required to participate in reinsurance.

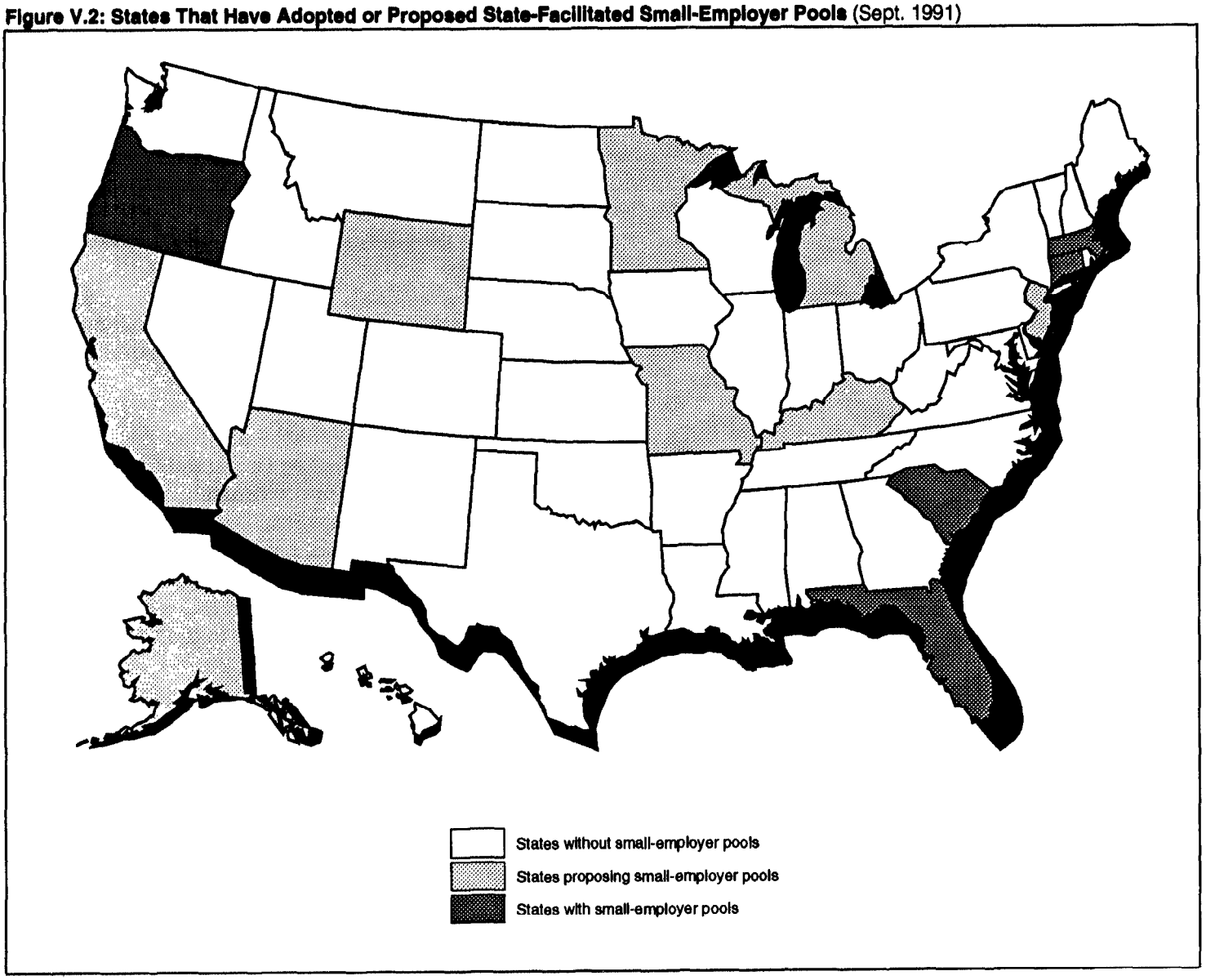
Reinsurance Pools Expected to Raise Insurance Premium Costs for Many Enrollees

While reinsurance pools may lower premiums for some high-risk people, they may raise average premiums for others. Reinsurance pools will not lower the cost of insurance unless the pools are subsidized by public funds, because insurers will pass their reinsurance assessments through to their customers. Indeed, reinsurance pools could actually raise insurance premium costs for many enrollees. The increased availability and lower premium costs for high-risk firms and individuals are likely to be accompanied by rising premiums for all other participants in the market.

Small-Employer Pools Generate Mixed Results

Grouping small employers into pools can help them overcome their disadvantages in the health insurance market. As of September 1991, 14 states had adopted or proposed state-facilitated small-employer pools (see fig. V.2). In addition, 45 states had private small-employer pools, which had been initiated without direct state support and 5 states had both state-facilitated and private pools. Some of the private small-employer pools have been in existence for a number of years.

Figure V.2: States That Have Adopted or Proposed State-Facilitated Small-Employer Pools (Sept. 1991)



Source: Information provided by states.

When states do not have restrictions on denial and exclusion of coverage and on rate setting, small-employer pools tend to draw a disproportionate number of high-risk groups. Healthy low-risk groups, meanwhile, take

advantage of lower prices elsewhere, further concentrating the risks and raising the premiums of small-employer pools. Some insurers are unwilling to provide insurance to employer pools because of the number of high-risk individuals.

Fraud, mismanagement, and inexperience in the operation of some private pools—particularly self-insured MEWAs—have left their members with large unpaid medical bills. These members usually are unable to obtain state assistance because MEWAs generally are not licensed by states.

Small-Employer Pools Use a Variety of Approaches to Improve Affordability

Using a variety of approaches, private and state-facilitated small-employer pools have been successful in obtaining lower cost health insurance for small employers.

Cleveland's Council of Smaller Employers (COSE)—a private multifunctional organization associated with the Cleveland Chamber of Commerce—arranges health insurance for approximately 8,600 member firms, representing over 150,000 persons enrolled. Twenty percent of the small businesses insured through COSE did not have health coverage before the COSE plan. Between 1986 and 1991, COSE was able to limit its premium increases to 57 percent, in comparison with trend increases of 152 percent over the same time period for other small businesses in the Cleveland area.

Because gravitation of high-risk groups to COSE raised average premiums, COSE created a separate group for such firms. Firms are classified as higher risk when their claims are greater than twice the premiums paid over a 2-year period. COSE negotiated with one of its insurers for the following:

- No more than 5 percent of the companies in COSE can be classified as higher risk.
- The surcharge for the higher risk group is 35 percent over the average risk group.
- Companies can earn their way out of the higher risk group through improved claims experience.

In return, this insurer offers discounts to the 5 percent of its COSE enrollees with the lowest claims.

The private Tulsa Health Option, an RWJF Community Programs for Affordable Health Care project endorsed by the Tulsa Chamber of

Commerce, takes a different approach to employer pooling. The Tulsa Health Option aggregates large and small businesses into one large employer pool to help small employer groups spread their risks more widely. It obtains premium reductions of 20 to 30 percent of market rates. As of January 1990, the pool included over 4,000 individuals enrolled from small firms.

Failed Pools and Unpaid Claims Have Tarnished the Success Record of Small-Employer Pools

Despite the success of some small-employer pools in assisting small employers to obtain more affordable health insurance, a number of private pools have gone out of business or have otherwise failed to pay claims, leaving groups and individuals with millions of dollars of unpaid bills. While small-employer pools in general have been able to offer small employers premium reductions of 10 to 40 percent, some pools have failed due to inexperience, fraud, or mismanagement.

Previously, GAO has found that private pools failed to pay over $123 million in claims for almost 400,000 employees and their families since 1988.[1] One MEWA in Florida, for example, accumulated over $3.2 million in unpaid claims before being closed by the state in 1989. Some MEWAs mistakenly asserted that they were exempt from state insurance regulation. Therefore, state regulators at times were unaware of MEWAs' existence until after receiving complaints from participants or others. Michigan now regulates MEWAs heavily, after a history of several MEWA failures in that state. Among state requirements is the mandate that MEWAs be in existence for 3 years before obtaining health insurance.

[1]Employee Benefits: States Need More Department of Labor Help to Regulate Multiple Employer Welfare Arrangements (GAO/HRD-92-40, Mar. 1992).

State and Private Sector Initiatives to Assist Small Businesses Obtain Coverage

Figure VI.1: States With Adopted or Proposed Insurance Market Reforms (Sept. 30, 1991)

	Reforms for obtaining coverage					Reforms for renewing coverage		
		Restrictions on				Prohibitions against		
	Guaranteed issue	Occupation exclusions	Pre-existing conditions exclusions	Pre-existing conditions waiting periods	Medical history used	Cancellation due to medical history	New or extended exclusions at renewal	New waiting periods at renewal
Alabama								
Alaska	○							1966 ●
Arizona								
Arkansas				1991 ●		1991 ●	1991 ●	1991 ●
California	○	○	○	○	○	○		○
Colorado				1991 ●	1991 ●			
Connecticut[a]	1990 ●	1990 ●	1990 ●	1990 ●	1990 ●	1990 ●	1990 ●	
Delaware		1953 ●		1987 ●		1991 ●		
Florida			1978[d] ●		1988[d] ●	1991 ●		
Georgia[e]				1978 ●	1989[d,f] ●			
Hawaii								
Idaho				1981 ●				
Illinois								
Indiana				1985 ●			1985 ●	1985 ●
Iowa						1991 ●		1991 ●
Kansas		1991 ●	1991 ●	1991 ●				1991 ●
Kentucky								
Louisiana	○					1991 ●		
Maine	○	○	○	○		○	1990 ●	1990 ●
Maryland					1990 ●			
Massachusetts	○	○	○	○		○	○	○
Michigan		1976 ●	1956[f] ●	1956[f] ●				
Minnesota	○	○	○	○	○	○	○	
Mississippi				1956 ●				
Missouri			1989[d] ●			1989 ●	1989 ●	1989 ●

Continuation of coverage guarantees			Premium pricing reforms			Disclosure required of		
			Restrictions on					
When employers change insurers	When employees change employers	When insurers leave market	Premium ranges	Rate increases	Medical history used	Methods of rating and underwriting	Methods of classifying firms	Mandated benefits excluded
			○					
○	○	○						
1990 ●		1990 ●						1991 ●
1991 ●	1991 ●	1991 ●	1991 ●	1991 ●				
○	○		○	○		○	○	○
1991 ●			1991 ●	1991 ●	1991 ●	1991 ●		
1985 ●	1990 ●	1990[b] ●	1990 ●	1990 ●				
○		○	1991 ●	1991 ●		1991[c] ●	1991 ●	
1975 ●			1991 ●	1991 ●		1991 ●	1991 ●	○
1990[f] ●		1990[f] ●		1990 ●				
1990 ●								
1991 ●	1991 ●	1991 ●	1991 ●	1991 ●		1991 ●	1991 ●	1991 ●
1991 ●	1991 ●	1991 ●	1991 ●	1991 ●				
1990 ●	1990 ●	1990 ●						
1977 ●			○	1991 ●				1991 ●
1990 ●	1990 ●	1990 ●	○	1989 ●		1989[c] ●		○
1991 ●					1990 ●			1991 ●
○	○	○	○	○		○		
1990 ●		1990 ●						
1980 ●	1986 ●	1987 ●	○	○	○	○		
1982 ●	○		○	○				
	1986 ●	1982 ●				1989 ●		1990 ●

(Continued)

	Reforms for obtaining coverage					Reforms for renewing coverage		
		Restrictions on				Prohibitions against		
	Guaranteed issue	Occupation exclusions	Preexisting conditions exclusions	Preexisting conditions waiting periods	Medical history used	Cancellation due to medical history	New or extended exclusions at renewal	New waiting periods at renewal
Montana			1991 ●	1991 ●	1991 ●			
Nebraska			1989[d] ●	1991 ●		1991 ●	1991 ●	
Nevada								
New Hampshire	○							
New Jersey	○[f]	○[f]	○[f]	○[f]		○[f]		
New Mexico				1991 ●		1991 ●	1991 ●	1991 ●
New York				Pre-1980[f] ●		1991[f] ●		
North Carolina	1991 ●	1991[g] ●	1991[g] ●	1991[g] ●		1991 ●		
North Dakota	○	○	1989[d] ●	○	○	○	○	○
Ohio								
Oklahoma				1988 ●				
Oregon	1991 ●	1991[g] ●	1991[g] ●	1991[g] ●	1991[g] ●	1991 ●	1991 ●	1991 ●
Pennsylvania				1979 ●		1978 ●		1978 ●
Rhode Island				1991 ●				
South Carolina				1976 ●	1980 ●	1991 ●	1991 ●	1991 ●
South Dakota						1991 ●	1991 ●	
Tennesee				1955 ●				
Texas								
Utah								
Vermont	1991 ●	1991 ●	1991 ●	1991 ●	1991 ●	1991 ●	1991 ●	1991 ●
Virginia								
Washington						1986 ●		
West Virginia				1991 ●				1991 ●
Wisconsin		1991 ●				1991 ●		
Wyoming				1990 ●				

○ Proposed
● Adopted

Continuation of coverage guarantees			Premium pricing reforms			Disclosure required of		
			Restrictions on					
When employers change insurers	When employees change employers	When insurers leave market	Premium ranges	Rate increases	Medical history used	Methods of rating and underwriting	Methods of classifying firms	Mandated benefits excluded
1981 ●	1981 ●	1991 ●	1991 ●	1991 ●	1991 ●			1990 ●
			1991 ●	1991 ●		1991 ●	1991 ●	
1987 ●		1987 ●						1991 ●
1982[f] ●			○	○				
	○		○	○	○	○	○	
1988 ●			1991 ●	1991 ●		1991 ●		
1973[f] ●	1986 ●			1991[f] ●				
		1991 ●	1991 ●	1991 ●		1991 ●	1991 ●	1991 ●
○	○	○	1991 ●	1991 ●	○	1991 ●		1991 ●
1991 ●	1991 ●	1991 ●	1991 ●	1991 ●				
1991 ●	1991 ●							
1985 ●	1991 ●		1991 ●	1991 ●		1991 ●	1991 ●	
1989 ●	1989 ●	1989 ●	1991 ●	1991 ●	1991 ●	1991 ●	1991 ●	
						○		
1982 ●			○	○		○		
1989 ●	1991 ●	1989 ●	1953 ●	1953 ●		1991 ●	1991 ●	
								1990 ●
1991 ●				1991 ●			1991 ●	1991 ●
1972 ●			1991 ●	1991 ●				

Note: A blank cell means a state has not adopted or proposed this initiative.

[a] Connecticut's 1990 legislation applies only to small-group health care plans.
[b] Continuation of coverage required for pregnant women only.
[c] Legislation requires disclosure of rating methods only.
[d] Legislation prohibits exclusions for specific diseases.
[e] Georgia requires each insurer to pool all of its small-group claims experience when determining premium rates.
[f] Established by insurance regulation rather than legislation.
[g] Measure included as part of guaranteed-issue legislation.

Figure VI.2: States With Mandated Benefit Waivers/Lower Cost Plans (Sept. 30, 1991)

State	State-mandated benefit waivers	Lower cost plans[a]	
		Voluntary private	State-mandated or state facilitated
Alabama			○
Alaska			
Arizona	1991 ●		1991 ●
Arkansas	1991 ●		1991 ●
California	○	●	○
Colorado	1991 ●	●	
Connecticut	○	●	1990 ●
Delaware			
Florida	1991 ●		1987 ●
Georgia	○	●	○
Hawaii			
Idaho			
Illinois	1990 ●	●	1990 ●
Indiana	[b]	●	○
Iowa	1991 ●		1991 ●
Kansas	1990 ●	●	1990 ●
Kentucky	1990 ●	●	1990 ●
Louisiana	○		○
Maine	○		○
Maryland	1991 ●	●	1991 ●
Massachusetts	○		○
Michigan	○	●	○
Minnesota	○		○
Mississippi			
Missouri	1990 ●	●	1990 ●
Montana	1991 ●		1991 ●
Nebraska			
Nevada	1991 ●		1991 ●
New Hampshire	○		○
New Jersey	1991 ●		1991 ●
New Mexico	1991 ●		1991 ●
New York	○		1988[c] ●
North Carolina	1991 ●	●	1991 ●
North Dakota	1991 ●		1991 ●
Ohio	○	●	
Oklahoma	1990 ●	●	1990 ●
Oregon	1991 ●	●	1987 ●
Pennsylvania			○
Rhode Island	1990 ●	●	1990 ●
South Carolina			
South Dakota		●	
Tennesee	○		○
Texas	○		○
Utah		●	
Vermont			
Virginia	1990 ●	●	1990 ●
Washington	1990 ●		
West Virginia	1991 ●		1991 ●
Wisconsin	○	●	○
Wyoming		●	○

○ Proposed
● Adopted (or in the case of private plans, established)

[a] Lower cost plans include basic benefits plans, which exempt some or all mandated benefits, and other state-facilitated or private plans, which provide insurance coverage at lower premium rates.
[b] Indiana has few mandated benefits and stated that none of those benefits has significant impact on premium costs.
[c] A proposal for the creation of a state wide basic benefit plan was introduced in 1991. Current legislation applies only to small-group health care pilot projects.

Figure VI.3: States With Subsidies (Sept. 30, 1991)

State	Subsidies to: Employers	Employees	Insurers	Tax credits	Premium tax waivers
Alabama					1971 ●
Alaska	○				
Arizona			1986 ●		
Arkansas					○
California	○	○	○	1988 ●	
Colorado				○	
Connecticut[a]					1990 ●
Delaware					
Florida			1989 ●		
Georgia					
Hawaii					
Idaho					
Illinois				○	
Indiana					
Iowa					1991 ●
Kansas				1990 ●	1990 ●
Kentucky				1990 ●	
Louisiana				○	
Maine	1987 ●	1987 ●			
Maryland					
Massachusetts[b]	1988 ●	1988 ●		1988 ●	○
Michigan[b]	1987 ●			○	○
Minnesota	○	○		○	
Mississippi					
Missouri				○	
Montana				1991 ●	1991 ●
Nebraska					
Nevada					1991 ●
New Hampshire					
New Jersey				○	
New Mexico					1991 ●
New York	1988 ●				
North Carolina					1991 ●
North Dakota					
Ohio[b]	1989 ●	1989 ●			
Oklahoma				1990 ●	
Oregon	1987 ●		1987 ●	1987 ●	
Pennsylvania				○	
Rhode Island					
South Carolina				○	
South Dakota					
Tennesee				○	
Texas					
Utah					
Vermont					
Virginia					
Washington					
West Virginia					1991 ●
Wisconsin[b]		1988 ●		○	
Wyoming					

○ Proposed
● Adopted

[a] Connecticut's 1990 legislation applies only to small-group health plans.
[b] As of September 1991, Michigan, Ohio, and Wisconsin had terminated their subsidy programs. Massachusetts terminated its subsidy programs in March 1992.

Figure VI.4: States With Pooling (Sept. 30, 1991)

State	High-risk pools[a]	Reinsurance pools	Small-employer pools: Private	Small-employer pools: State facilitated
Alabama	○			
Alaska	○	○	●	○
Arizona	○		●	○
Arkansas	○			
California	1989 ●	○	●	○
Colorado	1990 ●		●	
Connecticut	1976 ●	1990[b] ●	●	1990[b] ●
Delaware			●	
Florida	1982 ●		●	1987 ●
Georgia	1989 ●		●	
Hawaii				
Idaho				
Illinois	1987 ●		●	
Indiana	1981 ●		●	
Iowa	1987 ●		●	
Kansas	○		●	
Kentucky	○		●	○
Louisiana	1990 ●	○	●	
Maine	1987 ●	○	●	
Maryland			●	
Massachusetts		○	●	1988 ●
Michigan		○	●	○
Minnesota	1976 ●	○	●	○
Mississippi	1991 ●		●	
Missouri	1990 ●	○	●	○
Montana	1985 ●		●	
Nebraska	1986 ●		●	
Nevada			●	
New Hampshire	○	○	●	
New Jersey	○		●	○
New Mexico	1987 ●		●	
New York			●	
North Carolina		1991 ●	●	
North Dakota	1981 ●			
Ohio	○	○	●	
Oklahoma	○		●	
Oregon	1987 ●	1991 ●	●	1987 ●
Pennsylvania			●	
Rhode Island	1975 ●		●	
South Carolina	1989 ●		●	1989 ●
South Dakota	○		●	
Tennesee	1986 ●		●	
Texas	1989 ●		●	
Utah	1990 ●		●	
Vermont		1991[c] ●	●	
Virginia			●	
Washington	1987 ●		●	
West Virginia			●	
Wisconsin	1981 ●	○	●	
Wyoming	1990 ●		●	○

○ Proposed
● Adopted (or, in the case of private small-employer pools, established)

[a] In some states, Blue Cross-Blue Shield organizations offer guaranteed-issue plans with open enrollment and thus act as insurers of last resort.
[b] Connecticut's 1990 legislation applies only to small-group health care plans.
[c] Vermont's legislation permits but does not establish a state reinsurance pool.

The Robert Wood Johnson Foundation Health Care for the Uninsured Program

The RWJF Health Care for the Uninsured Program (HCUP) provided over $6 million for developing and launching innovative public and private health care programs designed to improve access to health care for the uninsured. Eleven pilot projects became operational; nine focused on assisting uninsured small employers and their employees to obtain affordable health insurance. Because the program tested a variety of approaches nationwide, we refer to its projects in several sections of our report.

The nine HCUP projects experimented with a variety of approaches for reducing the cost of insurance premiums and making insurance more widely available. These approaches included subsidies, small-employer pooling, and lower cost health plans. Michigan's One-Third Share Plan, for example, provided premium subsidies to small employers who began offering health insurance. Another project, the Florida Health Access Corporation, pools small employers together and uses state subsidies to provide administrative and marketing services for providers and to pay a portion of providers' stop-loss insurance policies. A third project, the Shared Cost Option for Private Employers (SCOPE), uses managed care, high deductibles, and copayments to achieve a low-cost insurance plan for small employers in Colorado.

The pilot projects have reported premium rate reductions of as much as 50 percent, and have assisted some employers and employees in obtaining lower cost health insurance. Despite their success in reducing premiums and enrolling over 26,000 individuals as of November 1991, small-employer response to the projects has been modest. Even the most successful project has enrolled less than 17 percent of its target market.

The HCUP projects provided additional insights, including these:

- Marketing insurance plans to the small-group market is costly and time-consuming.
- Low-income employers and employees need additional subsidies to be able to afford reduced-cost health insurance.
- Premium subsidies are effective at targeting participation by low-income individuals.
- State assistance to providers with such functions as marketing or administration helps projects negotiate with providers for lower premiums.

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