MENDING THE FLAWS IN THE SMALL-GROUP MARKET

by W. David Helms, Anne K. Gauthier, and Daniel M. Campion

Prologue: One of the truths that has emerged from Washington's ongoing debate over reforming the small-group health insurance market is that the major obstacle to broader coverage is its unaffordability. But that has raised the question, What would be considered affordable insurance for a small employer? One of the interesting lessons that emerges from this paper written by David Helms and his colleagues at the Alpha Center, based on their experience directing The Robert Wood Johnson Foundation’s Health Care for the Uninsured Program, is that most small employers are not interested in making health insurance available for their workers, even if premium reductions and eraging between 25 and 50 percent below prevailing rates are offered. The authors view the result as an important message: “While it is clear to us that voluntary efforts to expand coverage, particularly in the small-group market, will not achieve universal access, our society has to date been unwilling or unable to move to a mandatory system.” Helms is president of the Alpha Center, a Washington-based health policy center that he started in 1976. Helms holds a doctorate in public administration and economics from Syracuse University. Anne Gauthier, who formerly worked for the congressional Office of Technology Assessment and the National Leadership Commission on Health Care, is associate director of the Alpha Center. She holds a master’s degree in health administration from the University of Massachusetts. Daniel Campion, an associate at the Alpha Center, received a master’s degree in public and private management from Yale University. The Alpha Center directs two major programs for The Robert Wood Johnson Foundation: the State Initiatives in Health Care Financing Reform Program and the Health Care Financing and Organization Initiative.
The number of uninsured Americans poses a problem of increasing national importance, which is concentrated in the small-business portion of our employer-based health insurance market. Three out of four uninsured persons are employed or the dependents of employees; of these working uninsured, two-thirds are employed in businesses with twenty-five or fewer employees, and about half are in businesses with fewer than ten employees. Any attempts to achieve universal access must recognize that the small-group insurance market is fundamentally flawed and must mend those flaws or replace it with a new system.

Given Americans' preference for pluralism and our government's incremental approach toward change, it is not surprising that we tend first to try solutions for fixing the current employer-based market while avoiding government mandates. The Robert Wood Johnson Foundation's Health Care for the Uninsured Program undertook this approach, demonstrating what might be accomplished by public/private partnerships. The program was designed to test innovative, incremental strategies for expanding coverage to specific target groups, rather than attempting to enroll all uninsured persons in a given area. The foundation was particularly interested in projects that showed good potential for achieving permanent financing and could be replicated elsewhere. With these selection criteria, virtually all of the projects selected sought to develop or use more affordable and available new insurance products. Their strategies varied, but for the most part, they chose to focus on small businesses, the self-employed, and individuals.

Fifteen grants totalling over $6 million were awarded. Of these, eleven projects reached the operational stage: Ten have either developed new insurance products or subsidized existing products, and one has developed a health insurance information and referral service (Exhibit 1). Today, although grant funding has ended, eight of the projects offering insurance remain operational. Over 48,000 persons are enrolled, including about 26,000 from 5,500 firms, most of whom were previously uninsured because of the lack of affordable and available insurance.

This paper reports on five years of program experience and draws implications from those efforts to inform the current debate on how to improve financial access. Our conclusions are limited by the nature of this demonstration program: a collection of what could be construed as eleven related case studies with varying data available for each site. Even with this important caveat, the numbers are low in absolute and relative terms. Despite premium reductions averaging between 25 and 50 percent below prevailing rates, no single site that targeted small employers has yet enrolled over 10,000 persons, and most have yet to reach even 10 percent of their target market.
We briefly describe what we learned about the problems associated with the high rate of uninsured persons among small businesses. We then review the strategies the demonstration projects have pursued and examine their results. Finally, we explore what policymakers can learn as they consider ways to expand coverage for the uninsured.

### Problems With The Small-Group Insurance Market

Given this country's strong tradition for providing health insurance through the workplace, most of the projects conducted surveys of small
businesses in their areas to understand more thoroughly the nature of the small-business insurance market, the characteristics of these small employers and their employees, and their reasons for not offering insurance. The cost of insurance emerged as the major obstacle for small firms (Exhibit 2). Many small businesses have thin profit margins and thus fewer resources to pay for premiums. Cash flow is tight, and the uncertainty of both future income and expenses leads many new or marginal business owners to avoid the fixed cost of monthly insurance premiums. Seasonal businesses experience wide fluctuations in revenues, expenses, and employment levels. Also, many low-wage employees hired by these firms would not be able to contribute very much to the cost of insurance premiums even if coverage were available.

A major part of the cost problem is that small employers are usually charged more than large employers for comparable benefits. When setting premiums, insurers estimate administrative expenses at about 40 percent of claims for the smallest plans (one to four employees) and about 5.5 percent of claims for the largest (10,000 or more employees). The need to establish and service accounts and to market plans to different firms accounts for much of the difference. For example, insurers' expenses for general administration are about 12.5 percent of claims for the smallest plans, compared with 0.7 percent for the largest, and 8.4 percent for selling and commission costs, compared with 0.1 percent.

Another critical factor that prompts insurers to raise premiums and limit the availability of their products is the perception that small groups

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**Exhibit 2**

Relative Importance Of Reasons Given By Small Employers For Not Offering Health Insurance To Employees

<table>
<thead>
<tr>
<th>Factor in decision not to offer insurance</th>
<th>Relative importance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost</strong></td>
<td></td>
</tr>
<tr>
<td>Too expensive</td>
<td>1</td>
</tr>
<tr>
<td>Firm not sufficiently profitable</td>
<td>4</td>
</tr>
<tr>
<td><strong>Work-force considerations</strong></td>
<td></td>
</tr>
<tr>
<td>Many employees insured elsewhere</td>
<td>2</td>
</tr>
<tr>
<td>Employees can be hired without providing insurance</td>
<td>3</td>
</tr>
<tr>
<td>Employees don't want insurance</td>
<td>5</td>
</tr>
<tr>
<td>High employee turnover</td>
<td>8</td>
</tr>
<tr>
<td><strong>Insurance market</strong></td>
<td></td>
</tr>
<tr>
<td>Cannot find an acceptable plan</td>
<td>6</td>
</tr>
<tr>
<td>Company turned down because too small</td>
<td></td>
</tr>
<tr>
<td>Lack of information or difficulty in judging plans</td>
<td>9</td>
</tr>
<tr>
<td>Employees cannot qualify because of preexisting conditions</td>
<td>10</td>
</tr>
<tr>
<td>Company turned down because of type of business</td>
<td>11</td>
</tr>
</tbody>
</table>

**Source:** Alpha Center analysis of data from surveys conducted by grantees under The Robert Wood Johnson Foundation’s Health Care for the Uninsured Program.
pose higher risks than large groups. In part, the risk stems from the statistical phenomenon that risk can be spread more widely in a pool with a large number of enrollees than in one with fewer enrollees. Part of the markup, however, is also due to insurers' fears that small employers who have sicker employees are more likely to apply for insurance, a practice known as adverse risk selection, and that low-wage workers are more likely to consume more health care. In setting premiums, insurers build in a margin of 8.5 percent of claims for risk and profit for groups of one to four employees, compared with 1.1 percent for the largest groups.  

Fragmentation of the private insurance market has contributed to the high cost of insurance for many small firms. For a variety of reasons, our country has moved away from the simple concept of using one insurance pool for everybody in a geographic area. Many larger firms saw the clear advantages of self-insuring to cover the claims of their employees who were often healthier than the general population. Today, self-funded plans cover about one-third of privately employed full-time workers who have employer-sponsored health coverage. In the rest of the market, some relatively healthy groups get better-than-average rates, some cannot find an affordable plan, and others are excluded from coverage or are sharply restricted in what they can buy. The Employee Retirement and Income Security Act (ERISA), passed by Congress in 1974, exempts self-insured businesses from state insurance regulations that govern underwriting practices, minimum benefits requirements, premium taxes, and the like. In so doing, ERISA -exacerbates market fragmentation.

While not as significant as cost, problems with the insurance market were also cited by a number of small firms to explain why they do not offer insurance (Exhibit 2). First, insurers' methods of marketing insurance are not designed to meet the needs of small businesses. Many small employers say they cannot find an “acceptable plan” and often lack information or have difficulty judging plans. Small employers often lack staff to administer employee benefits and are generally less familiar with the options. Similarly, insurance brokers often find it difficult to schedule appointments with small employers to talk about health plans because the employers are consumed by business demands. The projects found these to be significant obstacles.

The final set of reasons for not offering health benefits relate to insurers' practices of excluding certain individuals or groups deemed high risk. Small employers said they were turned down because they were too small, their employees had preexisting medical conditions, or their type of business was considered high risk. Insurers commonly use a number of practices, including medical underwriting, that narrow the availability of insurance coverage for many small firms and individuals.
Given the way the insurance market is now structured, insurers still have a strong incentive to compete on the basis of selecting lower-risk cases.

Key Strategies To Improve Affordability Of Insurance

The projects' market research findings confirmed that barriers to both affordability and availability prevent small employers from obtaining health insurance. While these projects could not overcome all of the barriers, they attempted to make their insurance products both more affordable and available. There are two basic ways to lower the cost of insurance: either offer less coverage or provide subsidies. Projects unable to offer state subsidies had to rely on limiting the scope of services covered in their plans, increasing cost sharing, using very limited provider networks, or securing substantial discounts from hospitals. Projects that chose to use direct and indirect subsidies to reduce the cost of their plans generally provided more comprehensive benefits with only modest cost sharing. Each project used a mixture of the various strategies described below for making insurance more affordable (Exhibit 3).

**Limited benefits.** Projects that chose to cut premiums by limiting benefits used one of two approaches: (1) eliminating certain services from the benefit package, such as mental health care, alcohol and substance abuse treatment, dental and vision care, podiatry and chiropractic services, durable medical equipment, and transplants; or (2)

### Exhibit 3
Strategies For Making Health Insurance More Affordable

<table>
<thead>
<tr>
<th>Project</th>
<th>Limited benefits options</th>
<th>Major cost sharing</th>
<th>Very limited provider network</th>
<th>Subsidy option</th>
<th>Link to state high-risk pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Alabama Coalition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(BasicCare)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arizona (Health Care Group)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado (SCOPE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida Health Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MaineCare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan (One-Third Share Plan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee (MedTrust)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah (Community Health Plan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington (Basic Health Plan)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Wisconsin (Maximization Project)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Source: Alpha Center analysis of the projects.

* Project is sponsored by state government.
limiting the volume of covered services per year, such as the number of days for inpatient services or visits for outpatient services.

The most limited benefits package developed under the Health Care for the Uninsured Program is Alabama's BasicCare. In the absence of state subsidy funds, the project designed a plan that covers ten inpatient days and six physician office visits per year (plus diagnostic x-ray and laboratory services, prescription drugs, outpatient surgery, ambulance and emergency room services, and limited home health and skilled nursing facility services). BasicCare is the only group insurance plan designed under the program that required waivers from a state's mandated-benefits laws to be licensed. Although BasicCare has been offered for nearly two years in Birmingham, demand has been lower than anticipated, with fewer than fifty previously uninsured firms enrolling.

Through surveys and focus groups, the projects found that small employers generally want benefit packages similar to those of large employers. They believe that hospitalization coverage is an essential feature and are not interested in plans that substantially limit this benefit. The projects responded by fashioning plans that cover hospital services but also saw the importance of promoting preventive and primary care by limiting cost sharing for those services.

**Major cost sharing.** Another benefit design strategy for reducing premiums is to require patients to pay for a portion of the health care services they receive, in the form of either deductibles and coinsurance charges or copayments. Two projects—Colorado's SCOPE and the Utah Community Health Plan—require major cost sharing for hospital inpatient care and other costly services while encouraging enrollees to seek preventive and primary care by limiting cost sharing for those services.

The Colorado project is the only demonstration that designed a new indemnity insurance mechanism for small groups, offering very affordable preventive and primary care services and good catastrophic coverage. The plan covers certain preventive services free of charge, including routine physicals, well-baby visits, and immunizations. Most other doctors' office visits require a $15 copayment (if a procedure is performed, the enrollee pays 50 percent). Enrollees must pay a $250 deductible and 50 percent of the next $5,000 in charges for hospital inpatient services, outpatient surgery, and certain other services. The annual out-of-pocket maximum for these services is $2,750 per enrollee. SCOPE costs about 40 percent less than traditional indemnity plans and now has nearly 8,000 enrollees in the Denver market.

The Utah Community Health Plan also uses both copayments and coinsurance mechanisms to lower premiums. For example, the project's high-option plan requires enrollees to pay $150 per day for the first four
days of a hospital stay, and the low-option plan requires $200 per day for all days in the hospital. After detecting that a number of enrollees were misusing the emergency department by going there for nonemergency care, the project changed its cost-sharing provision for emergency services from a flat $50 copayment to 50 percent coinsurance; coverage under the low-option plan is also subject to a $300 deductible. The plan has enrolled about 1,700 members in the Salt Lake City area.

**Limited provider network.** All of the projects that developed new insurance plans use health maintenance organizations (HMOs) or preferred provider organizations (PPOs) to manage care. The Utah, Alabama, and Tennessee demonstrations further restrict enrollees' freedom of choice by channeling them to a limited group of less costly providers, including community-based clinics and/or public hospitals.

When given a choice between a very limited network of public providers and a broader network that includes private providers, most of the employers purchasing BasicCare in Birmingham, Alabama, have selected the private option. BasicCare's "public option" network comprises five county-run clinics for primary care services and the county-run hospital for most acute care services. Over 80 percent of the enrolled groups have opted to pay about 40 percent more in premiums to gain access to BasicCare's "private option" network, which has four additional private hospitals, plus university-based primary care physicians.

**Premium subsidies.** Direct premium subsidies encourage the purchase of health insurance by directly paying a portion of the designated premiums for individual small employers and/or their employees. Direct subsidies are provided only to those least able to pay for coverage. In four state-sponsored projects-Maine, Michigan, Washington, and Wisconsin-the state government provides direct premium subsidies for low-income enrollees using a sliding fee scale. The Florida project uses state funds to "buy down" the cost of coverage for employees' dependents.

Indirect subsidies facilitate the purchase of insurance by reducing the premiums charged to the entire small-group market. Indirect subsidies reduce insurers' costs by performing or subsidizing administrative, marketing, and pooling functions or by reducing the threat of adverse risk selection by paying for or facilitating the purchase of reinsurance or by providing stop-loss protection (in effect, a ceiling on catastrophic expenses). The Florida Health Access Corporation indirectly subsidizes the costs of pooling small employees into a single, organized buying cooperative. Arizona, Florida, and Maine have been able to lower premiums through a combination of these indirect subsidy mechanisms.

A key to the Florida project's success is its ability to carry out administrative functions commonly provided either by the employee benefits
department in a large company or by the indemnity or managed care plan. Staff members assist new enrollees in preparing their applications, perform limited underwriting, and calculate premiums. The project maintains membership records, collects monthly premiums from participating businesses, and pays the contracted plan in a monthly lump sum. Plans are thus able to treat the Florida Health Access Corporation as if it were a single large company, rather than a multitude of small businesses. The Florida project has its market clout to negotiate broader benefits, restrict underwriting, and lower premiums.

The marginal cost of enrolling a new member in a buying cooperative's plan is relatively small. Once the potentially high start-up costs of establishing the buying cooperative organization are met, the per capita costs for these operations decrease as enrollment increases. In contrast, a project that relies on direct premium subsidies pays the same amount to lower the cost for each new enrollee as for the first enrollee.

Projects using indirect subsidies have received more consistent and ongoing support from their state legislatures than those that rely exclusively on direct premium subsidy strategies; The Florida, Maine, and Arizona projects have each used cash and in-kind contributions to develop unique new health insurance products, negotiate underwriting contracts with HMOs, develop administrative systems, and market their plans extensively. In contrast, the Michigan and Wisconsin projects essentially provided direct subsidies to small firms to defray the cost of buying existing products for their low-wage workers; when these states experienced serious fiscal problems, they canceled their projects. This suggests that programs relying on direct premium subsidies alone may be more vulnerable than programs using indirect subsidies.

According to Ree Sailors, executive director of the Florida Health Access Corporation, the Florida project provides a better “match” for state funds than the Medicaid program. Sixty-six percent of the project's premium dollars come from employers, and only 37 percent come from the state. The project takes dollars that would have been spent sporadically on episodic health care and prudently marshals them, with the assistance of state dollars, into a program providing year-round coverage that includes preventive care, primary care, prenatal care, and hospitalization—all of the comprehensive benefits of an HMO package.

Provider discounts. Most projects have negotiated discounts from providers, especially hospitals. In return, the project channels patients to participating hospitals, and these hospitals receive payment for treating patients who might otherwise be uninsured and unable to pay. The Tennessee project negotiated an 80 percent discount on inpatient services from the Regional Medical Center in Memphis. In Salt Lake City,
six hospitals give the Utah Community Health Plan a 35 percent discount off billed charges for the first thirty days of an enrollee’s stay and waive all charges for additional days. While provider discounts can help to lower premiums significantly, projects have found it difficult to replicate such commitments when trying to expand into other communities.

Link to state high-risk pool. At least twenty-seven states have enacted laws to create high-risk insurance pools to cover individuals considered by insurers to be high risk or “uninsurable.” In the Maine and Wisconsin projects, the state government contributes to the premium payment for low-income, high-risk employees. This mechanism allows high-risk individuals to obtain additional financial assistance and permits the rest of the group to be offered coverage at a better price.

Strategies For Making Health Insurance More Available

These demonstrations were limited in their ability to address insurers' underwriting and exclusionary practices, which will require systemwide reform of the small-group health insurance market. While highlighting the need for insurance market reforms, the projects have made important strides in testing new mechanisms for creating larger and more stable insurance pools and marketing to uninsured small firms.

Limited medical underwriting and industry exclusions. The projects sought to limit the exclusionary practices used by many insurers to reduce the perceived risks of the small-group market. For example, the Arizona project created a new insurance product with no medical underwriting, and the Florida project permits women to obtain coverage through their sixth month of pregnancy. The projects did not exclude as many types of small businesses as is now common in the small-group market, and some included businesses in their first year of operation.

Larger, more stable insurance pools. Creating larger and more stable insurance pools makes insurance more available to uninsured small employers by spreading the risk more broadly and thereby lowering the cost of premiums. This strategy requires indirect subsidies to offset project design costs, administrative costs, and reinsurance premiums until the number of enrollees is large enough to make the cost per enrollee negligible, or at least closer to the administrative and reinsurance costs of large-group plans. Florida has created a buying cooperative for formerly uninsured small businesses; several projects have implemented risk-sharing and reinsurance mechanisms for developing these pools.

Innovative, aggressive marketing and advertising. In general, the projects found that uninsured small employers are a very “tough sell.” Insurers' traditional marketing methods are less effective in the small-
business market. Uninsured small employers are hard to reach, and
without full-time benefits managers on their staff, they require more
education and information, follow-up, and support, especially during the
application process. The most successful projects have used professional
advertising firms to develop marketing materials and campaigns and
have used public relations efforts to generate additional media coverage.
Those that have not invested substantially in marketing and public
relations have generally had disappointing enrollment growth.

A major reason for SCOPE’s marketing success in Colorado has been
its ability to engage the media, not merely as purveyors of advertising,
but as partners in reaching the target market. The project asked Den-
ver’s newspaper, radio, and television executives to donate substantial
advertising time and space. While the project spent approximately
$177,000 on its initial and follow-up advertising campaigns, it received
$80,000 to $90,000 in contributed media time and space. Many of the
projects have also used public relations efforts effectively to generate
television stories and newspaper articles about their initiatives. Such
reports can often explain the unique features of their products more
thoroughly and identify the target population more clearly than brief
media advertisements. Generating this coverage, however, requires sub-
stantial staff time to cultivate reporters and producers. Through these
cooperative arrangements, these projects have been able to use their
limited resources as leverage for more extensive marketing efforts.\(^8\)

Results Of The Projects

The results of these projects vary greatly, in terms of both enrollment
and market penetration. However, these results are also subject to differ-
ent interpretations, depending upon whether the reader is measuring
success in terms of covering the uninsured or in convincing policymak-
ers and the insurance industry that, with some changes in how insurers
do business, there is a profitable untapped market for their products.

**Premiums.** All of the projects offer premiums significantly below
national averages for HMO benefit plans (Exhibit 4). For the plans
targeted at uninsured small businesses, the premiums ranged from 9 to 60
percent below market rates, with most ranging from 25 to 50 percent
below market rates. Premium data on the Washington Basic Health Plan
show that subsidizing a comprehensive health plan for individuals below
200 percent of the poverty level can be very expensive. Since the Basic
Health Plan is not offered through employers, there are no employer
contributions to the premium. The program uses a substantial state
subsidy to reach the lowest-income persons. For those with incomes
**Exhibit 4**
Monthly Premiums For Demonstration Project Health Plans, As Of 1 January 1992

<table>
<thead>
<tr>
<th>Insurance product</th>
<th>Adult, age 35</th>
<th>Approximate discount below local market rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single (^a)</td>
<td>Family (^b)</td>
</tr>
<tr>
<td>Alabama (BasicCare)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private option</td>
<td>$ 73.96</td>
<td>$186.32</td>
</tr>
<tr>
<td>Public option</td>
<td>45.07</td>
<td>110.86</td>
</tr>
<tr>
<td>Arizona Option A</td>
<td>99.72</td>
<td>318.63</td>
</tr>
<tr>
<td>Colorado (SCOPE)</td>
<td>74.40</td>
<td>212.69</td>
</tr>
<tr>
<td>Florida Health Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High option</td>
<td>105.44</td>
<td>289.25</td>
</tr>
<tr>
<td>Standard option</td>
<td>98.00</td>
<td>269.14</td>
</tr>
<tr>
<td>MaineCare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-100 percent of poverty</td>
<td>55.97</td>
<td>167.34</td>
</tr>
<tr>
<td>201% or more of poverty</td>
<td>111.93</td>
<td>334.67</td>
</tr>
<tr>
<td>Tennessee (MedTrust)</td>
<td>71.98</td>
<td>194.18</td>
</tr>
<tr>
<td>Utah Community Health Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High option</td>
<td>73.29</td>
<td>216.78</td>
</tr>
<tr>
<td>Low option</td>
<td>66.27</td>
<td>196.39</td>
</tr>
<tr>
<td>Washington (Basic Health Plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-74% of poverty</td>
<td>7.50</td>
<td>22.50</td>
</tr>
<tr>
<td>200% or more of poverty</td>
<td>95.00</td>
<td>290.00</td>
</tr>
<tr>
<td>National HMO average</td>
<td>113.40</td>
<td>354.28</td>
</tr>
</tbody>
</table>

**Source:** Alpha Center compilation of data submitted by the projects.

\(^a\) Premiums for male only. Premiums may vary by age and sex.

\(^b\) Two adults plus children. Some plans offer lower rates to single-parent families.

Below 75 percent of poverty, the rates are about 94 percent below the prices that HMOs might charge for a similar benefit package, if such a plan were offered to individuals in the open market.

**Enrollment.** In total, the projects have enrolled over 48,000 persons, which includes about 26,000 employees and dependents through 5,500 small businesses and 22,000 individuals through the Washington Basic Health Plan (Exhibit 5). The projects appear to be the most attractive to very small employer groups: the average firm size is 2.8 employees and the average group, 4.9 persons (including employees and dependents).

The Florida and Colorado projects together have two-thirds of the program's total small-group enrollment. Both projects have plans available in multiple markets and have devoted significant resources to sophisticated marketing and public relations efforts. The Florida project is available in four sites covering sixteen of Florida's sixty-seven counties, and SCOPE is now available in all of Colorado's major population centers. Next highest is Arizona's Health Care Group, which is available in three sites and has devoted considerable resources to marketing.

Washington's Basic Health Plan, which enrolls only individuals, has
### Exhibit 5
**Enrollment And Size Of Firms In Demonstration Project Health Plans, As Of 1 January 1992**

<table>
<thead>
<tr>
<th>Project</th>
<th>Months enrolling</th>
<th>Persons enrolled</th>
<th>Firms enrolled</th>
<th>Average firm size&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Average group size&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Health Care Group</td>
<td>48</td>
<td>4,413</td>
<td>1.424</td>
<td>-c</td>
<td>3.1</td>
</tr>
<tr>
<td>Maine Managed Care Insurance Demonstration (MainCare)</td>
<td>37</td>
<td>1,593</td>
<td>522</td>
<td>2.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Washington Basic Health Plan&lt;sup&gt;d&lt;/sup&gt;</td>
<td>36</td>
<td>22,000</td>
<td>-</td>
<td>c</td>
<td>c</td>
</tr>
<tr>
<td>Tennessee Primary Care Association (MedTrust)</td>
<td>33</td>
<td>844</td>
<td>209</td>
<td>2.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Florida Health Access Corporation</td>
<td>31</td>
<td>9,635</td>
<td>2,206</td>
<td>2.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Colorado (SCOPE)</td>
<td>28</td>
<td>7,838</td>
<td>718</td>
<td>4.5</td>
<td>10.1</td>
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<tr>
<td>Utah Community Health Plan</td>
<td>27</td>
<td>1,689</td>
<td>289</td>
<td>2.5</td>
<td>5.8</td>
</tr>
<tr>
<td>Central Alabama Coalition for the Medically Uninsured (BasicCare)</td>
<td>21</td>
<td>341</td>
<td>44</td>
<td>5.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

**Source:** Alpha Center compilation of data submitted by the projects.

**Note:** This exhibit does not include two demonstrations that have ended. Michigan's One-Third Share Plan discontinued its subsidies in March 1991, with enrollment having reached approximately 1,100 persons from 200 firms. Wisconsin's Small Employer Health Insurance Maximization Project ended subsidies in June 1991, with enrollment having reached 319 persons from 82 firms.

<sup>a</sup> Firm size data include all employees in a firm, whether or not they are enrolled in the project's insurance program. Because of data collection constraints, Colorado (SCOPE) has reported only the number of enrolled employees, and Utah has estimated its figure.

<sup>b</sup> Group size data include enrolled employees and their dependents.

<sup>c</sup> Not available.

<sup>d</sup> Enrollment growth is constrained to 22,000 by a state budgetary ceiling; about 20,000 more persons are on the waiting list.

Capped enrollment at approximately 22,000, because of limited state subsidy funds. The project demonstrates the great appeal of offering a very highly subsidized insurance product directly to individuals. In just over two years of operation and with a minimal marketing budget, the project has enrolled far more people than any of the employer-group demonstrations. When such a publicly subsidized product is offered to individuals, however, some employers may perceive that it is not their responsibility to offer group coverage to their low-wage employees.

**Market penetration.** We asked the project directors to estimate the level of “market penetration” the projects have achieved. We define market penetration as the ratio of the number of firms or persons enrolled in the project’s plan(s) to the number of firms or persons in their target market. The projects define their target populations differently (Exhibit 6). They also did not use uniform data in making their estimates. While they all know precisely the number of firms or persons enrolled (the numerator), deriving an accurate estimate of the number of uninsured small firms and the numbers of uninsured persons associated with these firms (the denominator) is problematic. In calculating...
### Exhibit 6
**Target Market And Market Penetration Of Demonstration Projects**

<table>
<thead>
<tr>
<th>Project</th>
<th>Target market</th>
<th>Site</th>
<th>Months enrolling</th>
<th>Percent of uninsured firms/individuals enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>BasicCare (Alabama)</td>
<td>Uninsured firms with three or more employees that have not offered coverage in past twelve months</td>
<td>Birmingham</td>
<td>21</td>
<td>0.1%</td>
</tr>
<tr>
<td>Health Care Group (Arizona)</td>
<td>Uninsured firms with forty or fewer employees that have not offered coverage in past six months</td>
<td>Tucson/Pima Co., Cochise Co., Phoenix/Maricopa co.</td>
<td>48, 24, 21</td>
<td>5.5%, 10.9%, 4.0%</td>
</tr>
<tr>
<td>SCOPE Colorado</td>
<td>Insured firms with fewer than twentyfive employees, although any employer with fewer than fifty employees is eligible</td>
<td>Denver (although available in all major population centers)</td>
<td>28</td>
<td>3.7%</td>
</tr>
<tr>
<td>Florida Health Access Corporation</td>
<td>Uninsured firms with fewer than twenty employees that have not offered coverage in past six months</td>
<td>Tampa, Gainesville, Tallahassee, Orlando</td>
<td>29, 13, 11, 5</td>
<td>5.0%, 6.2%, 6.3%, 1.7%</td>
</tr>
<tr>
<td>MaineCare</td>
<td>Uninsured firms with fifteen or fewer employees that have not offered coverage in past twelve months</td>
<td>Bach/Brunswick, Skowhegan/Somerset Co.</td>
<td>37, 12</td>
<td>17.9%, 12.0%</td>
</tr>
<tr>
<td>One-Third Share Plan (Michigan)</td>
<td>Uninsured firms with fewer than twenty employees that employ a former Medicaid or general assistance client and have nor offered coverage in the past twenty-four months, although eligible firms of any size may enroll</td>
<td>Marquette and Genesee counties combined</td>
<td>27</td>
<td>6.7%</td>
</tr>
<tr>
<td>Utah Community Health Plan</td>
<td>Uninsured firms with fewer than twenty employees that have not offered coverage in past twelve months</td>
<td>Salt Lake City</td>
<td>27</td>
<td>3.5%</td>
</tr>
<tr>
<td>Med Trust (Tennessee)</td>
<td>Uninsured firms with fewer than forty employees that have not offered coverage in past three months</td>
<td>Memphis</td>
<td>33</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

**Source:** Alpha Center compilation of data submitted by the projects.

**Note:** All enrollment data are as of 1 January 1992 except the following: Florida Health Access, 1 November 1991; and Michigan, 3 August 1990.

*Because of a lack of baseline data on the number of uninsured self-employed individuals, this penetration rate estimate excludes the significant number of self-employed individuals enrolled in MaineCare (approximately 60 percent of enrolled firms); it includes only firms with two to fifteen employees.

Their market penetration rates, project directors used their project's survey of small employers, together with national and state surveys of the uninsured, to determine estimates for their target market. The methodology used is not uniform across sites, but the results show a consistent
pattern of reaching only a small proportion of the working uninsured. These low penetration figures may be due to several factors. Some projects are still relatively new and will need more time, perhaps several years, to reach their full potential. In general, the projects have reported higher penetration percentages in their smaller and more rural sites than in larger urban centers. The highest penetration rate of any project—17.3 percent—is reported in the Bath/Brunswick community of Maine. Similarly, the Arizona project estimates that it has reached nearly 11 percent of the uninsured small-business market in rural Cochise County but only 5 percent in urban Tucson, where the project began operating two years earlier.

The projects have targeted the chronically uninsured. All but one project (Colorado's SCOPE) require enrollees to have “gone bare” for a minimum period of time preceding enrollment, ranging from six to twenty-four months. The projects have tried neither to compete with existing insurers for the markets these insurers now serve nor to attract employers who are shopping for a better deal at the time of renewal. Instead, they have sought the “residual” market made up of a heterogeneous group of very small firms that many indemnity insurers and HMOs have ignored or purposefully excluded from their main lines of business.

Unfortunately, the rapid inflation in health insurance premiums during this demonstration period consumed virtually all of the subsidy offered. During 1987–1989, while the projects were developing their plans, the average price of a group health insurance policy nationwide shot up 48 percent for individuals and 51.7 percent for families. Therefore, even though the projects were able to offer these premiums significantly below market rates, most of this subsidy effort merely shielded them from the consequences of such rapid premium increases.

Utilization. Early utilization experience of these projects indicates that insurers' fear of adverse selection for the small-group market may not be justified. These plans' initial use of health services is lower than anticipated and lower than national averages for three common measures of use of inpatient services: discharges per thousand members, inpatient days per thousand members, and average length-of-stay (Exhibit 7). For three projects—Arizona, Florida, and Utah—these statistics are below the averages for HMOs nationwide and even further below the overall national average for persons under age sixty-five. Maine reported lower figures for both discharges and inpatient days but an average length-of-stay between the HMO and national averages.

These early utilization experiences are positive signs for those seeking to broaden coverage to the currently uninsured, because they indicate that if these small groups are channeled into managed care plans, their
Exhibit 7
Use Of Inpatient Services Among Demonstration Project Health Plans

<table>
<thead>
<tr>
<th>Project</th>
<th>Dates of data collection</th>
<th>Annual hospital discharges per 1,000 members</th>
<th>Annual inpatient days per 1,000 members</th>
<th>Average length-of-stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Group (Arizona)</td>
<td>1/1/91 - 11/30/91</td>
<td>63.0</td>
<td>242</td>
<td>3.8</td>
</tr>
<tr>
<td>Florida Health Access Corporation</td>
<td>1/1/90 - 9/30/91</td>
<td>68.3</td>
<td>282</td>
<td>4.1</td>
</tr>
<tr>
<td>MaineCare</td>
<td>7/1/90 - 6/30/91</td>
<td>50.9</td>
<td>241</td>
<td>4.7</td>
</tr>
<tr>
<td>Utah Community Health Plan</td>
<td>1/1/91 - 9/30/91</td>
<td>30.3</td>
<td>74</td>
<td>2.2</td>
</tr>
<tr>
<td>Basic Health Plan (Washington)</td>
<td>1/1/91 - 12/31/91</td>
<td>91.8</td>
<td>376</td>
<td>4.0</td>
</tr>
<tr>
<td>HMO average&quot;</td>
<td>1989</td>
<td>72.2</td>
<td>316</td>
<td>4.3</td>
</tr>
<tr>
<td>National average&quot;</td>
<td>1989</td>
<td>93.7</td>
<td>499</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Source: Alpha Center compilation of data submitted by the projects. For data on health maintenance organization (HMO) and national averages, D. Hodges, K. Camerlo, and M. Gold, HMO Industry Profile, Physician Staffing and Utilization Patterns (Washington, D.C.: Group Health Association of America, September 1991), 18-24. HMO averages were derived using data from the GHAA Annual Survey; national averages, using data from the National Hospital Discharge Survey.

Note: Data for the Alabama, Tennessee, Michigan, and Wisconsin projects are not displayed because their enrollment was less than 1,000 members. Data from Colorado were not available.

a Under age 65.

use of hospital services, at least, may be no higher than that of large groups. Enrollment in the demonstration projects, however, is still relatively low, and further research is needed to adjust these data for health status, demographic characteristics, and other factors, to compare them more accurately with the utilization experience of enrollees in other plans. The Robert Wood Johnson Foundation is currently supporting research to examine utilization data from several of these demonstration projects and other pools of small businesses. These research projects are examining whether employees of small firms and individual health plan subscribers use more health care services than employees of large firms and groups, whether previously uninsured persons use more health care services once they receive coverage than those already insured, and whether medical underwriting really lowers insurance costs.

Implications For The Small-Group Insurance Market

As distinct from national demonstrations organized to test a single model or intervention, these projects used different strategies to make insurance more affordable and available. Taken as a whole, the projects' experiences offer a better understanding of the problem of uninsured workers and enable us to draw important implications for public policy.
These projects test whether small employers would buy a less expensive, more available product voluntarily. They also provide insight into whether the types of public/private partnerships used in these demonstrations could expand access substantially, short of major federal and/or state interventions to change the way health care is financed.

**Universal participation.** The major policy implication from these demonstrations is that efforts to expand the current employer-based insurance system are not likely to achieve universal financial access to health care without requiring universal participation. While public/private partnerships focused on the small-group market offer the prospect of using limited public dollars as leverage to attract employer and employee contributions, the results of these demonstrations suggest that it will be extremely difficult to achieve significant market penetration. To date, the highest penetration rate reported by any project is 17 percent of formerly uninsured employers; most others have attracted 10 percent or less. Although the projects did not test whether more extensive subsidies could result in higher penetration rates in the small-group market, we question whether subsidies greater than 50 percent are the most efficient way to solve this problem. A variety of obstacles must be overcome if all employers are to offer health benefits. The decision to begin offering health benefits is a decision to increase labor costs, but many small firms are forced to minimize costs to stay in business. Competitive pressures are felt especially keenly by new firms and those in low-margin industries. Some employers can hire workers without offering insurance, a factor that varies widely by industry, region, local labor supply, and local economies.

Given our results, some may view employer mandate (play-or-pay) proposals as an attractive strategy for expanding health insurance coverage. While none of the demonstration projects tested an employer mandate explicitly, their experience tells us that it would be especially onerous to require all small employers to buy insurance in the current market. Even with the reform proposals being considered at the federal and state levels to make small-group insurance coverage more available, it would still be more costly to administer health insurance for small groups than for large groups. Under an employer-based system, we do not believe it is fair that employees in small firms are forced to pay more for health insurance than their counterparts in large firms. Thus, governmental support would be needed to consolidate the purchasing power of small businesses and to subsidize administrative costs, if the disparity between large and small groups is to be reduced.

Employer mandates would reduce insurers' fears that firms that purchase insurance are more likely to have employees with a current need
for health care. Employer mandates also would reduce the kinds of
intensive marketing efforts needed to locate small-business owners and
persuade them to offer health insurance, but would not eliminate the
need for more thorough educational and sales/support services than
insurers have traditionally provided. Also, mandates would not obviate
the need to assist low-income workers, especially those below 200 per-
cent of poverty. Finally, the projects' experience tells us that an em-
ployer mandate approach should not exclude firms with fewer than five
employees; this would fail to address a significant part of the problem.

Improving the current system. These demonstrations indicate that
before or until we achieve our apparent goal of providing universal
financial access to health care, some significant steps can be taken to
improve the current voluntary insurance system. If this country intends
to continue using employers as the basic mechanism for distributing
health insurance, policymakers must address three fundamental and
interrelated problems, already discussed, regarding the small-group
health insurance market: (1) the small-group health insurance market is
highly fragmented; (2) administrative costs are higher in the small-group
market than for larger groups; and (3) the majority of uninsured persons
can no longer afford the average cost of health insurance at today's rates.
Each step described below addresses one or more of these problems.

First, government regulations are needed to stabilize the small-group
market by limiting abusive rating practices, guaranteeing the availability
and renewability of coverage, and spreading excess cost of insuring
high-risk groups more broadly. While such regulations reduce barriers to
the availability of health insurance for small businesses, they do not
address the primary problem of affordability and are likely to raise costs
for some currently insured groups. Under these regulations, no small firm
would be denied coverage, and premiums for all groups would be con-
fined to a much narrower range than is now the case. If more average-
risk or higher-risk groups seek coverage, premiums for lower-risk groups
could rise over their current levels. On the other hand, preliminary data
from these projects suggest that an expanded pool of enrollees from small
groups may not result in significantly higher premiums.

Second, if the current employer-based system is to continue, govern-
ment can encourage the development of buying cooperatives, in which
small firms in the same geographic area consolidate their market power
and share administrative costs. Government could subsidize these ad-
ministrative costs to equalize the net costs to both small and large firms
for providing coverage to their employees. As the number of enrollees
grows, the marginal cost of these indirect subsidies per new enrollee
would drop. The Florida project can serve as a model for policymakers.
seeking to implement such a strategy. At the time of this writing, Florida Health Access had over 9,600 members (all previously uninsured); it is the fastest-growing of all of the demonstrations.

Third, governments can encourage aggressive marketing and education aimed at small firms. Employers report that some employees do not want health benefits. Low-wage workers, in particular, may prefer cash income to health benefits, and young "invincibles" feel they do not need insurance protection. Business owners may have an individual policy for themselves or know that key employees already have other coverage. Insurers have traditionally designed their marketing campaigns to target the large-group market, yet these techniques are generally not sufficient to meet the needs of small firms. A state could simplify small employers' task of shopping for an acceptable plan and reduce insurers' marketing costs by giving its "seal of approval" to a limited number of health plans in each market. Further public subsidies could support the marketing services needed to reach uninsured small firms and educate them about these select products. Policymakers can benefit from the innovative marketing practices tested by the Denver, Florida, and San Francisco demonstrations, in particular. Even with aggressive marketing, these projects found it very difficult to convince small-business owners to begin offering health care benefits.

Fourth, government subsidies can help low-income workers and their families to obtain health coverage in the current system. About 60 percent of uninsured persons under age sixty-five have incomes below 200 percent of the federal poverty level, and the premiums of an average HMO plan would consume at least 16 percent of gross income for such a person's family. Even after market reforms and indirect subsidies to small-group health insurance, insurance premiums would continue to be too expensive for many small employers and their low-wage employees.

The demonstration projects have tested specific mechanisms for targeting public dollars to lower health insurance premiums for the neediest workers. The Michigan and Wisconsin projects offer lessons on using income-based subsidies for employees with incomes below 200 percent of poverty. The Florida project shows how to subsidize the portion of the family premium used to cover an employee's spouse and children, because employers generally contribute less for dependent coverage than for the individual employee's coverage. The Maine project also has a mechanism for identifying and assisting financially vulnerable firms as well as self-employed individuals.

One drawback to relying on government subsidies is the potential for small employers not to enroll because they do not want to offer a benefit that they would have to take away if the subsidy were eliminated. This
fear was clearly justified in the Michigan and Wisconsin projects, where the legislatures cut off funding for direct premium subsidies amidst state fiscal crises. If governments want subsidies to work, they must provide assurance that the programs will be maintained.

Finally, in a voluntary system, it is also important to cover those employees not offered coverage by their employers, including part-time and seasonal workers. To cover these workers and their families, government should ensure that affordable individual coverage is available. It could approve and subsidize an existing product or create a new publicly supported insurance plan for those not covered through employers. The Washington Basic Health Plan is an example of how a state can successfully contract with managed care organizations in local markets to provide a uniform benefit package to families with incomes under 200 percent of poverty and use state funds to make that basic coverage affordable. Another option, which would require federal waivers, is to use Medicaid as the public fail-safe program open to all persons, with enrollees contributing premiums based on their ability to pay.

Concluding Thoughts

These demonstration projects have shown that it is possible to help some who want coverage to obtain it. If extending these strategies nationally could cover even 20 percent of the working uninsured, over 4.6 million people would gain financial access to care. While it is clear to us that voluntary efforts to expand coverage, particularly in the small-group market, will not achieve universal access, our society has thus far been unwilling or unable to move to a mandatory system. As various options are debated and tried, the lessons learned by these projects should prove useful. Furthermore, these projects provide objective information about a segment of the health insurance market-the small-group market-which until recently has received little attention.

While theory can suggest how a particular strategy for increasing access might work, we need the reality of demonstrations to illustrate how difficult implementation can be. The Robert Wood Johnson Foundation's Health Care for the Uninsured Program shows how easily it is to underestimate the operational complexities of achieving reform. Further experimentation is needed. This will require encouragement and flexibility from the federal government, leadership and creativity from the states, and the technical expertise and support of the private sector. Such programs would provide further lessons for policymakers and valuable data for designing the details of future national proposals. Further experimentation will help this country resolve its long-standing struggle
over how to best achieve our generally accepted goal of providing universal access to care for all Americans.

The views expressed in this paper are those of the authors; endorsement by The Robert Wood Johnson Foundation is not intended and should not be inferred. The authors gratefully acknowledge the commitment and hard work of the project staff who undertook the challenge of developing these innovative programs for uninsured small businesses and individuals. Without their efforts, we would not have had the opportunity to monitor and report on their considerable progress. We also thank Nancy Barrand, Judith Glazer, and Stanley Jones for their helpful comments and advice. Finally, we appreciate the constructive comments from three anonymous reviewers.

NOTES

1. Authors’ calculations using data from the National Medical Expenditure Survey, as reported in P. Short, A. Monheit, and K. Beauregard, A Profile of Uninsured Americans, National Medical Expenditure Survey Research Findings 1, Pub. no. (PHS) 89-3443 (Rockville, Md.: National Center for Health Services Research and Health Care Technology Assessment, September 1989).

2. For more detailed information on the projects, see Health Care for the Uninsured Program Update, 1–12 (Washington, DC.: Alpha Center, 1986–1991).

3. The planning and development phase for what became known as the Washington Basic Health Plan was supported by The Robert Wood Johnson Foundation (RWJF) through a grant to Health Systems Resources under the Health Care for the Uninsured Program. The staff of the Basic Health Plan participated in workshops and meetings and received technical assistance materials as did other program grantees.

4. For more detailed information on the projects’ employer surveys, see D.M. Campion et al., “Meeting the Health Insurance Needs of Uninsured Small Businesses: Market Research and New Products,” Robert Wood Johnson Foundation Health Care Perspectives Series (March 1992). For a free copy, write to the RWJF Communications Office, P.O. Box 23 16, Princeton, New Jersey 08543-2316.


6. Ibid.


9. MaineCare project officials did not include self-employed individuals in calculating market penetration levels, because they have not been able to reliably estimate the number of uninsured self-employed businesses, even though these smallest of firms comprise about 60 percent of all “firms” enrolled by the project.


11. The average annual HMO family premium is about $4,250; twice the poverty level for a family of four is $26,800.