



Show Me Series: Report 10

Expanding Insurance Coverage for Workers in Small Businesses Lessons from Massachusetts and California

Prepared at The Urban Institute by Linda Blumberg, PhD, and John Holahan, PhD



The Missouri Foundation for Health (MFH) was created on January 6, 2000, as part of a negotiated agreement among Blue Cross/Blue Shield of Missouri (BCBSM), the Missouri Department of Insurance and the Missouri Attorney General following the for-profit conversion of BCBSM. The Foundation received a significant portion of the assets of RightChoice, the for-profit created by the conversion. MFH is dedicated to improving the health of the people in the BCBSM service area, which encompasses 84 Missouri counties and the City of St. Louis.

In support of its mission, MFH publishes the Show Me Series, which includes studies on a variety of health system issues as well as reports on statewide public opinion polling. These papers consider topics of significance to Missouri which have relevance both to other states and to the nation.

Preface

As health care costs continue to increase, businesses of all sizes face challenges in providing health insurance to their employees. Small businesses, in particular, are susceptible to high prices for health insurance products and are therefore less likely than large businesses to offer employer-sponsored insurance (ESI). As this study notes, only 57.3 percent of non-elderly workers in Missouri that work for firms with fewer than 24 employees have ESI, while 82.7 percent of non-elderly workers in Missouri that work for firms with 100 or more employees have ESI.

Increasing access to health insurance for small business employees has been a topic of discussion in many state legislatures, including Missouri's. The recent legislation in Massachusetts and the proposed legislation in California both address this topic within the context of broad health care reform. In an effort to inform the policy discussion regarding options to expand health insurance to workers in small businesses, the Missouri Foundation for Health has commissioned this study.

The analysis focuses on the impact of subsidies and mandates on access to health insurance for small business employees as well as on the applicability of a Massachusetts or California style reform in Missouri. It concludes with specific recommendations for Missouri, based on insights gained from the approaches taken in Massachusetts and California. We hope this study adds value to the discussion of how Missouri can expand health insurance coverage opportunities to its small business community.

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Expanding Insurance Coverage for Workers in Small Businesses: Lessons from Massachusetts and California

By Linda Blumberg, PhD, and John Holahan, PhD, of The Urban Institute

This paper describes state government efforts that encourage or require small businesses to provide health insurance to their workers. Massachusetts and California have enacted or proposed such approaches as part of more comprehensive reform packages. We begin by discussing the general issues that states face in subsidizing the purchase of coverage by either employers or individuals. We then outline the issues related to mandates for employers (that they provide some financing for health insurance coverage) and for individuals (that they enroll in coverage of some type). We also describe the rationale and options behind establishing a guaranteed source of insurance coverage under such reforms. Subsequently, we describe the approaches taken by Massachusetts and California, concluding with recommendations for Missouri.

The most common form of health insurance coverage in the United States is obtained through employers. But the likelihood of employer-sponsored insurance (ESI) increases with income and with the size of the firm in which an individual (or their spouse or parent) is employed. Low-income individuals are much less likely than high-income people to have an employer offer of insurance or to be eligible for ESI if their employer offers insurance to at least some workers. For example, in 2005, only 55 percent of workers with incomes below the federal poverty line (FPL) had an offer of coverage, and only 72 percent working for an offering firm were eligible to enroll (Table 1).¹ In contrast, 93 percent of those above 400 percent of FPL had an offer of coverage and 97 percent were eligible. Surprisingly, take-up rates are relatively high at all income levels. Of those below poverty, 63 percent of those who had an offer and were eligible for it enrolled in insurance, as did 78 percent of those between 100 and 199 percent of FPL. Of those above 400 percent of FPL, 84 percent took up the offer of coverage.

The likelihood that a worker's employer offers insurance coverage also varies by firm size. Only 50 percent of those in firms with fewer than 10 workers had an offer of coverage in 2005; in contrast, about 94 percent of those in firms with more than 100 workers had an offer of coverage (Table 1).² Eligibility rates did not vary considerably by firm size, and were consistently over 90 percent. The likelihood of a worker taking up an offer of insurance ranged from 78 percent of workers in offering firms with fewer than 10 workers to 85 percent in firms of 100 or more workers.

**Table 1. Employee's Employer-Sponsored Health Insurance Coverage by Family Income
(as a Percentage of the Federal Poverty Level) and Firm Size, 2005**

2005	Firm Sponsors Health Plan	Eligible for ESI (conditional on offer)	Takes Up Offer (conditional on eligibility)	Own ESI Coverage	ESI Coverage as Dependent	Any ESI Coverage
ALL	84.2%	93.4%	83.2%	65.4%	12.0%	77.4%
Family Income						
Under 100%	55.4%	71.8%	63.5%	25.3%	5.1%	30.4%
100% to 199%	69.5%	86.7%	78.2%	47.1%	4.6%	51.7%
200% to 399%	85.2%	93.7%	86.3%	68.9%	9.6%	78.5%
400% and above	92.6%	96.8%	83.7%	74.9%	17.2%	92.2%
Employer Size						
Fewer than 10	49.9%	91.6%	77.9%	35.6%	17.0%	52.6%
10 to 24	67.7%	92.8%	76.8%	48.2%	14.8%	63.1%
25 to 99	83.7%	93.3%	79.3%	61.9%	13.0%	74.9%
100 or more	93.6%	93.7%	85.2%	74.7%	10.4%	85.1%

Source: The Urban Institute analysis of the February 2001 and 2005 Contingent Work Supplement of the CPS and the March 2001 and 2005 Annual Social and Economic (ASEC) Supplement of the CPS.

The Current Population Survey (CPS) data show that only 22 percent of workers without insurance coverage are both employed by a firm that offers coverage and are eligible to enroll in the coverage that is offered by their employer.³ In other words, 78 percent of workers who lack insurance do not have an employer plan in which they can enroll. Thus, if ESI is to be increased, it is necessary to increase the number of employers offering coverage and expand eligibility for currently excluded workers in offering firms. Employer and individual mandates are policy tools that might be used in such an effort. It is also important to create affordable coverage for employees that have an employer offer but do not have the means to pay for their share of the premium. Take-up rates are well below 100 percent, particularly for the lowest-income workers, and have been falling in recent years.⁴ Thus, significant coverage expansions will also necessitate subsidizing individuals.

Evaluating the appropriateness of different policy options for expanding coverage for workers (and their dependents) requires an understanding of how firms currently make their offer decisions, why small firms are less likely to offer than are large firms, and why offers are more likely to be made in firms with higher-income workers. The reasons behind these firm level choices are grounded in

federal and state tax policies, in administrative realities of selling health insurance, and in the ways in which premiums are set for private health insurance in the U.S.

First, because employer payments toward workers' health insurance are not taxed as income and wages are, there is a substantial financial incentive for workers to prefer to take part of their compensation as health insurance. Such a tax advantage is not generally available when an individual purchases health insurance directly, via the non-group insurance market. If, as economists believe is true, a worker's value to an employer is equal to the total amount of compensation that is paid to that worker, this tax advantage implies that workers would be willing to accept lower wages and obtain the balance of compensation in the form of health insurance. Given that marginal tax rates increase with taxable income, this tax exclusion is of much greater value to those with higher incomes than to those with lower incomes. In addition, making a trade-off of wages for health insurance is a more difficult choice for those with less disposable income. Even for those lower-income workers who would prefer to make such a trade-off, the minimum wage limits the extent to which employer health insurance costs can actually be passed back to these workers. These realities combine to explain why lower-income workers would be less likely to seek out jobs with insurance offers and why employers with higher percentages of lower-income workers would be less likely to make such offers.

While smaller firms do tend to have lower average-wage workers than do their larger firm counterparts, these wage differentials do not wholly explain the differences between small and large firms' likelihood of offering insurance. Additional factors relate to the pricing of health insurance. First, insurers apply higher administrative loads to insurance purchased by small firms than to insurance purchased by large firms. This is because a significant share of insurers' administrative costs are fixed (i.e., they do not vary by the size of the group); consequently, those administrative costs will be a larger percentage of benefits when spread over a small group than over a large group. For example, the administrative loads for large group insurance products can be 25 to 30 percent lower than for small group insurance products.⁵ Second, the variance of expected health care costs decreases as group size increases. In other words, there is a risk-pooling economy of scale that accrues only to groups, and to greater degrees in larger groups. This price disadvantage for smaller groups can be substantial: the risk premiums required for very small groups often exceed 15 percent of benefits.⁶ Therefore, it is not surprising that small firms are significantly less likely to purchase insurance on behalf of their workers than are large firms.

In conclusion, while increasing the offer rate among small employers might appear to be an obvious strategy for increasing ESI, doing so means pressing for an expansion of coverage by purchasers that are relatively inefficient at buying health insurance. Because small employer purchasers face

higher prices for the same set of benefits and tend to face barriers related to having a lower-wage workforce, changing their offer decisions absent a mandate is unlikely. It is important to keep this in mind when considering reform design options and the incentives they implicitly create.

Employer Subsidies

One approach to increasing small employer offers is to provide subsidies to employers, e.g., providing a tax credit for a certain share of the employer's costs of providing health insurance. But targeting subsidies to employers is difficult. First, most firms, including small ones, have a mix of high- and low-income workers; therefore, subsidies would benefit all income levels and thus poorly target those in need. Second, firms know wages but do not know the household incomes of their workers. This means that while subsidies could be well targeted to workers based upon their wages, in actuality they could benefit higher-income families. Third, while the barriers to coverage faced by small firms suggest that some of the subsidies targeted to small firms would be worthwhile, doing so would not address the needs of low-wage workers in larger firms. Also, as already noted, subsidizing small employers to purchase insurance coverage means subsidizing relatively inefficient insurance purchasers.⁷

Beyond the targeting problems, the evidence suggests that employer subsidies will not have much of an effect on employer offers. Research by Hadley and Reschovsky indicates that even generous employer subsidies directed at small firms would only increase the share of firms offering coverage from the current 60 percent to about 69 percent.⁸ Also, such subsidies risk displacing a considerable amount of current private spending on insurance coverage. Limiting subsidies to low-wage small firms would displace a significant amount of employer payments for health insurance because 42 percent of establishments in firms with fewer than 50 workers currently offer coverage.⁹ An employer subsidy that only applies to firms which currently do not offer coverage would be more attractive in terms of spending public dollars efficiently (i.e., increasing coverage through new government spending) but would be undesirable on equity grounds and therefore difficult to design. Also, while limiting subsidies to small firms will result in better targeting of those without offers (because the vast majority of large firms already offer insurance), it would exclude from subsidization low-wage workers in larger firms who could benefit equally from such assistance.

Individual Subsidies

The research evidence clearly suggests that it is more efficient to target subsidies to individuals directly as opposed to giving subsidies to employers.¹⁰ Individual subsidies can be more easily directed to those in greatest need. Evidence also suggests that individual subsidies lead to less

displacement of existing private spending than would be the case if subsidies are provided to small firms or to firms with low-wage workers.

Income-related subsidies can be designed to limit an individual's health care spending (premiums or premiums plus out-of-pocket costs) to a given percentage of family income, with the percent of income cap rising as income increases. Alternatively, a subsidy could limit a low-income family's direct payments to a particular percentage of an insurance premium, with that percentage possibly varying with income level. Other options may also be considered.

Another important but difficult design issue is determining the level of generosity of the subsidies, and, relatedly, determining what level of health care spending is "affordable" for those of different income levels. The more individuals are expected to pay, the lower the cost to the government, but the higher the burden on the family. Income-related subsidies also work best within some kind of a purchasing pool arrangement (discussed below).

One of the issues with income-related subsidies is that take-up rates may not be particularly high in voluntary arrangements. It is clear that significant numbers of individuals will not choose to enroll in coverage even with reasonably generous subsidies. Further, income-related subsidies can also result in potentially significant displacement of current spending on private coverage particularly as income increases. Such displacement, or crowd-out, concerns should be balanced with a desire to create a system that is as equitable as possible, one that offers similar subsidies to those in parallel economic circumstances. By excluding from subsidization those low-income people who currently have private insurance coverage, a system would create troubling inequities and perverse incentives, such as discouraging private insurance coverage. The administrative costs of subsidizing individuals according to their incomes are also likely to be greater than the costs of subsidizing employers, primarily because there are so many more individuals than firms.

Because even generous employer or individual subsidies will not fully enable a state to reach universal coverage, both Massachusetts and California have considered employer and individual mandates. Both kinds of mandates raise a number of difficult issues.

Employer Mandates

Employer mandates provide a revenue source and create equity in the sense that all firms must pay something. But the Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured employer plans, and thereby significantly hampers states' flexibility in designing employer requirements in the realm of health insurance. For example, a state cannot require that employers provide a defined set of health insurance benefits to their workers. As a

consequence of this federal constraint, the only type of employer mandate with the potential to withstand a legal challenge is one structured as a “pay or play” reform. Under such an approach, employers face a tax on payroll, but they get a credit offsetting this tax liability for contributions that they make toward health insurance.

In structuring an employer mandate, many decisions must be made. One is whether exemptions should be made for small firms, part-time workers, and/or for dependent workers. The difficulty is that each of these groups is likely to have high uninsurance rates. Thus, the more of these groups exempted, the more limited the effect of the employer mandate. A state implementing an employer mandate must also set a tax rate (such as 6 or 8 percent of payroll) and a tax base (for example, the first \$25,000 of wages or the entire payroll). A high rate or high base means that more would choose to provide coverage directly, as opposed to paying a tax. This means a higher cost to business, but a lower cost to government. By contrast, a low tax or low base means more would choose to pay the payroll tax, lowering the cost to business, but increasing the cost to government. This is because more workers and their dependents would need subsidized insurance outside of the employer system, and the payroll tax revenue collected would be lower, requiring other significant sources of revenue. In addition, a low payroll tax rate might lead some employers to drop current health insurance, particularly if significant subsidies were made available for the individual purchase of coverage through an alternative source.

Even a well-designed employer mandate, in and of itself, would not solve all of the coverage problems facing a state. This is because some workers would choose not to enroll in coverage, even when it is offered to them, and some individuals are not connected to the workforce. It is also necessary to set up coverage availability (a) for those whose employers choose to pay instead of provide coverage directly, (b) for workers who are exempt from the employer mandate, and (c) for non-workers. The policy must also arrange for subsidies for those with low incomes in order to ensure that coverage be affordable to all. As noted, the greater the size of the population seeking coverage from a source other than an employer (if, for example, the payroll tax is set low or there are many exemptions from the mandate), the higher will be the government’s subsidy costs.

A further issue with an employer mandate is that they can be highly regressive, unless individual subsidies are carefully designed to offset the regressivity. The employer health insurance contributions or taxes can be expected to eventually shift back to workers through reduced wages.¹¹ Because workers without ESI currently tend to have lower incomes, the impact of the legislation and the pass-back of newly required employer costs will fall most heavily on low-income workers. Higher-income workers are most likely to currently have ESI, and so an employer mandate should have little to no effect for them.

Finally, an employer mandate, even of the pay or play variety, is likely to face an ERISA challenge. The Maryland decision on the Fair Share bill suggests that a tax which in reality has the underlying purpose of inducing firms to provide coverage is really an attempt to influence the design of employer benefits and thus is susceptible to a successful legal challenge.

Individual Mandates

The alternative to employer mandates is to have an individual mandate or to couple an individual mandate with an employer mandate. An individual mandate is a requirement to obtain coverage meeting at least a minimum set of standards. Under a viable individual mandate, a state would have to make the minimum level of coverage affordable. This means making a difficult determination of what is affordable for families in different circumstances. The more that people are expected to pay, the lower the government cost of providing subsidies, but the higher the burdens on individuals and families. The lower the expectations of what people can pay, the lighter the individual and family burdens, but the greater the government costs.

Under an individual mandate, it would be most expedient to develop a purchasing arrangement where insurers can offer coverage, subsidies can be determined, and people can be guaranteed a source for purchasing coverage. It is necessary to develop an outreach program that convinces people that having insurance is in their best interest, thus increasing compliance with the mandate. Beyond this, enforcement is likely to require the tax system.

In addition, an individual mandate could result in some employers dropping coverage. This is not likely among firms with predominantly middle- and high-income workers, because the federal and state tax benefits of purchasing coverage through employers is likely to maintain the workers' preferences for employer-based coverage. However, firms with large numbers of low-income workers might drop coverage so that their workers can take advantage of new subsidies being made available outside of the employer context. Low administrative costs in large firms may also very well dissuade them from dropping coverage, as the administrative costs in a purchasing pool are likely to be somewhat higher. The same is not likely to be true for the smaller firms.

Recent efforts in Massachusetts and the proposal in the California Governor's plan require firms to offer Section 125 plans (which refer to ESI plans paid on a pre-tax basis according to Section 125 of the Internal Revenue Code). The reforms allow for workers to make the pre-tax payments for health insurance when purchasing through new non-employer based purchasing pools. Such reforms could increase the likelihood of employers dropping coverage, as they extend the tax benefits currently afforded only to employer plans to coverage purchased elsewhere.

An important political advantage of an individual mandate is that it does not engender political opposition from small- and medium-sized businesses, a significant problem with employer mandates. It also obviates the implementation barrier of legal challenges under ERISA. However, depending upon their structures, individual mandates may tend to require greater sources of revenue either through new taxes or through the redirection of funds that are already in the system.

Creating a Guaranteed Source for Purchasing Insurance

A critical component of any successful reform is determining where individuals and employers will be able to purchase insurance coverage and where they will be able to apply any government subsidies that are made available. This is of particular concern in relation to a reform’s effect on small employers and their workers, since small employers are the least likely to offer health insurance to their workers at this time (Table 2), and workers in small firms are more likely to be uninsured than are workers in larger firms (Table 3).

Table 2. Percent of Private-Sector Establishments That Offer Health Insurance, 2004						
	Total	Fewer than 10 workers	0 to 24 workers	25 to 99 workers	100 to 999 workers	1,000 or more workers
U.S.	55.1%	34.1%	64.0%	81.2%	94.3%	98.9%
Missouri	54.6%	34.3%	58.6%	87.8%	92.2%	99.6%

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2004 Medical Expenditure Panel Survey (MEPS) – Insurance Component.

Individuals shopping for health insurance in the existing private non-group insurance market potentially face even greater hurdles than do small group purchasers. In most states, including Missouri, there is no guarantee that an individual can purchase an insurance policy in the non-group market. Individuals who are not HIPAA eligible can be denied coverage outright or may be offered insurance only subject to elimination riders. Elimination riders are amendments to insurance policies that can temporarily or permanently exclude from coverage a particular health condition, body part, or body system. Also, there is no general regulation in Missouri that would limit how much a non-group insurer can vary premiums by age, gender, health status, family status, or other factors. This means that even some individuals who are offered a private non-group policy for purchase may not effectively have access to a policy because of the high cost of the premium.

Health Insurance Status	Total	Fewer Than 24 Workers	25 to 99 Workers	100 or More Workers
Employer	74.3%	57.3%	74.8%	82.7%
Medicaid	4.4%	5.7%	5.3%	3.5%
Medicare/Champus	0.9%	2.0%	0.8%	0.4%
Private Non-Group	5.6%	11.0%	2.7%	3.5%
Uninsured	14.8%	24.1%	16.4%	9.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: The Urban Institute analysis of the 2004/2005 March CPS.

Since the vast majority of uninsured individuals are not offered health insurance by their own employer or by the employer of a family member, they do not have a guaranteed source for purchasing insurance, even if a subsidy is made available. As a consequence, providing subsidies alone would not sufficiently guarantee Missouri residents accessible, affordable, and adequate health insurance coverage. In conjunction with subsidies, a successful reform must also develop an approach to guaranteeing universally accessible coverage that provides benefits sufficient to meet the health care needs of the target population.

There are a number of options for developing such an approach. A design could be structured to build on existing purchasing entities in the state or could rely upon building new purchasing options. Missouri has at least three existing health insurance purchasing entities that could be used to form the basis of a guaranteed source of health insurance coverage for subsidized and/or unsubsidized residents. These are the Missouri Consolidated Health Care Plan (MCHCP), which contracts with private insurers to provide health insurance benefits to state employees; the Missouri Health Insurance Pool (MHIP), which contracts with private insurers to provide subsidized health coverage for individuals with high medical care needs; and MC+ for Kids, which contracts with private managed care plans to provide coverage to children up to 300 percent of FPL as part of the State Children’s Health Insurance Program (SCHIP). Each has the experience necessary to undertake such an effort, and offers the advantage of existing administrative structures and relationships with private insurers. As such, they would be likely to have a shorter start-up period and could avoid many of the pitfalls associated with starting a new organization. The idea here is to take advantage of the existing administrative structure but to maintain separate risk pools.

Alternatively, the state could set up a new purchasing entity, in much the same way that the Commonwealth of Massachusetts has done. The advantage of taking that route is that it separates the new program from any political tensions associated with existing programs and may allow for more creativity in administrative design.

Regardless of whether the state decided to rely upon a new or existing purchaser for this purpose, a number of design issues should be considered seriously. Some key examples are:

- Who would be eligible to purchase coverage in the pool? Small businesses, individuals (those with and without employer offers or only those without such offers), larger employers? Eligibility will have a significant impact on the average health expenditures of enrollees and the size of the purchasing entity, which in turn will impact bargaining leverage and costs.
- Will subsidies only be made available to those purchasing through the pool? The answer will impact administrative difficulty (affecting both public and private costs) and the size of the purchasing entity.
- How will premiums be determined? Will risk adjustment be used across health insurance plans participating in the pool? Will mechanisms be used to spread risk across those purchasing inside *and* outside of the pool? These decisions will have important implications for enrollment and hence the size of the pool, for the health expenditure profile of those who enroll, and for the affordability of coverage inside the pool.
- What benefits will be offered? Will insurers have to offer standardized benefit packages to participate? Will benefits be comprehensive, limited, or will both be offered? These decisions will affect the premiums charged, the attractiveness of the pool's plans to different types of individuals and employers, the value of the insurance coverage to different types of people, effective access to health services for individuals of different incomes and levels of need, and expected reductions in uncompensated care.

Massachusetts Legislation Enacted in 2006

The recently enacted Massachusetts health reform includes a Medicaid expansion, income-related premium subsidies to individuals, and a new purchasing pool called the Commonwealth Health Insurance Connector (the Connector). Under the reform, eligibility for the Massachusetts Medicaid program, MassHealth, will be expanded to make children up to 300 percent of FPL eligible. In addition, the reform raises the Medicaid enrollment caps on certain categories of persons with disabilities, some childless adults, and persons with HIV/AIDS. The purpose of the Connector is to bring together small businesses (those with 50 or fewer workers) and individuals without access to ESI and to facilitate their purchasing private insurance coverage. The Connector will determine the

types of benefits offered to participants, will negotiate with insurance plans, and will provide the administrative structure for enrolling individuals and small employers. The Connector is also responsible for running the Commonwealth Care Health Insurance Plan (CCHIP), which is the new subsidized insurance program for low-income individuals and families below 300 percent of FPL. CCHIP plans are distinct from the unsubsidized plans available in the Connector. The board of the Connector is also given an array of other policymaking responsibilities related to the implementation of the reforms.

But at the core of the Massachusetts reform proposal is the individual mandate. Individuals are required to obtain coverage through Medicaid, through employers, through the existing private non-group insurance market, or through the Connector. The individual mandate will be enforced through the tax system.

Employers with 11 or more workers are required to provide coverage. They must offer Section 125 plans whereby individuals can make their health insurance contributions on a pre-tax basis. Employers with 11 or more workers are also required to make a “fair and reasonable contribution” (not yet defined) to workers’ coverage. Those employers with 11 or more workers that do not make a fair and reasonable contribution are subject to a \$295 annual assessment per full-time worker. This is by all accounts a modest penalty, but to put the financial burden that it might impose into context, there are 13 workers, on average in Massachusetts establishments in firms with 10 to 24 workers.¹² The average for firm size 25 to 99 workers is 31. Some of these are part-time or seasonal workers, and the assessment would be pro-rated to take this into account. In Missouri, establishments of firms in the category of 10 to 24 workers average 11 employees while companies with 25 to 99 workers have an average of 31 workers.

Workers are required to take up the employer’s offer if the latter contributes at least 33 percent to the worker’s plan and 20 percent to a family plan, even if they could have been eligible for subsidies in the Connector. This latter requirement could be waived at the discretion of the Connector. Small firms can purchase coverage for their workers through the Connector. If employers do not offer insurance, workers can purchase coverage independently through the Connector and obtain subsidies if they are income-eligible.

There are roughly three alternative paths that a small firm can take in Massachusetts:

1. As required by law for firms with 11 or more workers, the firm can set up a Section 125 plan, and offer a plan outside the Connector or in the unsubsidized portion of the Connector, making a “fair and reasonable” contribution to coverage. In this case, workers must take up the employer offer and pay the

employee share (as long as the employer makes the minimum contribution toward that coverage), even if the worker would be eligible for subsidies in CCHIP. If the Connector approves a waiver of this requirement, the worker can then buy coverage in CCHIP, but the employer must contribute the same amount toward CCHIP coverage as they do for other workers enrolling in coverage outside of the pool.

2. The firm can opt to neither offer coverage nor set up a Section 125 plan. If the firm has 11 or more workers and chooses this, it is out of compliance with state law and must pay the \$295 per worker assessment. In addition, the firm is liable for some share of the cost that its workers incur in using the free care pool; this liability is known as the free rider surcharge. Workers in such firms would have to purchase coverage in the Connector or outside of it. For those with income less than 300 percent of FPL, income-related subsidies would be available in the Connector.
3. The firm can set up a Section 125 plan only and make no contribution to it, or the firm can offer coverage with a contribution that is less than the “fair and reasonable” standard. In these cases (where the firm has 11 or more workers), the employer would have to pay a \$295 assessment per worker per year. The worker would have to either: obtain unsubsidized coverage outside of the Connector; obtain coverage in the Connector on a subsidized basis if income eligible; or purchase an unsubsidized plan inside the Connector.

All of these options are more or less the same for larger firms, except that the large firms cannot offer a plan inside the Connector. As long as the large firm makes a fair and reasonable contribution to coverage, the individual must take up that coverage and is not eligible to buy coverage in the Connector, even if their income would otherwise make them eligible for subsidies. An individual in a large firm that does not offer insurance could also purchase coverage in the Connector or outside in the directly purchased unsubsidized private market.

In summary, the requirements on small firms in Massachusetts are relatively small. They must arrange for employees to have access to a Section 125 plan and make a “fair and reasonable” contribution to coverage; otherwise, they will have to pay a \$295 per worker annual assessment. While in effect a mandate, it is not a particularly onerous one and received broad support from the business community, most of whom already offered coverage. There is no effort to provide subsidies to employers; all subsidies are directed at individuals. One provision that is potentially more costly to small employers is the requirement that an employee take up an employer’s offer of coverage if the employer has made a minimum contribution. This could increase take up significantly for some employers, thus increasing the costs to firms that already offered coverage prior to reform.

The California Governor's Proposal

The health care reform proposal developed by California's Governor is an ambitious one. It includes a mandate that all Californians have at least a minimum level of health insurance coverage;¹³ makes all children (including undocumented residents) in families with incomes up to 300 percent of FPL eligible for state subsidized health insurance; makes all legal adult residents up to 100 percent of FPL eligible for Medicaid at no cost and makes those between 100 and 250 percent of FPL eligible for subsidized coverage through a state purchasing pool.

The implications of the reform plan for California's small businesses vary by employer size, by whether the employers currently offer coverage to their workers and by the distribution of wages at a firm. One of the central financing mechanisms for the reform is a 4 percent payroll tax assessed on employers who do not offer health insurance and who employ 10 or more workers. The tax is based on total wages. Employers with fewer than 10 workers are exempt from the tax. Consequently, the reform should not impact the smallest employers at all, but will provide new subsidies and a source for buying coverage for their low-income workers.¹⁴

On its own, making subsidized coverage available for the population that falls within 250 percent of FPL would be a significant change for employees of small firms in California. Over half of California's uninsured workers are employed by firms with fewer than 25 workers, and approximately two-thirds of uninsured workers employed in these small firms have incomes that would make them eligible for subsidized insurance.¹⁵ The lower-income workers in these small firms therefore account for over one-third of all uninsured workers in California. Similar statistics hold for Missouri.

Of greatest concern to small employers with 10 or more workers, however, will be the 4 percent payroll tax assessment on non-offering firms. Sixty-two percent of California establishments that are in firms with 10 to 24 workers offer health insurance coverage to their workers,¹⁶ as do 85 percent of establishments in firms with 25 to 49 workers.¹⁷ In other words, under the reform, roughly 38 percent of establishments in firms with 10 to 24 workers and 15 percent of establishments in firms with 25 to 49 workers would either have to pay a 4 percent payroll tax or begin offering their workers health insurance that meets or exceeds the minimum standards. A comparable reform in Missouri would affect 41 percent of establishments in firms with 10 to 24 workers and 11 percent of establishments in firms with 25 to 49 workers.

Average earnings for workers in California firms of fewer than 100 workers is approximately \$19,000.¹⁸ A comparable figure for workers in Missouri is slightly higher, about \$22,500. While wages in firms that do not offer health insurance tend to be somewhat lower than those for firms that do offer insurance, those figures are not readily available at the state level. Therefore, for

purposes of illustration, we assume away such a wage differential. On average then, a non-offering California firm can expect to pay about \$760 per worker in payroll taxes under the governor's reform proposal. Using the California payroll assessment in Missouri would imply an average payroll assessment of about \$900 per worker on those small employers not offering coverage. Employers with workers below the average rate would pay less than that assessment while those with workers paid above the average rate would pay more.

Employers could, of course, decide to purchase coverage on behalf of their workers and avoid the payroll tax assessment. The minimum required coverage under the California plan is quite limited, with a deductible of \$5,000, considerably higher than what is typical of employer group insurance today. The premiums of such plans would also fall significantly below the current average for employer-based insurance policies. Because all residents of the state would be required to purchase some type of coverage in order to comply with the individual mandate, there may be interest on the part of workers to have that coverage available through their employer. If an employer does offer coverage, its low-income workers (those below 250 percent of FPL) would be eligible for state subsidies on the worker portion of the premium. Under the proposal as it currently stands, employers would not be able to purchase coverage through the new purchasing pool. They would have to do so in the existing private insurance market.

The proposal provides some competing incentives which make it uncertain whether workers in currently non-offering small firms (of 10 or more workers) would prefer to have their employers begin to offer coverage or would prefer to purchase coverage on their own and have their employers pay the payroll tax. First, as noted earlier, small firms do not tend to be efficient purchasers of health insurance. The administrative loads associated with small group insurance can be quite high and might be significantly higher than those in the new purchasing pool. This imbalance, combined with the inability of small groups to spread their health risks broadly, implies a significant incentive for workers in small businesses to prefer enrolling in pool-based coverage. This incentive would be particularly strong for lower-wage workers in small firms, who could enroll in a subsidized comprehensive health insurance product through the purchasing pool.

However, the payroll tax assessment works in the reverse direction of these incentives. As mentioned earlier, economists believe that the burden of employer-paid payroll taxes made on behalf of workers are effectively passed back to workers through lower wages paid over time. In the case of the California proposal, this would mean that workers whose employers opt to pay the tax would experience declines in their incomes relative to what they would have been absent the reform. At the same time, these workers would be required to purchase health insurance directly. In essence, they would be paying twice – once for the payroll tax and once for the insurance policy;

they would get no credit toward the purchase of health insurance to take into account that their employer (and indirectly they themselves) would be paying the payroll tax.

While those workers eligible for generous subsidies on a comprehensive health insurance package might still be better off this way than having their employer offer insurance, the same is unlikely to be true for the unsubsidized workers. The only unsubsidized product available in the new purchasing pool would be very high deductible insurance policies. These policies may be very unattractive to modest income workers over 250 percent of FPL who would be ineligible for subsidized coverage and could not afford to pay such a high deductible. In effect, these workers would remain severely limited in their access to medical services. Those that do not buy policies in the new pool and do not have employer insurance offers would be required to purchase a policy in the existing private non-group market. In this way, they would face all the shortcomings inherent in that market. This would be a particularly unattractive option for older workers and workers with significant health care needs. Taken together, these issues might create significant incentives for workers to ask their employers to begin offering health insurance, in exchange for wage reductions commensurate with their employer's contributions.

Conclusions and Recommendations

Based on our review of the Massachusetts legislation and California's recent proposal, we draw the following conclusions and recommendations for Missouri:

- Subsidies to employers have not proven to be effective in increasing coverage. They are difficult to target efficiently and they provide subsidies to employers who are often not well equipped to efficiently purchase insurance products.
- Income-related subsidies to individuals more directly target those in need and can reduce the cost of insurance to the individual. Individual subsidies should be tied to income by decreasing the subsidy as income increases. Individual subsidies are a more efficient use of public dollars because they involve less risk of displacing existing coverage.
- Because of the high prices and barriers small employers face in purchasing health insurance, attempts at using policy to change their offer decisions absent a mandate might prove relatively ineffective. Both the Massachusetts reform and the California proposal contain versions of an employer mandate. Employer mandates can create a number of serious problems, including the risk of sharp opposition from small- to medium-sized businesses and potential legal challenges. Both California and Massachusetts use relatively "light" versions of employer mandates, with Massachusetts imposing a considerably lower burden than California. If Missouri were to choose an employer mandate, we would suggest

moving more in the direction of the path followed by the Massachusetts reform than the California proposal.

- To obtain coverage for all workers in small businesses, it is necessary to have an individual mandate. But this also raises difficult political issues of compulsion and enforcement. An individual mandate should be accompanied by a subsidy schedule that makes coverage affordable for those who would otherwise choose not to purchase coverage.
- It is widely upheld that some form of purchasing arrangement is necessary. This not only reduces both the time costs to individuals and firms in choosing insurance products but also reduces the administrative costs faced by small employers in the existing private market. Fortunately, Missouri has alternative vehicles already in place that could be adapted to serve this function. These include the state health employees' plan, the state high risk pool, and the SCHIP program. All are already actively purchasing private insurance products for their clients.
- Being sensitive to the impacts of reform on the pooling of individuals by health risk is critical. Within the unsubsidized portion of Massachusetts' Connector, multiple benefit packages of differing levels of comprehensiveness are expected to be made available. While this is a scenario that would seem ripe for risk segmentation (the healthy being attracted to less comprehensive plans, the less healthy to more comprehensive plans, thus leading to premiums spiraling upwards for the comprehensive plans), the Massachusetts plan has several strategies in place to prevent such a phenomenon. Instead of charging premiums for each plan as a function of the specific health risks of those that actually enroll in that plan, the Connector bases premium cost on what they would be if a much broader population were enrolled. Ensuring broad-based sharing of health risk will be a very important component of guaranteeing access to adequate and affordable coverage for all, regardless of health status.

There are features of the California proposal and the Massachusetts reform that we recommend Missouri consider very carefully before adopting:

- The mandatory take-up feature that Massachusetts has adopted, and California has proposed, requires employees to take up the employer's offer if the employer makes a contribution that meets an acceptability threshold. This reduces the cost to the state of subsidizing low-income workers employed by offering firms. But it also increases the cost to firms that now offer coverage and have less than complete take up. While the share of uninsured workers currently declining employer offers is quite small, this forced take-up provision may be financially onerous for certain firms. In addition, preventing low-income workers from obtaining subsidies for coverage that may be more comprehensive than their

employer's offer creates inequities, additional financial burden, and disincentives to work in offering firms.

- Both states require employers to provide their workers with Section 125 plans for purposes of making payments toward health insurance. This allows individuals to receive the same tax deduction that comes with employer coverage when purchasing insurance independently through a purchasing pool. By shifting some of the cost on to the federal government, this mechanism reduces the costs of insurance coverage outside of employer plans. While attractive for this reason, the equalization of tax treatment also reduces the relative attractiveness of buying coverage through an employer-based plan. This could lead to higher rates of employers dropping coverage, which would increase the government cost for subsidies.
- The only insurance plan to be offered through the purchasing pool under the California plan would be one with a very high deductible. Doing so will hold down the cost of premiums, but it creates another problem. Since the purchasing pool is the only guaranteed issue policy that will be available outside of the employment context, modest income people who do not qualify for the comprehensive subsidized plan (i.e., those with incomes greater than 250 percent of FPL) may have this plan as their only option. However, such high deductible plans may not significantly increase access to needed medical care for those who cannot afford the annual deductible and cost-sharing on top of the insurance premiums. For those without ESI, whose incomes exceed subsidy levels, the high deductible insurance policy may have little practical value.

Endnotes

- ¹ L Clemans-Cope and B Garrett, "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005" (Issue Paper), Kaiser Family Foundation, 2006.
- ² L Clemans-Cope and B Garrett, 2006.
- ³ L Clemans-Cope and B Garrett, Unpublished calculation from a merge of the February 2005 Contingent Work Supplement of the CPS and the 2005 ASEC Supplement to the CPS, 2006.
- ⁴ L Clemans-Cope and B Garrett, 2006.
- ⁵ Congressional Research Service, *Costs and Effects of Extending Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1988).
- ⁶ D Cutler, "Market Failure in Small Group Health Insurance" (Working Paper No. 4879), National Bureau of Economic Research, Inc., 1994.
- ⁷ Creating organized purchasing entities through which small employers could purchase coverage could address this problem in large part. Such purchasing entities are discussed below. However, if workers in small or even larger firms could purchase coverage individually through such an entity, it is not obvious why one would direct the subsidy to the employer as opposed to the individual.
- ⁸ J Hadley and J Reschovsky, "Small Firms' Demand for Health Insurance: The Decision to Offer," *Inquiry* 39.2 (2002):118-137.
- ⁹ An establishment is one location of a particular employer, whereas a firm refers to all of the establishments comprising a particular employer. Agency for Healthcare Research and Quality, Published tables from the 2004 MEPS, Table I.A.2, 2004. Available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2004/tia2.pdf
- ¹⁰ D Ferry et al, "Health Insurance Expansions for Working Families: A Comparison of Targeting Strategies," *Health Affairs* 21:4 (2002): 246-254.
- ¹¹ The exception, as noted earlier, is that it is often difficult to shift these costs on to lower wage workers, e.g., due to minimum wage constraints. Consequently, employer mandates may also lead to some negative employment impacts, particularly for low-wage workers.
- ¹² Agency for Healthcare Research and Quality, Published tables from the 2004 MEPS – Insurance Component, Table II.B.1. , 2004. Available at: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2004/tiib1.pdf
- ¹³ The minimum benefits are a \$5,000 deductible plan with a maximum out-of-pocket limit of \$7,500 per person and \$10,000 per family.
- ¹⁴ It should be noted that this "carve-out" of employers with fewer than 10 workers may provide incentives for the smallest employers to stay small and may also create incentives for somewhat larger employers to break up into smaller pieces.
- ¹⁵ Authors' estimates from the 2004/2005 March CPS.
- ¹⁶ Agency for Healthcare Research and Quality, Published tables from the 2004 MEPS – Insurance Component, Table II.A.2, 2004. Available at: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2004/tiia2.pdf
- ¹⁷ Authors' calculations based on published data from the 2004 MEPS – Insurance Component, Table II.A.2.
- ¹⁸ Authors' estimates from the 2004/2005 March CPS.



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