

**At Risk:  
Small  
Business  
Health  
Coverage**  
in Maine

**MECEP**

Maine  
Center for  
Economic  
Policy

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*Jointly Published with:  
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## **Maine Small Business Health Insurance Project Sponsors**

The Maine Small Business Health Insurance Project is jointly sponsored by the Maine Center for Economic Policy (MECEP) and Consumers for Affordable Health Care Foundation. The project's purpose is to involve more small businesses in current policy development to improve health care coverage in Maine. Publishing *At Risk: Small Business Health Coverage in Maine* is the first phase of this project.

MECEP was established in 1994 with the mission to promote a sustainable and equitable economy through analyzing and identifying solutions for Maine's economic and fiscal challenges. The Center is one of twenty-two state groups who are funded through the Ford and Charles Steward Mott Foundation's State Fiscal Analysis Initiative.

Consumers for Affordable Health Care Foundation (CAHC Foundation) is a Maine public charity whose mission is to assist Maine people in obtaining affordable, quality health care. CAHC Foundation provides non-partisan research, training and education to the public, government officials, businesses and organizations.

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At Risk: Small Business Health Coverage in Maine  
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## **At Risk: Small Business Health Coverage in Maine**

### **Executive Summary**

Private employers are a source of health coverage for more than half of Maine people. Almost half of all Maine workers are employed at firms with less than 50 employees. Thus, the ability of small firms to offer employee health insurance is critical to assure health care access for Maine citizens. But current trends indicate that small business health coverage is at risk.

This report reviews the results of a 1999 survey of Maine small businesses regarding the health insurance coverage they offer employees. Four thousand small businesses were sent a survey, and 381 respondents met the survey criteria of having 2-49 employees.

The survey indicated that the majority of respondents still offer health insurance to some of their workers. They have a strong interest in providing employee health insurance, but future premium increases similar to those they have experienced in recent years will likely force them to decrease coverage. In fact, 64% of respondents who offered health insurance coverage at the time of the survey reported that a future increase of 20% or less would cause them to reduce their coverage.

The overall rate (68%) at which firms reported offering health insurance in this survey is slightly higher than in other Maine and national surveys; however, many of these firm's employees were not eligible for this coverage. Just over half of the full-time employees worked for firms that offered health insurance to all full-time employees, and less than a third were associated with firms that offer coverage to their dependents. The availability of coverage to part-time employees and their dependents was significantly less.

Wage rates were also closely related to offer rates. Lower wage workers were more likely to work for a firm that did not offer health insurance. Size of firm also mattered. Firms with under 10 workers were less apt to offer health insurance and only half of the firms with two to four workers offered any health coverage.

Only a third of the firms that offered health insurance reported that all of their employees participated in their health insurance program. Many employers believed that most of the nonparticipating employees were covered by another family members' plan; however, one out of five firms believed that the cost of their workers' premium share kept them from participating.

The number of employers offering coverage has been declining. Over three-quarters (77%) offered insurance at some time in the previous three years, versus the two-thirds (68%) who are currently offering coverage. Half (51%) of those offering coverage in the previous three years reported that their last premium increase was over 10%. Over half (57%) had changed their insurance company in response to rate increases in that time period.

A large majority (81%) of respondents characterized health insurance as very or somewhat important to their efforts to attract and retain employees, and 87% also believed it was very or somewhat important to offer coverage as a matter of principle or employer philosophy.

Small business health coverage presents a serious concern for policy makers to address. In the early 1990s Maine was at the forefront of states' efforts to make small business health insurance more available and affordable. It now appears that the benefits of those reforms – such as community rating, continuity of coverage, and guaranteed issue – are not sufficient to assure continued widespread coverage of employees through small employers.

This report reviews a number of current policy proposals that might assist small businesses and their employees with health insurance. One proposal shifts some of the risks and costs of the small business insurance market onto larger businesses and so-called “self-insured” businesses through an assessment on larger businesses. These funds could be used to reduce costs in the current small business health insurance market or to provide some form of public coverage. Tax credits and purchasing pools are found to offer relatively little hope for shoring up current levels of insurance coverage. Various state models for directly providing publicly subsidized coverage to small business employees, such as expanding Medicaid coverage to low-income individuals, are proving to be quite effective.

Helping small businesses secure affordable employee health coverage will help them attract and retain employees and will also allow them to do what they feel is right for their workers and their families. To offer no help means that more and more Maine workers will likely join the ranks of the uninsured.

“Small businesses are key to job growth in the United States, accounting for more than three quarters of job expansion in most years.... Yet this source of economic opportunity and growth is also the weakest link in America’s employer-based health system.”

*Changes in Employee Health Coverage by Small Businesses. 1998. Kaiser Family Foundation*

## Glossary of Terms

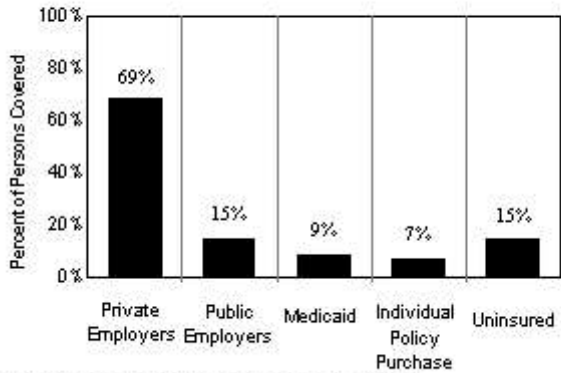
<b>Adverse selection</b>	A pattern of enrollment in a particular health plan, which results in a higher proportion of high risk enrollees or enrollees presenting higher medical costs than among other plans.
<b>CHIP Program</b>	The federal Children’s Health Insurance Program block grant that is available for states to expand health coverage for children.
<b>Deductible</b>	A fixed amount of health care dollars of which a person must pay 100% before his or her health benefits begin.
<b>Dependent</b>	An individual who receives health insurance through a spouse, parent, or other family member.
<b>Employee contribution</b>	The portion of the insurance premium paid by the employee.
<b>HMO (Health Maintenance Organization)</b>	A form of health insurance in which its members prepay a premium for health services, which generally includes inpatient and ambulatory care. A Primary Care Physician (PCP) is designated for each patient and a referral from the PCP is required for most other services.
<b>Offer rate</b>	The percentage of employers offering health insurance to any employees.
<b>Premium</b>	The cost of insurance, usually broken down in monthly amounts due.
<b>Self-insured employers</b>	Employers who cover some employee health expenses through a combination of direct payments by the employer to providers on behalf of employees up to a certain threshold, and through a “stop-loss” or excess insurance policy for expenses above the threshold.
<b>Stop-loss or excess insurance</b>	Insuring with a third party against a risk that the plan cannot financially manage. For example, a health plan can self-insure hospitalization costs, or it can insure hospitalization costs with one or more insurance companies.
<b>Take-up rate</b>	The percentage of employees choosing to accept the offer of insurance from their employers.

## Overview

Health care costs continue to dominate headlines and policy discussions in Maine and around the country. Although employment has risen to record levels, health insurance coverage of employees has fallen to levels not experienced in previous economic recoveries.

The majority of Americans have historically obtained health coverage from their employers; however, employer coverage declined in the 1990s. In 1989, estimates from the US Census Current Population Survey suggest that 69% of the nonelderly population nationally

Figure 1  
1998 Sources of Health Coverage  
Among Nonelderly People in Maine



Source: March 1999 Current Population Survey, as reported by EBRI

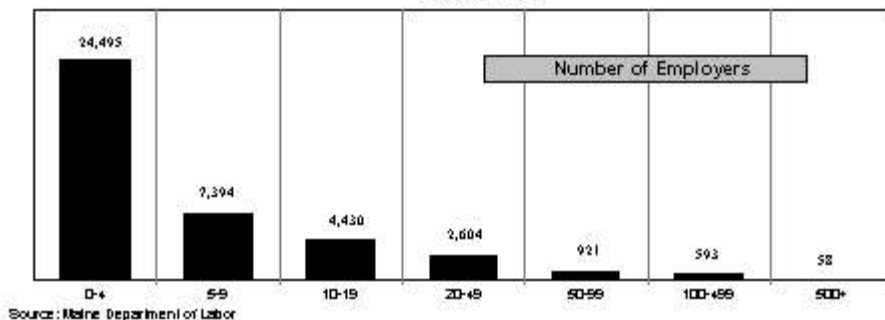
received coverage from private employers. In 1998, the proportion had fallen to 65% nationally. In Maine in 1998, Current Population Survey estimates indicated that 69% of the nonelderly population was insured through private employers, 15% through public employers, 9% through Medicaid, and 7% bought individual policies. Fifteen percent of this population was estimated to be uninsured.<sup>1</sup> (See Figure 1)

The source of coverage is not the same as the source of medical bill payment. The government covers parts of the population which are older and sicker through Medicare and Medicaid and,

therefore, government sources pay about half of all health care bills.<sup>2</sup>

In Maine, small businesses make up the vast majority of firms. Employers with less than 50 employees represent 96% of all Maine employers, and they employ 49% of all Maine workers. (See Figures 2 and 3) The ability or inability of small businesses to provide employee health coverage is thus a crucial factor in Maine's overall health access picture.

Figure 2  
Maine Private Employers by Firm Size  
March 1999

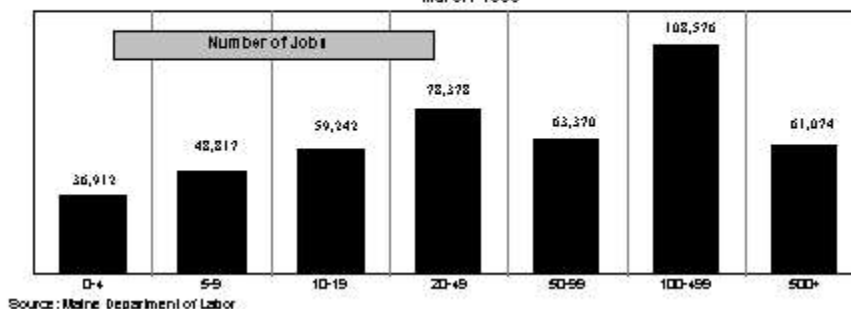


Source: Maine Department of Labor

<sup>1</sup> EBRI Health Benefits Data Book. 1999. p. 55. Data from the March 1999 Current Population Survey. Note that percentages add to more than 100% because individuals may receive coverage from more than one source.

<sup>2</sup> Trish Riley, National Academy of State Health Policy, presentation to Year 2000 Commission on Health Care Costs. www.mdf.org

Figure 3  
Maine Private Employment by Firm Size  
March 1999



In fact, the size of a business is a major indicator of whether or not employee health coverage is offered. There is considerable evidence that among all employers, other than self-employed individuals, small businesses are experiencing the most acute problems in sustaining employee health coverage.

### **The Maine Small Business Health Insurance Project**

The Maine Small Business Health Insurance Project was established to provide current information about Maine small businesses' experience with health insurance and to identify policy solutions that would improve employee health insurance access. The project is a collaboration between the Maine Center for Economic Policy and Consumers for Affordable Health Care Foundation. It has received support from the Access Project, a national initiative of the Robert Wood Johnson and Casey Foundations, and from the Bingham Program.

The first phase of the project involved a survey of Maine small businesses, which is the basis of this report. Subsequent phases will involve small businesses in discussions of the report's findings and policy options. A Maine advisory committee of small businesses and health care and health insurance professionals have assisted with the project.

### **Survey Methodology**

In the summer of 1999, a mail-in survey was sent to a random sample of 4,000 Maine businesses with fewer than 50 employees. There were 472 respondents. Public and non-profit organizations and self-employed individuals without employees were excluded because their health insurance options are different than small group options. After also excluding those who now had fifty or more employees, 381 businesses remained in the sample. (See Appendix for more on sampling methodology.) The results of the survey, hereafter referred to as the Maine Small Business Survey, are outlined in Part 1 of this report.

Since participation in a mailed survey is based on self-selection, non-response bias may have affected the results. For example, businesses providing health insurance may have been more likely to respond than those who did not provide insurance. Inferences from these responses to all Maine small businesses must thus be treated with caution. The results are

therefore compared with other Maine and national data to gain the best possible picture of Maine small business health insurance experience.

Part 2 of the report provides an overview of Maine’s small group reforms to date and other current events that are impacting the overall health insurance market. Part 3 identifies and analyzes public policy options being discussed to assist small businesses in their efforts to provide employee health insurance.

“State demonstrations have shown that in order to provide coverage to significant numbers of the uninsured in a voluntary market, benefits must be comprehensive, affordable, carefully marketed, and offered through a simplified accessible, eligibility process. They have clearly demonstrated that affordability of coverage poses a significant barrier to accessing coverage.”

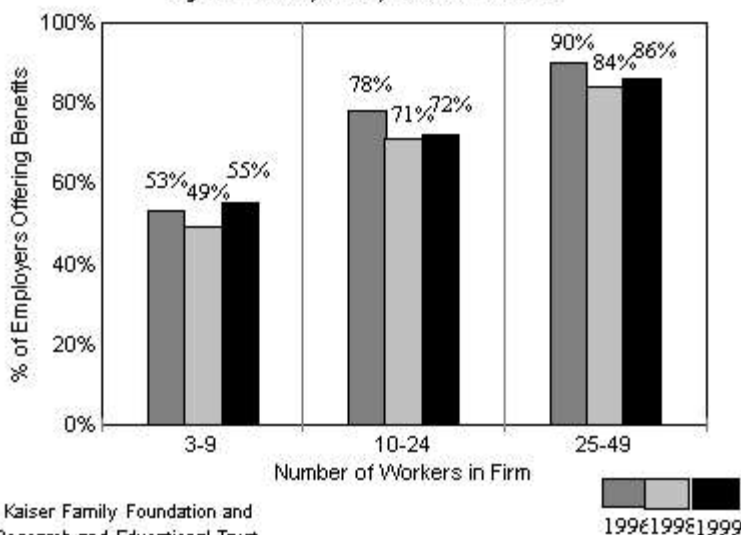
*Trish Riley and Barbara Yondorf. The Flood Tide Forum. Access for the Uninsured: Lessons from 25 Years of State Initiatives. National Academy for State Health Policy. January 2000*

## I. Employer Offer Rates and Insurance Experience

### Employer Health Coverage Offer Rates in the U.S. and in Maine

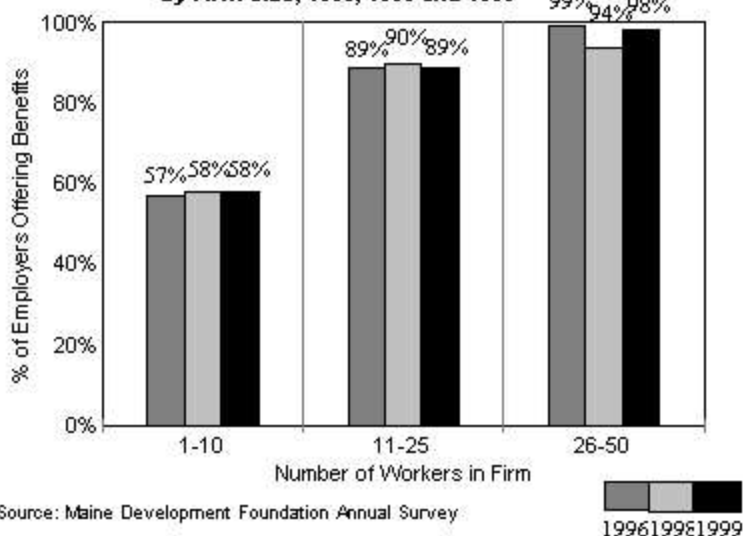
Several national and state surveys have studied the number of employers offering health coverage. National employer surveys conducted in 1996, 1998 and 1999 have shown that offer rates (the proportion of firms offering any health insurance) are lower among smaller firms than among larger firms. Offer rates among the smallest firms (3-9 employees) averaged 52% over the three surveys. Offer rates among firms with 10 to 24 workers averaged 74%, and offer rates among firms with 25 to 49 workers averaged 87%.<sup>3</sup> (See Figure 4)

**Figure 4**  
Percentage of U.S. Firms Offering Health Benefits by Firm Size, 1996, 1998 and 1999



Source: Kaiser Family Foundation and Health Research and Educational Trust

**Figure 5**  
Percentage of Maine Firms Offering Health Benefits by Firm Size, 1996, 1998 and 1999



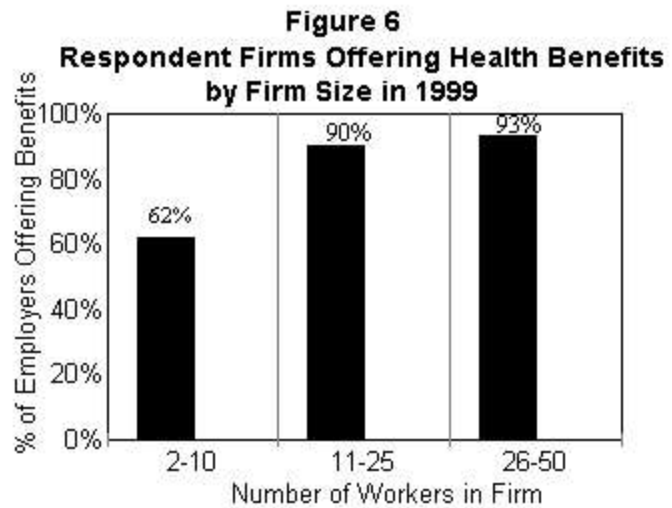
Source: Maine Development Foundation Annual Survey

Employer surveys done in Maine over the last five years by Market Decisions for the Maine Development Foundation show that the average percentages of employers offering health insurance for 1996, 1998 and 1999 are slightly higher: 58% for employers with 0-10 workers, 89% of firms with 11-25 workers, and 97% of firms with 26 to 50 workers. This survey source indicates that among firms of all sizes in Maine, 64%

<sup>3</sup> Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 1999 Annual Survey*. p. 25

offered coverage to some employees in 1999.<sup>4</sup> (See Figure 5)

Respondents to the Maine Small Business Survey reported similar offer rates of health insurance. In 1999, among the 381 respondents, 261 (68%) offered a health insurance plan to at least some of their employees. Sixty-two percent (62%) of employers with 2-10 employees offered health insurance, 90% of firms with 11-25 employees, and 93% of firms with 26-50 employees. (See Figure 6) A further breakdown shows that the offer rate declines to half in firms with 2-4 workers.



Source: Maine Small Business Survey

Even though offer rates have fluctuated over the decade, overall coverage through private employment is in decline. It appears that fewer employees and their dependents are eligible for their employer's health insurance and fewer eligible employees accept or "take-up" their employers' offers of insurance.

### **Employee and Family Eligibility**

Employers make choices about which employees to cover and whether to cover their dependents. The Maine Small Business Survey revealed that among firms that responded, almost 75% of all full-time employees reported by the survey respondents worked for firms that offered health insurance to all full-time employees, while very few of the part-time employees worked in firms offering all part-time employees insurance.

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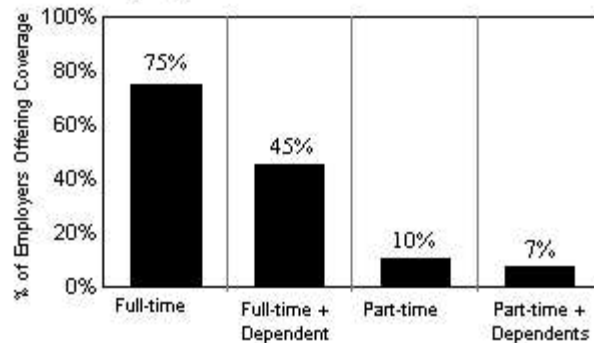
<sup>4</sup> Annual Survey Data of Maine Businesses. Augusta: Maine Development Foundation. www.mdf.org. Market Decisions, Inc. conducted these surveys by mail. The 1999 survey was delivered to 2095 businesses, and 593 returns were received, for a response rate of 28%.

In addition, only about 45% of the full-time employees worked for firms which reported contributing to coverage for employees' families, and fewer than one in ten of the part-time employees work in firms that offer part-time employees family coverage. (See Figure 7) Of the 3,380 employees in respondent businesses, 592 (17%) worked in firms offering no coverage at all.<sup>5</sup>

It has also been shown that lower paid employees are more likely to work for a firm that does not offer health insurance. A national survey in 1999 found that 36% of full-time workers with an annual salary of less than \$20,000 were not offered health insurance by their employer, while only 3% of those earning over \$60,000 were not offered health insurance.<sup>6</sup>

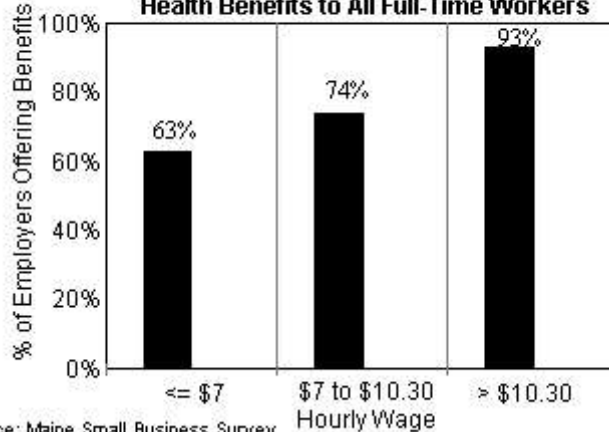
The evidence from the Maine Small Business Survey is consistent with these findings. Over one-third (82 out of 220 total) of those with wages of \$7 an hour or less worked for firms that did not offer health insurance to all full-time workers. By contrast, about one-quarter (143 out of 778 total) of those reported to be earning \$7.01 to \$10.30 and only one in seven (106 out of 1,420 total) of those who earned over \$10.30 worked in firms which did not offer health insurance to all full-time workers.<sup>7</sup> (See Figure 8)

**Figure 7**  
**Employees and Dependents Eligible for Employers' Health Insurance in 1999**



Source: Maine Small Business Survey

**Figure 8**  
**Percentage of Workers at Various Wages Who Work in Respondent Firms That Offer Health Benefits to All Full-Time Workers**



Source: Maine Small Business Survey

<sup>5</sup> 354 out of 381 respondents provided information about the number of employees in their firm, making a total of 3,380 employees represented by this group.

<sup>6</sup> Duchon, Lisa et al. 2000. Listening to Workers. Findings from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance*. www.cmf.org.

<sup>7</sup> 319 out of 381 respondents provided employee wage information, making a total of 2418 employees represented by this group.

## Premium Cost Sharing

The amount of the total premium paid by the employer also has been declining in recent years, putting greater financial pressure on workers trying to maintain their insurance. In 1996, the amount of employee contribution to the premium for single coverage averaged 17% in Maine, just under the national average. Employee premium contributions for family coverage averaged 33% (\$1,686), which was slightly higher than the national average.<sup>8</sup>

The Maine Small Business Survey revealed that of the 261 respondents who offered any employee coverage, only 138 (53%) paid the full premium. Of the 261 offering insurance, the following employers pay more than 50% of their full-time workers' health insurance premiums:

- 177 (68%) for all full-time employees
- 74 (28%) for all full-time employees' dependents

For the 245 respondents with part-time employees, the following percentage of employers pay more than 50% of their part-time workers' health insurance premiums:

- 19 (6%) for all part-time employees
- 9 (4%) for all part-time employees' dependents

Nationally, in the late 1980s and early 1990s the percentage of the health insurance premium that employers required workers to pay increased. This percentage stabilized in the second half of the 1990s; however, as premiums have risen, the actual dollar amounts paid by employees has increased.<sup>9</sup> As a result, the required premium contributions may be too high for many workers, particularly those at low wages, to take up the offers of insurance made by their employers.

## Eligibility and Take-Up Rates

National surveys show that employee eligibility and take-up rates are, in fact, declining. According to Census data in 1999,<sup>10</sup> there were 88.2 million workers at firms offering some health insurance. Of those, only 78.1 million were eligible for coverage. Among those eligible, 66.7 million (85%) accepted coverage. Among those who were eligible for coverage but rejected it, almost two-thirds were covered through another family member. About 22% of the eligible

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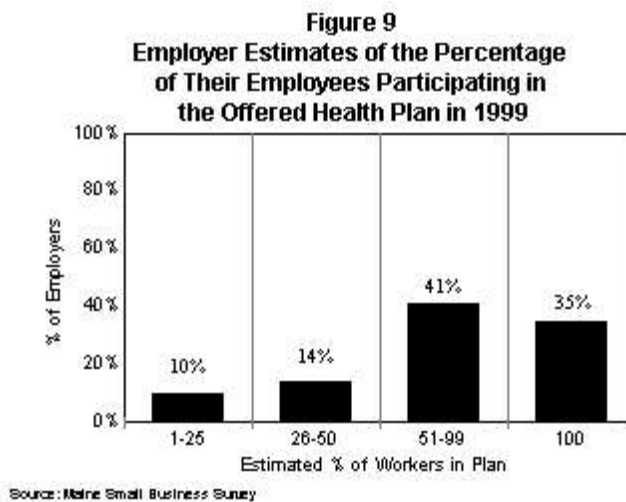
<sup>8</sup> James Branscome et al. "Private Employer-Sponsored Health Insurance: New Estimates by State." *Health Affairs*. January/February 2000, XIX:1. p. 145 (analysis of the Medical Expenditure Panel Survey)

<sup>9</sup> Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 1999 Annual Survey*. p. 60

<sup>10</sup> Based on the contingent worker supplement to the Current Population Survey of February 1997, in Kenneth Thorpe and Curtis Florence. "Why Are Workers Uninsured?" *Health Affairs*. March/April 1999, p.213

remained uninsured. Over two-thirds (68%) of these uninsured workers said that the cost prohibited them from accepting the coverage offered to them by their employers.<sup>11</sup>

The Maine Small Business Survey asked employers who offered coverage to estimate the percentage of employee participation in that coverage. Only 91 firms (35% of the 261 firms with some plan) reported 100% participation. Another 106 (41%) reported participation rates between 51-99%, and 62 (24%) reported participation rates of 50% or less.<sup>12</sup> (See Figure 9)



Respondents were asked why they thought that employees did not take the coverage offered.<sup>13</sup> More than half of those employers offering any coverage (161 or 62%) believed that their workers were declining coverage because they were covered by another family member's plan. A fifth (53 or 20%) of the employers believed that the premium cost caused employees to decline coverage and 30 firms (12%) suggested that their young employees were not interested in coverage.

### Why Employers Do Not Offer Coverage

Employers base their decisions to offer health coverage on a variety of factors. Cost is frequently the critical issue. In 1996, Maine annual premium costs for a single employee in the private employer insurance market averaged \$2,063 and family coverage averaged \$5,142. These averages were slightly higher than the national averages but lower than averages in other New England states. In the summer of 2000, annual premiums are more typically \$2,500 for a single worker and \$6,000 for family coverage.<sup>14</sup>

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<sup>11</sup> A further note on eligibility and coverage: Of the 10.1 million (12%) workers nationally who were not eligible for coverage, about 57% were insured through another family member, while one-quarter remained uninsured. Of those uninsured and ineligible for their employer's coverage, some worked too few hours, some had not worked for their employer long enough, and some were hired on a temporary or contract basis making them ineligible for benefits. Thorpe and Florence *op cit* p. 216.

<sup>12</sup> In order to secure the protections of community rating, explained in Part II, a 75% participation rate is required.

<sup>13</sup> Respondents could select more than one answer.

<sup>14</sup> Maine Bureau of Insurance. What Small Employers Should Know About Health Insurance. <http://www.state.me.us/pfr/ins/smallemp.htm>

The amount of employee contribution to the premium for single coverage in Maine in 1996 averaged 17%, just under the national average. Employee premium contributions for family coverage averaged 33%, which was slightly higher than the national average.<sup>15</sup>

Cost was the principal reason employers gave for not offering coverage in the Maine Small Business Survey. When asked about their main reason for not offering coverage, the 120 employers who did not offer cited the following reasons:

- 76 (63%) cost
- 14 (12%) “company is too small” to offer insurance
- 11 (9%) largely have part-time workers or a seasonal business
- 9 (8%) all or most employees have coverage elsewhere.

### **Dealing with Market Changes**

The health insurance market place has been changing rapidly in the last few years, with rising premiums and changing insurance carriers. Small businesses have choices to make almost every year as to which carrier to use, what type of plan to offer, and what, if any, cost share to require of employees. As costs have increased, many firms must continually decide how much of a priority health coverage is to the firm, both as a matter of principle and responsibility to employees but also, in a tightening labor market, as a necessity to attract and keep good employees. The Maine Small Business Survey indicates the premium increases Maine employers have been dealing with and how they are responding to those increases.

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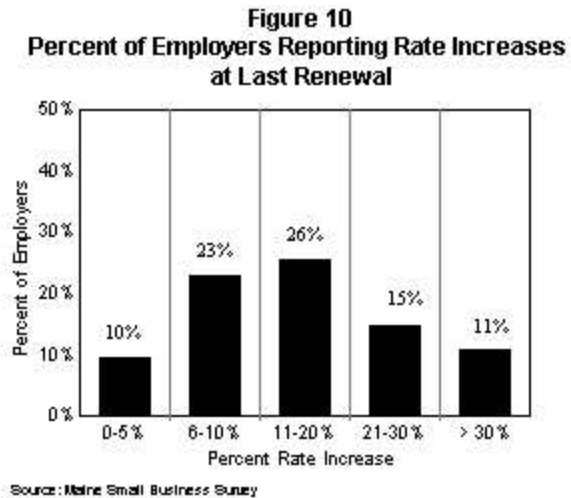
<sup>15</sup> James Branscome et al. “Private Employer-Sponsored Health Insurance: New Estimates by State.” *Health Affairs*. January/February 2000, XIX:1. p. 145 (analysis of the Medical Expenditure Panel Survey)

## Large Rate Increases At Last Renewal

Of the total sample of 381 respondents in the Maine Small Business Survey, 295 (77%) provided health insurance at some time in the last three years. Of those, 249 (84%) indicated that their premiums had increased in that time period.<sup>16</sup> Of those who experienced increases, 52% experienced increases of more than 10%.<sup>17</sup> (See Figure 10)

## Health Care Costs are a Significant Financial Concern

A substantial majority (334 or 87%) of respondents said that health insurance costs were either a major or a moderate financial concern for their company, while only 28 (7%) reported health costs to be only a minor concern.



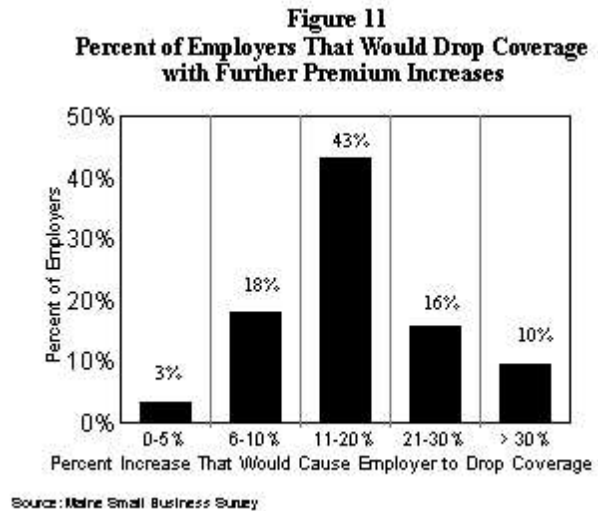
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<sup>16</sup> Of the total sample of 381 respondents, 295 indicated having provided health insurance at some time in the last three years.

<sup>17</sup> The survey responses were collected in July through September of 1999, before Tufts Health Plan of Maine announced its departure from the state. Tufts' premiums were among the lowest among Maine carriers; other carriers suggest that Tufts' losses stemming from inadequate premiums forced them to withdraw from the market. Thus, when they announced their departure from Maine, small firms were forced to seek higher priced alternatives. One knowledgeable observer commented in the summer of 2000, "The situation a year ago when this survey was done was positively 'rosy' compared to today."

## Future Premium Increases Would Cause Employers to Decrease Coverage

Of those currently providing health insurance, there was a strong indication that further premium increases would cause the employer to decrease coverage. When asked to note at what level of future premium increase employers would decrease coverage, 47 (18%) reported a 6-10 percent increase, 113 (43%) reported an 11-20 percent increase, 41 (16%) said a 21-30 percent increase, and 25 (10%) reported that a premium increase of over 30 percent would cause them to decrease coverage. (See Figure 11)



## Responses to Cost Increases

Many of the 381 respondents had made changes in the last three years in response to cost increases including:

- 170 (45%) changed insurance companies
- 160 (44%) changed to an HMO or other managed plan
- 110 (29%) raised the plan deductible
- 58 (15%) reduced health benefits
- 55 (14%) shifted part of the premium cost to employees
- 62 (16%) delayed wage increases as a response to rising health costs.

Many small businesses have undergone frequent insurance carrier changes either as carriers left the market or as the business sought lower rates. These changes have caused incalculable but real costs for employers and employees. Employers incur the cost of researching and negotiating new policies; the employees must learn the terms of their new coverage and sometimes even change providers.

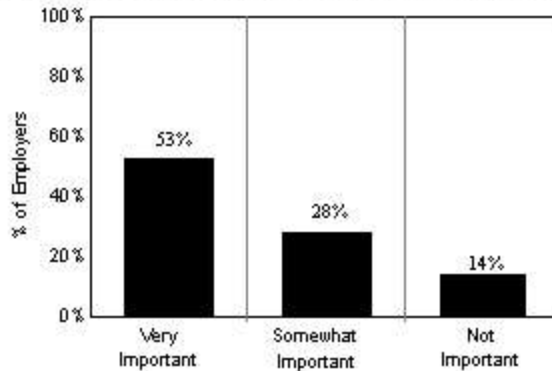
## The Importance of Employee Attraction and Retention

When asked how important the provision of health benefits was to their company's attraction and retention of employees, 309 (81%) noted that it was very or somewhat important, while only 55 (14%) said that it was not important. (See Figure 12)

### The "Right" Thing to Do

The vast majority of respondents (324 or 85%) also said that providing health benefits was very or somewhat important as a matter of principle or employer philosophy.

**Figure 12**  
**Importance to Employers of Providing Health Coverage for Employee Attraction and Retention**



Source: Maine Small Business Survey

### Summary

This survey suggests that many small Maine employers have a strong interest in providing employee health coverage, but are having an increasingly difficult time doing so. The majority of these small firms were offering coverage in 1999, but recent reports suggest an increasing pace of dropping coverage by both employers and employees. Rising premiums have led some employers to pass increases onto their employees or limit which employees are eligible. Many workers appear to be declining the offer of insurance because of the rising cost of their share and low wage rates. The smaller the firm, the less likely it is to offer any health coverage and small businesses employing low-wage workers are less likely to offer insurance. Further increases are very likely to bring further decreases in the rate of insurance offers and take-ups.

## II. Maine's Small Group Reforms

### Background

In order to understand and provide context for the survey data provided in this report, it is helpful to review the small group reforms enacted in Maine and the impact they have had on Maine's small group market. Unlike large groups, small groups suffer from administrative diseconomies of scale, inability to spread risk broadly, and lack of bargaining power with health insurance carriers and health care providers. These conditions lead to higher and less stable premiums for the same or less generous benefits than experienced by larger businesses.

Many states, including Maine, enacted small group reforms during the 1990s in an effort to make health insurance more affordable and available to small groups with higher risk

workers.<sup>18</sup> In fact, Maine has been a leader in reforming its non-group and small group<sup>19</sup> markets since the early 1990s.<sup>20</sup>

Maine lawmakers were concerned that without reforms, non-profit carriers like Blue Cross and Blue Shield of Maine would be in financial jeopardy because they did not engage in the same level of risk selection as other carriers did to differentiate between high-risk and low-risk groups. Moreover, lawmakers were concerned that competition among health plans was increasingly based on risk selection rather than service, quality, or health care cost management.

Maine adopted fundamental market reforms to prevent carriers from hiking rates or canceling coverage when an employee in a small group became ill or from excluding coverage of a worker's medical conditions when she or he changed jobs. These reforms, called "community rating"<sup>21</sup> and "continuity of coverage,"<sup>22</sup> put Maine in the forefront of states protecting employers and workers from discriminatory pricing and coverage practices.

### **Continuity of Coverage**

Maine enacted a comprehensive "continuity of coverage" law in 1989.<sup>23</sup> This law enabled workers to move from job to job without fear of losing their or their dependents' medical coverage. In most instances, workers have 90 days within which to obtain new coverage after their previous coverage ends. This period may last up to 180 days if the person is unemployed and receives unemployment compensation prior to becoming employed and seeking new medical coverage.<sup>24</sup>

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<sup>18</sup> R. Curtis, S. Lewis, K. Haugh and R. Forland, "Health Insurance Reform In The Small Group Market", *Health Affairs*, May-June 1999 at 151-160 states "By the end of 1997 forty-seven states had implemented access and rating reforms."

<sup>19</sup> For purposes of Maine's community rating laws, small group is defined as "50 or fewer eligible employees" and allows for groups of one defined as a "sole proprietor, a partner of a partnership or an independent contractor." 24-A M.R.S.A. §2808-B(1)(C)

<sup>20</sup> The enactment of Public Law Chapter 422 (1989) (24-A M.R.S.A. §2808-A) may have made Maine the first state in the nation to adopt small group rating reforms. The law applied to all policies executed, delivered, issued for delivery, continued or renewed in Maine on or after January 1, 1990.

<sup>21</sup> 24-A M.R.S.A. §2808-B

<sup>22</sup> 24-A M.R.S.A. §§2849, 2849-A, 2849-B, and 2850

<sup>23</sup> Public Law Chapter 867 (1989) was enacted in 1989 and had three application dates: October 1990 for group continuity, December 1990 for limitations on exclusions and wait periods, and April 1991 for individual continuity. Maine appears to have been the first state in the nation to enact this type of law.

<sup>24</sup> 24-A M.R.S.A. §2849-B(2)(B)

## Community Rating

Maine lawmakers were concerned that competition among health plans had become increasingly based on risk selection and risk avoidance rather than service, quality or health care cost management. However, they were also concerned with the potential effects of proposed reforms. Some carriers claimed that reforms like “community rating” would drive carriers and employers from the market due to “rate shock.” These carriers also claimed that proposed reforms would start a “death spiral,” leaving fewer insured employers in the small group market facing increasing rates and an aging workforce with deteriorating health. While these dire predictions did not come true, a number of profit-motivated carriers did exit the market primarily, or solely, due to the “guaranteed issue” requirement.<sup>25</sup>

Because Maine was in the forefront of many reforms, there were few state models to follow. Maine lawmakers undertook reforms cautiously. They incrementally supplemented or modified these reforms as they gained experience and observed their effects.

In simple terms, Maine prohibited carriers from using factors like gender and health status in determining rates, but permitted them to use factors like age and occupation. Under current law, an older member’s rates can be 50% higher than a younger member’s rates in a group.

In 1989, the Maine legislature enacted the first in a series of small group rating rules,<sup>26</sup> as a precursor to community rating. For groups with fewer than 25 insured members, the law established limits on rate increases based on the groups’ claims experience.<sup>27</sup> It allowed groups to be divided into tiers for rating purposes. Rates for the highest tier could not exceed the average rate for all tiers by more than 20%. In 1991, Maine enacted its “community rating” law covering small groups with “fewer than 25 eligible employees.” This was expanded to “fewer than 50 eligible employees” in 1997. The community rating law prohibited carriers from varying rates based on gender, health status, claims experience or policy duration. It restricted rate variations based on age, smoking status, occupation or industry, and geographic area to no more than 20% above or below the community rate.<sup>28</sup>

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<sup>25</sup> Maine Bureau of Insurance, “The Effects of Maine’s Health Insurance Reform”, December 1997 at p. 4 states that a “handful of carriers” withdrew from Maine’s small group and individual market.

<sup>26</sup> *Supra*, fn 2.

<sup>27</sup> It also restricted rate increases between different subgroups of a group that were based on claims experience.

<sup>28</sup> Maine, like many states, limited the rate variation to a percentage above or below a “midpoint” or “index” – here the “community rate.” To determine the total variation allowed based on these factors, divide the higher permitted percentage by the lower permitted percentage (e.g., 120/80 = 1.5 or 50%). In addition, carriers can vary rates without restriction based on family membership, participation in wellness programs and group size.

In addition to the rating reforms, Maine adopted access reforms. These laws require carriers to “guarantee the issue and renewal”<sup>29</sup> of coverage to all groups and members in a group. A carrier offering small group coverage must offer coverage to all comers and cannot cancel coverage upon application for renewal except for failure to pay premiums, or fraud.

### **Impact of Small Group Reforms on Maine’s Small Group Market**

In a December 1997 report,<sup>30</sup> the Maine Bureau of Insurance commissioned Towers Perrin Integrated Health Systems Consulting to conduct a survey of carriers in the non-group and small group markets and to evaluate the effects of Maine health insurance reforms adopted in the early 1990s. The report concluded that:

“Some critics of reform legislation predicted that modified community rating would cause an assessment spiral. The evidence presented in this report, however, shows that the demographics of the insured population have nearly reached equilibrium. The 20% bands within which the small group and individual rates must lie are wide enough to prevent the onset of an assessment spiral.”<sup>31</sup>

The report also concluded that:

“The proportions of Maine’s population that are insured and uninsured have not changed because of reform. However, what has changed are the characteristics of the insured population. Some healthy persons have dropped their health insurance coverage, while older, less healthy persons make up a larger portion of the insured population.”<sup>32</sup>

In 1998, the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine<sup>33</sup> took no action regarding Maine’s reforms. The commission noted comments by John Benoit of the Holden Insurance Agency, which he recently recapped as follows:

“The biggest issues for small business are cost and access. However, because community rating has diminished the differential in pricing between carriers, the deciding factor for most small businesses will increasingly become access as carriers aggressively contract within narrowing networks on price.... Pricing has

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<sup>29</sup> 24-A M.R.S.A. §§2808-B (4) and 2850-B

<sup>30</sup> Maine Bureau of Insurance. “The Effects of Maine’s Health Insurance Reform.” December 1997.

<sup>31</sup> Id at p. 36

<sup>32</sup> Id

<sup>33</sup> Final Report of the Blue Ribbon Commission to Study the Effects of Government Regulation and Health Insurance Costs on Small Businesses in Maine, January 1998

come into conformity within the community rated market as the result of spreading a maturing risk across competing carriers.”<sup>34</sup>

### **Ongoing Cost Increases and Changes in Maine’s Small Group Market**

National health care spending statistics suggest that there has been a period of relatively moderate growth in health care costs following the effort to adopt major health care reform at the national level in 1994. But that period appears to have come to an end. Real (inflation-adjusted) health spending growth, less than 3% each year in 1995-1997, accelerated to 4.5% in 1998.<sup>35</sup> While public spending slowed, largely due to Medicare constraints, private health insurance premium increases rose from 3.5% in 1997 to 8.2% in 1998. These increases raise alarm about potential further losses in health coverage rates and they show no sign of immediate abatement.

Current market changes are impacting the overall health insurance situation in Maine. For example, Blue Cross Blue Shield of Maine has the longest record of providing coverage to Maine businesses and employees and still has the largest market share. Yet the sale of Blue Cross to Anthem, an out-of-state for-profit corporation, could bring about significant changes in costs and coverage. Additionally, the 1999 withdrawal of Tufts Health Plan from the Maine market and the reorganization of Harvard Pilgrim have impacted costs.

While, some for-profit insurance companies are reported to have a claims ratio of 80% or less – meaning that 20% or more of premiums received are spent on administration, profits, or costs other than health care claims – that does not appear to have been a substantial factor in recent premium increases for Maine small businesses. News reports suggest that Blue Cross and other carriers have been underpricing their insurance products to gain market share and have thus operated with significant losses for several years. This competition may have “suppressed” premium increases below the rate of underlying health care cost increases. With fewer carriers in the market in the last year, the reduced competition may be permitting the remaining carriers to “catch up” with actual health care costs.

Maine health care providers report that their prices have not risen as fast as premiums have. They note that greater utilization of medical services and very rapid increases in the cost and use of pharmaceuticals have been significant cost drivers. The Maine State Employee Health Plan is not necessarily representative of small group health insurance, but its experience with underlying costs offers a useful parallel. The plan’s July 1999 annual report notes that the point-of-service plan premium increased only 6% in 1999 due to a price cap negotiated with the carrier, after several years of stable premiums. “If premiums had been determined by actual claims experience, rates would likely have increased by approximately 15%.” Among the factors

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<sup>34</sup> Id at Appendix F, p. F-5; remarks reviewed and clarified through personal communication to the authors from John Benoit, July 11, 2000

<sup>35</sup> Katherine Levit et al. “Health Spending in 1998: Signals of Change.” *Health Affairs*. January/February 2000, XIX:1, p. 124

cited for the increased costs were an aging population, drug costs increasing 20% in each of the years 1998 and 1999, and reduced competition in the managed care industry.<sup>36</sup>

Another related event is that self-employed business owners have been able to buy “small group” health insurance products from Aetna and Cigna. In the summer of 2000, those companies discontinued offering their “group” coverage to “one-employee groups”, now matching the Anthem Blue Cross practice of only offering individual policies to such businesses. The individual market was further rocked when Mutual of Omaha, Washington National and Consec announced their withdrawal from the Maine market in the summer of 2000, leaving an estimated 12,000 policyholders to search for a different carrier or drop coverage. The resulting acute problems for self-employed individuals and other individual health insurance purchasers are significant although beyond the scope of this report.

In response to such events, Maine’s Governor in early 2000 formed a commission with several objectives: to “identify the cost elements of Maine’s health care system...; determine the current allocation of costs and cost shifting...; recommend potential strategies for stabilizing overall health care costs; and identify payment options for health care services....”<sup>37</sup> The commission will report its findings in November 2000.

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<sup>36</sup> Maine Health Information Center. Annual Report to the Governor on the State Employee Health Plan. Manchester, ME, July 1999.

<sup>37</sup> Year 2000 Blue Ribbon Commission on Health Care, [www.mdf.org/chc/](http://www.mdf.org/chc/)

### **III. Current Policy Proposals**

#### **Searching for Solutions**

A number of public policy interventions are being discussed at both the state and national levels to address small business health coverage. Maine's Bureau of Insurance recently reviewed numerous options for addressing problems in the individual health insurance market.<sup>38</sup> A few of these proposals could also be applicable to and favorable for the small group market. On the other hand, some proposals that address problems with individual insurance could cause higher costs in the small group market.

These proposals can be divided into two groups: those that reduce the costs of health care or health insurance coverage for all purchasers; and those that reduce health insurance costs specifically for small business purchasers. The latter is achieved by shifting some of the costs small businesses now bear to either other purchasers or to taxpayers through public programs.

#### **1) The partial integration of the individual and group health insurance market**

The Bureau points out that individual health insurance can be purchased by retired and unemployed individuals who are often at greater risk for health problems than employed people. Therefore, there would naturally be "adverse selection" in this individual market where those who are older or have more health problems are more likely to purchase this coverage and bring higher costs with them. Within the group health insurance market, by contrast, the insured group members are currently employed, suggesting better health and, therefore, lower costs, and the employer contribution to cover the cost makes the insurance more affordable for the members.

Presently, carriers pool all individual purchasers together and all small group purchasers together, resulting in rates that are considerably higher for individual purchasers than for group purchasers. In turn small groups generally pay higher rates than larger groups for several reasons: the higher marketing costs to reach many different groups; the stronger bargaining power of the largest groups which brings their rates down; and the experience that small groups generally cost slightly more in health costs than large groups.

The Bureau suggests that a "risk adjustment mechanism" could share the risks between the two markets. The clearest way to do this would be an assessment or fee for all group plan holders based on the number of covered lives in all health insurance policies and "stop-loss" policies (purchased by so-called self-insured employer groups).<sup>39</sup> While an assessment on group

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<sup>38</sup> Maine Bureau of Insurance. "White Paper: Maine's Individual Health Insurance Market." Maine Department of Professional and Financial Regulation. January 2000. <http://www.state.me.us/pfr/ins/indivpaper.htm>

<sup>39</sup> So-called "self-insured" employers usually purchase a "stop-loss" or excess insurance policy. This means that the employer pays an employee's medical claims up to a certain level and anything over that level is billed to the

plans for the benefit of individual policies would further increase employer costs generally, it achieves the goal of sharing some of the risks and costs associated with both the individual and small group markets with the large group market.

A relatively small assessment on all group policies could indeed provide significant relief to individual policy holders because the ratio of the size of the number of group market participants to that of individual insurance purchasers is sixteen-to-one. However, the ratio of the number of large group market participants to that of small group market participants is closer to one-to-one. Therefore, shifting relief proportionately from one group to the other appears to cause a loss for one of the two groups. If so, this would result in a zero-sum situation. This would be harder to sustain politically, although an argument can be made that sharing all risks in as large a pool as possible has the best chance of preserving a viable private insurance market.

## **2) Assessment on all health insurance and stop-loss policies of the so-called “self-insured”**

An assessment on all stop-loss and group health policies as discussed above would essentially transfer costs in order to offset the higher costs associated with higher risks in the small group and individual markets. Another approach would be to use such an assessment more directly to fund care for uncovered populations.

Increasingly, larger groups are successfully bargaining for prices that do not include the providers' traditional provision of care to uninsured people. Those costs are then being shifted to payers (arguably patients who are self-pay or are in individual and small group policies) who are not in a position to avoid them. If the burden of such cost shifts was more broadly shared among small and large groups, it could reduce costs to those covered in small group insurance policies.

## **3) “Bare Bones Policies” -- Limiting “mandates”**

Some business groups have promoted, and some states have adopted, allowing insurance carriers to sell policies that are exempt from state benefit mandates as a way to reduce the cost of coverage. The Maine Bureau of Insurance reviewed the cost of mandated health insurance benefits in individual policies. They found:

“It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates.... The true cost impact is less than this for two reasons: 1. Some of these services would likely be provided even in the absence of a

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stop-loss or excess insurance carrier. To the extent that such employers are purchasing insurance to cover medical claims, the term “self-insured” is a misnomer. However, such plans gain tremendous advantage for the employer since the Federal law known as ERISA preempts states from regulating these so-called self-insured plans. While ERISA preemption has been found to preclude a direct assessment on such plans, courts have permitted an indirect assessment that can reach all payers, such as a mandated surcharge on hospital charges.

mandate. 2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas.”<sup>40</sup>

In the late 1980s and early 1990s several states responded to the theory that bare bones policies might permit broader health insurance coverage, and by 1995, 43 states had passed such laws. Recent studies found that the resulting bare bones policies were soundly rejected in the marketplace and failed to deliver expected lowered costs or expanded coverage. In the words of one study, “Sales of limited benefit plans have generally disappointed insurers, the business community, and public policy makers... In most states enrollment within the first year of product sale has been only one to two hundred.”<sup>41</sup>

#### **4) Purchasing alliances**

Over the years, many “purchasing alliance” proposals have been advanced. These might take the form of pools or co-ops in which small employers could band together to contract with one or more health plans to provide coverage for members’ employees. The theory is that if enough small groups band together they may gain enough united bargaining power to obtain better rates than those afforded to any purchaser in the small group market through community rating.<sup>42</sup>

Maine already has several dozen business associations that have exemptions from the state’s community rating law to allow the groups to negotiate on the basis of their pooled groups’ own experience. These include chambers of commerce in the Bethel, Greater Portland, and Boothbay areas, and trade groups ranging from homebuilders and grocers to oil dealers and innkeepers. Of all respondents in the Maine Small Business Survey, 56 (21%) purchased their coverage through an association.

Many of these groups are able to sell insurance at rates their members find acceptable. However, insurance theory suggests that such groups would need to be much larger to have a pool of covered lives big enough to successfully spread risk. This would include engaging enough young healthy subscribers who make fewer claims in order to bring the rates down. When groups get big enough to attract the number of members needed to get a competitive rate, they will hold these members only as long as the members could not get as good a rate on their

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<sup>40</sup> Maine Bureau of Insurance “White Paper: Maine’s Individual Health Insurance Market.” *op cit* p. 29

<sup>41</sup> Butler, Patricia. 1992. “Flesh or Bones? Early Experience of State-Limited Benefit Health Insurance Laws.” Portland, ME: National Academy of State Health Policy, quoted in Riley, Trish and Barbara Yondorf. *The Flood Tide Forum: Access for the Uninsured: Lessons from 25 Years of State Initiatives*. National Academy for State Health Policy, January 2000, p. 29

<sup>42</sup> “Community rating” refers to the requirement of Maine law effective in 1993 that small group health insurance be rated not based on the claims experience of the particular employer group but on the pool of all small group purchasers of the particular insurer.

own. As groups' members age and bring with them higher risk, the rates inevitably rise and newer, younger employee groups find it cheaper to buy outside of the pool.

Existing Maine associations typically contract with a single carrier for a single product for all members. The purchasing alliance or co-op model would typically offer more than one kind of product. This theoretical difference may become a hollow distinction in the Maine market as the number of carriers and products affordable to small businesses continue to dwindle.

A recent GAO study examined the experience of five of the larger small business health purchasing cooperatives.<sup>43</sup> They concluded that while the co-ops offered their members and employees greater choice of products, they had not succeeded in bringing insurance prices below what small businesses could obtain on their own outside of the co-ops. The study suggested that the groups had not been able to capture a sufficient market share to bargain for better rates; that they did not offer significant administrative savings; and that they were frequently constrained by state regulations to offer rates based on community experience, rather than specific group experience. The one co-op that had been permitted to vary its rates significantly from what small businesses could get outside the group encountered exactly the predicted problem: they attracted higher risk groups; the prices rose above market rates; they began to lose members; and they changed their rating practices and eventually dissolved.

Purchasing alliances may still offer some benefit where they can secure the participation of the majority of employers and providers in a discreet community, but it will be more difficult for alliances operating on a statewide voluntary basis to achieve savings.

## **5) Publicly funded programs of direct coverage for low-income people**

In recent years, the Maine legislature has expanded Medicaid coverage and Medicaid-like coverage (Cub Care) for children in families with income up to 200% of the federal poverty level (\$28,300 for a family of three). In 2000, Medicaid was expanded for parents with income up to 150% of the federal poverty level (\$21,225 for a family of three). These programs should modestly offset some employer cost increases by reducing the number of uninsured people and the costs hospitals incur to serve them through charity care and bad debt, since these costs are ultimately shifted onto employers or those privately paying for their own health care. Additional expansions of publicly funded coverage for parents and single adults would provide additional relief from such cost shifting.

The Cub Care program, pursuant to federal law, is available only for children who have not been covered in the three months prior to application. A modest change in federal law could make it easier for parents to switch their children from their employers' dependent coverage to state-provided coverage. This would in turn reduce costs for the relatively few small employers who still provide any significant contribution to dependent coverage.

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<sup>43</sup> United States General Accounting Office, "Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices, March 2000, GAO/HEHS-00-49, [www.gao.gov](http://www.gao.gov)

For businesses which employ only low-wage, low-income workers, such programs could provide alternative coverage for all their employees, and the employers would be relieved of all health insurance costs. But most employers typically have employees both below and above the eligibility threshold for publicly funded programs, and thus will not be able to use public programs as a complete substitute for all of their employee health coverage.

The Center for Studying Health System Change used Community Tracking Study Household Survey data from 1996-1997 and 1998-1999 to show that while there were gains over the period in low-income children's coverage in public programs, losses in private employer insurance resulted in no significant change in the uninsurance rate. At the same time, the surveys showed continued erosion of coverage among low-income parents. The study authors summarized, "Further increases in health insurance costs — as many predict will happen — will only increase the financial burden and, therefore, the pressure on low-income families to find alternatives to private insurance or do without insurance altogether."<sup>44</sup>

## **6) Tax credits for employers' health plans**

Employer costs for employee health insurance are, of course, presently deductible as business expenses for purposes of both federal and state business income taxes. They are also excluded from income when calculating individual income taxes for employees receiving the benefits.

Federal law presently allows a deduction of 60% in 1999, going to 70% in 2002 and 100% in 2003, for individual self-employed persons. The state has recently adopted the same provision. A pending Congressional proposal would accelerate the phase-in to a 100% deduction of health insurance costs for individual self-employed people.

In addition to the deduction, the Maine legislature added a modest tax credit (maximum \$125 per year) for employers of fewer than five low-income employees who purchase dependent coverage for those employees. Tax year 1999 is the first year in which taxpayers could claim the credit and thus returns seeking the credit are just beginning to be filed. The Bureau of Revenue Services informs us that their data retrieval system allows compiled data on tax credits only for corporations. Since many of the small companies targeted for this credit may not be organized in corporate form, it is doubtful whether the number of businesses taking advantage of this credit can be calculated. The steady decline of dependent coverage among small businesses would suggest that the credit is likely not large enough nor broadly advertised enough to induce the majority of small employers who no longer provide dependent coverage to change their course and purchase such coverage.

From January 1991 through December 1993, a federal tax credit for a maximum of \$428 was available for families with incomes up to \$21,250 to cover part of their costs for dependent coverage. A study of the credit concluded that "if a tax credit program is to be effective, first, the

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<sup>44</sup> Center for Studying Health System Change. "Recent Trends in Children's Health Insurance Coverage: No Gains for Low-Income Children." Issue Brief Number 29, April 2000

eligible recipients will need to be educated regarding the program and, second, the tax credit/subsidy will have to be relatively high compared to the out-of-pocket costs borne by the target population.”<sup>45</sup>

This study further noted that existing income tax exclusions and deductions for health care cost over \$111 billion in lost tax revenue to the federal government. An additional \$13.6 billion is lost revenue for state governments. The biggest share of this tax loss is due to the exclusion of employer-provided health benefits from income.

Three other tax provisions affect only a minority of taxpayers. Individual taxpayers who itemize deductions may deduct medical expenses including their share of premiums in a group or individual policy to the extent that such costs exceed 7.5% of their adjusted gross income. Most taxpayers do not reach this threshold, so only 4% of all taxpayers took advantage of the medical expense deduction in 1996. About 2.5% of all returns included a claim for the self-employed deduction discussed above.

There are three forms of health reimbursement accounts recognized under current federal tax law that assist another small minority of taxpayers. Some, mostly larger, employers set up a “cafeteria plan” under which employees may choose between levels of health coverage or other benefits such as child care, and cash. Employers may also establish a “flexible spending account” (FSA) into which either employer contributions or employee payroll deductions are deposited. These are exempt from taxation and employees may draw from them for their premium share or deductible health costs. About one in five workers in small firms are estimated to have an employer sponsored FSA available to them, while nearly half of all workers in medium or large firms do.<sup>46</sup>

Finally “medical savings accounts” (MSA) may be established by employees in small firms with certain high-deductible health insurance products which are not currently sold in Maine. Employers’ contributions to MSAs are excluded from taxable income as are certain levels of employee contributions. One of the concerns expressed about medical savings accounts is that they provide the greatest benefit to families and individuals that can afford the exposure to high deductible expenses, while they do not address low- and moderate-income families or individuals who cannot easily save for emergencies and whose lives could be seriously disrupted by even \$1000 of out-of-pocket costs.

Health insurance tax subsidies have some negative effects. The current system favors people with employer coverage over individual coverage and offers little help to the uninsured. The largest subsidies are provided to taxpayers with higher incomes. Nearly 70% of health-related tax subsidies go to the 36% of the population with incomes over \$50,000. The federal

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<sup>45</sup> Meyer, Jack et al. “Assessing Tax Subsidies to Cover the Uninsured; Tax Reform to Expand Health Coverage: Administrative Issues and Challenges” Economic and Social Research Institute for Kaiser Family Foundation. January 2000, p.11

<sup>46</sup> Ibid. p. 8

portion of the tax subsidies is slightly higher than total federal Medicaid expenditures for low-income people.<sup>47</sup>

## **7) A sampling of current federal proposals**

The federal government is currently considering numerous proposals to address the growing number of uninsured people. Some proposals expand the level at which health insurance premiums can be deducted from federal taxes. Others provide additional tax credits for health insurance purchase.

In January 2000, the Clinton administration announced a four part proposal to expand coverage to an estimated 5 million uninsured Americans. The administration's budget included a proposal to provide higher Medicaid matching funds for state programs to cover parents of children eligible for the Medicaid or S-CHIP (Cub Care in Maine) programs. The proposal included the option for states to assist families in meeting their share of premiums for an employer health insurance plan if that plan meets certain criteria, including a 50% employer premium contribution.

Smaller initiatives in the President's proposal included a tax credit for small firms that have not previously offered health insurance that would offset 20% of their premium contribution if the policy was purchased through a purchasing alliance.

Vice President Gore has included the administration's proposals in his own and has gone further to propose expansions of the CHIP program to cover children in families up to 250% of poverty and to allow "buy-ins" by individual families above that income level. Gore also proposes to expand the CHIP program to parents. He proposes a refundable 25% tax credit for premium costs when small businesses participate in health purchasing co-ops, and a new 25% tax credit for those buying individual coverage if they have no access to employer-sponsored coverage.

The Republican presidential candidate, Texas Governor George Bush, has also proposed a refundable tax credit of \$1000 for individuals and \$2000 for families toward the cost of health insurance. Bush has also proposed an expansion of medical savings accounts.

While he was in the presidential primary race, former Senator Bradley proposed a more sweeping plan that would require parents to cover their own children and provide subsidies to all low-income people. The plan would allow low-income people to buy insurance through the federal employees' insurance program, and would provide a new tax deduction for all premium payments.

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<sup>47</sup> Ibid. pp. 9 and 10

## 8) Direct subsidies of small business health insurance

The state of New York adopted at the end of 1999 a comprehensive “Health Care Reform Act of 2000” which legislative leaders argued would “establish the most comprehensive health care program in the nation...” extending insurance to an estimated 1 million uninsured New Yorkers. One of the bill’s provisions creates a new “streamlined benefits package” for businesses with 50 or fewer employees, and at least 30% of employees earning under \$30,000 annually, which had not offered health insurance in the previous 12 months, and which contribute 50% or more of the premium. The state will require all HMO’s operating in the state to offer the package, and will reimburse claims from policyholders between \$30,000 and \$100,000. Though the benefit package is described as “streamlined,” it will include inpatient and outpatient hospital services, physician diagnostic and treatment services, family preventive and primary care, x-ray and lab services, and a prescription drug benefit. The state will further subsidize the cost of the same benefit package for individuals who are not offered insurance through their employers, with the state providing stop-loss coverage for claims between \$20,000 and \$100,000.<sup>48</sup>

The federal State Children’s Health Insurance Program (CHIP) enacted in 1997 enabled states to provide coverage to uninsured children with a higher federal “match” rate than provided through Medicaid. Maine used this program to expand Medicaid and adopt Cub Care as described above. The federal government has also provided guidance to states on how the program could be used to subsidize employer-based coverage. Massachusetts, Wisconsin, and Mississippi have been granted approval for various plans to subsidize employer-sponsored health insurance. Rhode Island permits home-based child care providers to participate in a Medicaid-like program, while child care centers are eligible for a 50% state subsidy for the purchase of private insurance.

Finally, the State of Washington has permitted employer groups to “buy into” the Washington Basic Health Plan, which was funded with state funds to provide subsidized coverage for families below 200% of federal poverty income guidelines.<sup>49</sup>

## Conclusion

The range of options currently being discussed are not likely to bring small businesses significant relief in providing employee health insurance in the short-term. Federal proposals that would have brought significant savings and choice to small businesses were defeated in 1992 and 1993. The health insurance industry and other strong interests opposed these major changes by successfully persuading the public and their political representatives that most Americans stood to lose more than they stood to gain.

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<sup>48</sup> New York State Senate. Press Release: Senate Gives Final Passage to Historic Health Care Reform Bill. [www.senate.state.ny.us/Docs/press99/press100.html](http://www.senate.state.ny.us/Docs/press99/press100.html)

<sup>49</sup> Riley, Trish and Barbara Yondorf. *The Flood Tide Forum: Access for the Uninsured: Lessons from 25 Years of State Initiatives*. National Academy for State Health Policy, January 2000

Employers like those responding to the Maine Small Business Health Survey may soon be ready to consider more significant reforms that would truly help them and their employees maintain and expand health coverage. The challenge is to identify policy options that offer the best chance of strengthening the current system of employer-provided coverage, while also providing coverage to the increasing number of employees left out of that system.

Many observers suggest that more public funds will be required to offset the higher costs currently borne by most small employers. For taxpayers to assume all of the health care coverage costs currently provided by employers would require a major shift of resources. If the state is not ready for such a shift, it will face the difficult question of how to target increased public spending in ways that will achieve the greatest health coverage for those at greatest risk.

## Appendix

### Methodology

The goal of the survey was to find out what percentage of Maine's small businesses are currently offering employee health coverage, and what characterizes those who offer and those who do not.

In June, 1999, a random sample of 4000 firms with one to 49 employees was selected using listings from Tower Publishing in Standish, Maine. There were 30,346 listings of firms in this size range in all, representing about 80% of the state's firms of this size.<sup>50</sup>

In order to achieve the most accurate geographic and firm size representation possible in the sample, specific sampling quantities were requested from Tower for each county by four firm sizes: 1-4 employees, 5-9, 10-19 and 20-49. These were based on the percentages that each county and firm size represented of the entire sample.

For example, of the 30,346 total number of firms with 1-49 employees, 2070 firms (6.8%) were located in Androscoggin County; therefore, the sample of 4000 included 273 firms (6.8% of the total) from Androscoggin County. Furthermore, there were 1099 firms – 53% of the total 2070 firms in Androscoggin County – with 1-4 employees. Thus, the sample included 145 firms with 1-4 employees from Androscoggin County, (53% of 1099).

The 4000 surveys were sent in late June, 1999 with a cover letter signed by three business and economic development leaders under the name of the Small Business Health Insurance Project. Responses were collected through September, 1999. Approximately 100 were returned with inadequate addresses for forwarding.

There were a total of 472 respondents. Of these, 48 were eliminated because they were public or non-profit organizations, were currently out of business, or now had 50 or more employees. In addition, 43 individual business owners with no employees were eliminated since their health insurance options are different from firms with at least one other employee. The total sample of firms in the survey then is 381.

Of these, 354 answered the questions regarding their total number of employees. The total number of employees that were reported by these respondents was 3,380.

A comparison of the number of employers and employees in this sample to the total number of employers and employees in firms of these sizes in Maine indicates that the sample is biased toward larger firms. For example, of the total number of possible firms of this size in Maine, 63% are in the 1-4 employee category whereas in this sample, only 35% are of this firm

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<sup>50</sup> As of March 1998, there were 37,807 firms of this size in Maine. Maine Department of Labor. 1999. Maine Employment Statistical Handbook.

size. This is partly because individual proprietors were excluded from the sample, reducing the percentage in the 1-4 employee category. Likewise, while only 7% of the firms with 1-49 employees in Maine are in the firm size with 20-49 employees, 12% of this sample represents firms of this larger size.

Thus, the total rate of health insurance coverage offering may be higher in this sample because larger firms offer insurance more frequently than do smaller firms.

**Comparison of Survey Sample to Statewide Number of Employers and Employees  
by Firm Size (of 354 firms identifying number of employees)**

	<b>Total 1-49</b>	<b>1-4</b>	<b>% of Total</b>	<b>5-9</b>	<b>% of Total</b>	<b>10-19</b>	<b>% of Total</b>	<b>20-49</b>	<b>% of Total</b>
<b>Total Maine Employees</b>	214,248	35,409	<b>17%</b>	47,519	<b>22%</b>	56,237	<b>26%</b>	75,083	<b>35%</b>
<b>Sample of Employees</b>	3,380	379	<b>11%</b>	745	<b>22%</b>	950	<b>28%</b>	1,306	<b>39%</b>
<b>Total Maine Employers</b>	38,923	24,495	<b>63%</b>	7,394	<b>19%</b>	4,430	<b>11%</b>	2,604	<b>7%</b>
<b>Sample of Employers</b>	354	125	<b>35%</b>	114	<b>32%</b>	74	<b>21%</b>	41	<b>12%</b>