

ROUNDTABLE REPORT:

IMPROVING THE FUNCTIONING OF
THE SMALL GROUP AND
INDIVIDUAL MARKETS

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NOTICE

THIS DOCUMENT IS A SYNTHESIS OF THE CONCEPTS DISCUSSED AT A ROUNDTABLE MEETING IN WHICH MANY STAKHOLDERS EXPRESSED THEIR OWN VIEWS AND THOSE OF THEIR ORGANIZATIONS. THIS PAPER IS NOT MEANT TO IMPLY, UNLESS SPECIFICALLY STATED, THAT THERE WAS CONSENSUS ON ANY GIVEN ISSUE. IN FACT, THERE WAS A WIDE RANGE OF OPINION. THE AUTHORS HAVE MADE AN ATTEMPT TO CAPTURE THAT RANGE OF OPINION WHILE PRESENTING A COHERENT SUMMARY OF THE DAY'S PROCEEDINGS. HOWEVER, THE FOLLOWING REPORT DOES NOT NECESSARILY PRESENT THE VIEWS OF INDIVIDUAL PARTICIPANTS NOR THE ORGANIZATIONS THAT THEY REPRESENT.

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I. Introduction

On June 14, 2000, the Kaiser Permanente Institute for Health Policy sponsored a roundtable discussion entitled, “Improving the Functioning of Small Group and Individual Markets.” The goals of the meeting were twofold:

1. To identify barriers and explore solutions for improving the functioning of the marketplace for small group and individual health insurance; and,
2. To identify work that needs to be done to address the most important barriers and consider next steps.

Conference attendees included a diverse group of representatives from the insurance and managed care industries, academia, foundations, health policy organizations, the broker industry, and state government. A participant list is included with this report as Attachment A.

This report provides an overview of the day’s proceedings and major conclusions reached by the group. This document is a synthesis of the concepts discussed at the roundtable and does not necessarily present the views of individual participants nor the organizations that they represent.

The first section provides an overview of the opening presentation by Professor Alain Enthoven of Stanford University regarding his view of problems in the current small group and individual markets. This is followed by comments by consultant Lynn Etheredge on assumptions about the future of the markets. Following Mr. Etheredge’s comments, meeting participants developed their own assumptions about the future of the markets. These comments are also presented. The following section of the report is a summary of the discussion regarding barriers to the more effective functioning of the small group and individual markets. This is followed by a discussion of options for overcoming these barriers. Finally, the report summarizes participants’ ideas regarding next steps that they and other parties can take to improve the functioning of the small group and individual markets.

II. A View of Problems in the Current Marketplace

Professor Alain Enthoven of Stanford University opened the roundtable by presenting his views on some of the major problems limiting access to the current individual and small group health insurance markets.¹ Citing data from both the Employee Benefits Research Institute and the Henry J. Kaiser Family Foundation, Professor Enthoven stated that the self-employed and employees of small firms are much more likely to be uninsured than employees of larger firms.² One reason for this phenomenon may be that small firms are less likely than large firms to offer

¹ The following is a summary of Professor Enthoven’s remarks and is not intended as a verbatim re-creation of his presentation.

² EBRI analysis of the March 1999 CPS data.

insurance to their employees, presumably because of concerns about cost.³ Why, then, does individual and small group insurance cost more than large-group insurance?

Transaction Costs. A widely held assumption is that a portion of the relatively higher costs in the small group and individual markets is attributable to insurance carriers' transaction costs (or "administrative loads") in providing a product to these populations. For example, Professor Enthoven noted that the administrative overhead costs of CalPERS (with over 1 million covered lives) are close to 0.5% of premium, while the corresponding costs for Pacific Health Advantage ("PacAdvantage"), a small-employer pool of some 140,000 lives, are close to 11.5% of premium (including brokers' fees). These differences beg the question of whether there is a difference in the internal administrative costs of carriers. Few data are available on this subject. The following table summarizes the few sources that are available.

Administrative Load for Smaller Groups	Administrative Load for Larger Groups	Data Sources
<ul style="list-style-type: none">• 50% for individual insurance	<ul style="list-style-type: none">• 15% for group insurance	Phelps, Charles E., 1997, <u>Health Economics</u> , 2 nd Ed. Reading, MA: Addison-Wesley ⁴
<ul style="list-style-type: none">• 30-49% for small groups (1-10)• 60-80% for individuals	<ul style="list-style-type: none">• 5-8% for very large groups (1,000+)	Phelps, Charles E., 1997, <u>Health Economics</u> , 2 nd Ed. Reading, MA: Addison-Wesley
<ul style="list-style-type: none">• 25% for groups under 25	<ul style="list-style-type: none">• 6% for groups over 2,500⁵	Health Insurance Association of America, Research Department, May 2000. ⁶

Loading costs for small groups and individuals are substantially higher, although the magnitude and causes are not clear. This is problematic because in many cases, individuals and employees of small groups are more likely to be price sensitive because their incomes are likely to be lower and less secure.

Professor Enthoven raised the question of whether the use of e-commerce to support procurement of health insurance might be expected to bring down the administrative costs associated with small group and individual insurance. Sites such as www.ehealthinsurance.com allow an individual to select a plan, fill out a medical review form, and purchase coverage on-line (provided there are no complicated medical issues requiring further investigation). Further research and experience are needed to determine whether such sites will be effective in providing value to individuals and small groups.

³1999 *California Employer Survey*, Henry J. Kaiser Family Foundation/ Health Research and Educational Trust/ University of California at Berkeley, January 2000.

⁴ These figures are based on data from the Health Insurance Association of America for 1995, and are cited in: Pauly, M., and A. Percy, "Cost and Performance: A comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy, and Law*, V25, N1, Feb. 2000. Pauly and Percy note that most of the information available on loading comes from consultants' expert opinions, not from survey data.

⁵ The 19% difference includes 1% more for claims administration, 5% more for plan administration, 5% for risk and profit, 6% for sales expenses, 2% for state tax, and 2% for federal income tax.

⁶ Provided by Tom Wildsmith, HIAA, June, 2000. Prepared for Congressional testimony.

Variation in Costs and Instability. Other factors contributing to higher costs in the small group and individual markets are the wide variation in per-person medical costs among these populations (i.e., low insurance credibility) and carriers' inability to spread risk broadly. This variation leads to a number of consequences: inequity (if one believes the healthy should subsidize the sick); unavailability of insurance when needed, if the premiums of small groups are experience rated; pricing coverage out of reach of the sick; and instability of premiums when small groups have one or a few members who become sick.

There have been a number of state interventions to mitigate these effects. Many states, including California, have passed laws for the small group market that eliminate or constrain the use of health status as a rating factor, that limit premium variations, and that provide for guaranteed renewal.⁷ However, Professor Enthoven concluded that in California, although health status was not allowed as a rating factor, there were so many allowable factors for rating (age, industry, etc.) that variations in premium among small groups continue to be quite wide.

Segmentation of Small Group and Individual Markets. Market segmentation leads to less competition and less elastic demand. Non-standard coverage contracts also raise switching costs for employers and individuals, making it harder for people to understand price differences and/or react to them.

Lack of Individual Choice of Plans within Groups. In general, individuals have a wide choice among health plans, provided that they are healthy. However, employees of small employers tend to have fewer choices. Twenty-seven percent of California firms with 3-50 workers offer a choice of plans, compared with only 9% of small firms nationwide.⁸

Professor Enthoven believes that "choice" among plans should include a wide access plan (such as a PPO), a POS plan, and several closed-panel HMOs, all competing on the basis of price and quality. Competition can be maximized if an employer offers choices among close substitutes, making demand price-elastic. A small employer who offers only one, closed-panel HMO and wants to change plans due to premium increases will need almost unanimous employee consent, as changing plans will likely mean changing doctors.

Conclusions. The small group and individual markets work much less efficiently than do large group markets, such as those created by CalPERS and FEHBP, for all of the reasons described above. In addition, risk adjustment of premiums is important to be sure provider groups that care for sicker people are appropriately compensated. However, risk adjustment cannot be implemented in small groups, absent a large purchasing pool to yield economies of scale and large enough sample sizes for stable estimates.

III. Assumptions about the Future of the Marketplace

To begin this session, consultant Lynn Etheredge presented his assumptions/predictions about what the small group and individual markets will look like and the forces that will affect them in

⁷ In California, this law (AB1672, passed in 1993) applies to groups of 2 to 50.

⁸ *1999 California Employer Survey*, Henry J. Kaiser Family Foundation/ Health Research and Educational Trust/ University of California at Berkeley, January 2000

the next several years. Mr. Etheredge's comments, reproduced from his handout ("Fifteen Assumptions about Improving the Small Group and Individual Insurance Markets"), are as follows:

1. The number of uninsured will continue to grow.
2. State initiatives and insurer actions will not change this trend.
3. To enable substantial reductions in the uninsured population, there will need to be financing from the federal government.
4. The federal government, and most state governments, will have enough funds to finance a major expansion of insurance coverage.
5. Neither Al Gore nor George Bush will seek or gain an electoral mandate for comprehensive health reform. Both will propose some incremental reforms.
6. The election will not grant either party automatic legislative majorities; health insurance expansions will need bipartisan support.
7. Expanded coverage for the uninsured will not be a "must have" initiative for either a new President or Congress. Coverage initiatives will need to compete with tax reforms and other priorities, including Medicare prescription drugs.
8. There is a brief window of opportunity, at the start of the new administration and Congress, when the chances for expanding coverage will be highest.
9. There is a fairly narrow range of options for expanding health insurance coverage that could attract Presidential and bipartisan support.
10. Much of the financing for expanded coverage will likely come from tax credits for private insurance benefits of uninsured workers, supplemented by public insurance (e.g., SCHIP).
11. Major issues to be resolved in the use of tax credits will include effectiveness, efficient administration, and the potential to unravel employer group coverage.
12. The most politically difficult issues facing reforms will be in devising market rules for the small group and individual insurance markets.
13. Enactable insurance market regulation will need to be based on federalism (i.e., a national legislative framework with state discretion).
14. HIPAA and SCHIP offer federalism models to deal with the two key issues of: a) availability (portability, pre-existing conditions), and b) affordability (national benefits/rating rules with state flexibility for actuarial equivalence).

15. The potential for expanding coverage will be greatest if the insurance industry, with others, can agree on the basic elements of a new initiative for coverage of the uninsured and improved functioning of small group and individual insurance markets.

Following this presentation, participants were asked to provide their own views about what will take place during the next three years regarding the small group and individual health insurance markets. The following is a compilation of participants' assumptions, divided into comments about expected trends in the individual market, the small group market, and the two markets together. (Note that no attempt has been made by the authors of this report to reconcile contradictory points of view expressed by meeting participants.)

Individual Market Expected Trends:

- Carriers will continue to withdraw from the individual market, resulting in fewer choices, higher premiums, and a higher rate of uninsurance.
- Premiums will rise significantly in the individual market, particularly for the 55- to 65-year-old age group. This will result in further adverse selection.
- There will be more political pressure for guarantee issue of individual plans and additional regulation in this segment of the market.
- The Federal government will establish tax credits for the purchase of individual insurance, but this change may or may not be accompanied by laws or rules to improve the functioning of the individual health insurance market.
- Congress may revisit the Health Insurance Portability and Accountability Act (HIPAA) to make it more effective, particularly in the area of establishing rating rules to make coverage more affordable.
- There will be changes in the benefits available in the individual market. One participant thought more high-deductible/catastrophic plans would be sold, while another thought policy-makers might be successful in standardizing benefits in the individual market.
- Existing “high-risk pools,” designed for individuals unable to purchase insurance at any price (due to a health condition) will develop financial problems and increased waiting lists. States that do not have such pools may develop policies requiring all carriers to contribute to a high-risk fund.
- Financial institutions will increasingly become involved in health care financing, attracted in part by opportunities to support new products, such as medical savings account. This will accelerate risk segmentation problems.
- The proliferation of e-commerce in health insurance markets will improve access to care mostly for people without significant health problems. E-commerce sites may also improve the availability (but not necessarily the quality) of information about individual products.

- Policy-makers and others will need to initiate efforts to convince low-risk individuals that purchasing insurance is in their best interest.

Small Group Market Expected Trends:

- Premium increases will continue to out-pace inflation, resulting in decreased take-up rates among employees.
- There will be continued erosion of employer “sponsorship” of insurance. Employers will continue to decrease their contributions toward coverage (in response to rising premiums), forcing workers to bear a greater financial burden. Many employers will move entirely to defined contribution plans, in which employees are given a fixed amount of money and expected to purchase a health insurance plan through the individual market or among choices in a cafeteria plan. Consequences of this trend will include increased premium cost-sharing for employees, increased uncertainty, and a movement in the direction of an individual purchasing model. Some providers are likely to support the movement from an employer-based to an individual-based health system as a means to “push back” against managed care.
- The number of plan designs available in the small group market will be reduced. There will be more standardization of benefits with employees permitted to “buy up” to a limited number of higher option plans if they wish.
- Some participants thought there would be less standardization of benefits, reflecting insurance carriers’ attempts to attract low risks through product differentiation.
- Choice of plans within groups will expand. This trend would be facilitated by broadening of carriers’ minimum participation requirements and the development of pooled purchasing arrangements that would support contracting with multiple carriers.
- Other participants believed choice of carriers within small employer groups would be decreased and that only employers participating in health care purchasing pools (such as PacAdvantage in California) would be able to offer choice to employees.
- States will continue to reform the small group markets, building on the successes and failures of the 1990s.
- Pooled purchasing arrangements, as they exist today, will continue to lose enrollment. Other types of entities, such as business associations and multiple employer welfare associations (MEWAs), may attempt to act as sponsors.

Expected Trends in Both the Small Group and Individual Markets:

- The number of uninsured will continue to grow, particularly if growth of the economy becomes more moderate.

- Premiums will continue to rise, causing healthier people to opt out of both small group and individual markets. Conversely, in the absence of subsidies, very sick people will be priced out of the market. Premium inflation will be largely driven by improvements in medical technology and rising pharmacy costs. Enrollee movement to less managed care plans (e.g., PPOs) will accelerate this trend.
- There will be market consolidation as some carriers purchase others and/or exit markets, or as pooled purchasing arrangements fail. This will result in decreased choice for consumers. On the other hand, a reduction in the number of players in the market could result in opportunities to develop new distribution channels or other creative means of keeping costs down.
- There may also be market consolidation on the provider side, possibly leading to higher prices for medical services.
- Both the states and the federal government will increase regulation in these markets. State and federal regulation of the same product may result in conflicting requirements.
- States will consider State Children’s Health Insurance Program expansions as a means of increasing insurance coverage.
- An increasing number of states will attempt to finance coverage expansions by building on private insurance options for individuals and small group employees, thus avoiding purely publicly-funded expansions for groups with incomes over 200% FPL.
- There will be an increase in the use of e-commerce/on-line tools for comparing and buying health insurance. Brokers’ roles will become more uncertain as the Internet replaces some of their functions. Some e-commerce sites may develop “virtual” risk pools by bringing small employers together on-line and providing a full range of human resource solutions.
- There will be a lack of consensus around which health policy issues are most important:
 - As a policy priority, Medicare prescription drug coverage will be more important to federal policy-makers than will the problem of the uninsured. Federal legislation designed to significantly improve access for uninsured persons is unlikely in the near future.
 - Following this year’s election, there will be federal action around Medicare drug benefits, patient protection, external review, right-to-sue at the state level, confidentiality, and limited rights of physicians to collectively bargain.
 - It is unlikely that there will be significant insurance marketplace reform due to economic and political resistance from existing vested interests.
 - If there is federal action regarding the uninsured, it will most likely come in the form of tax credits and expansion of existing public programs.

- Risk segmentation by carriers, including efforts to target profitable ethnic groups, will become more sophisticated and widespread.

IV. Major Barriers to a More Effective Marketplace

Participants were asked to identify the major barriers to a better functioning small group or individual marketplace. The following is a consolidated list of participants' remarks, listed roughly in the order of importance to the group.

Barriers to a Better Functioning Individual Market:

- **Sponsorship.** There are few effective pooled purchasing mechanisms for people in the individual market. Individuals lack a "sponsor" when attempting to purchase insurance. In this instance, "sponsor" refers to an entity, such as an employer or a purchasing pool, that can negotiate with health plans (using its large size to increase its buying clout), facilitate choice, provide comparative information, etc. (Of course, individuals do have access to agents and brokers who can assist them in some of these ways.) Individuals also lack a political advocate.
- **Affordability.** Individual insurance coverage is not affordable for many:
 - The transaction costs associated with selling individual insurance are higher than those associated with group insurance. Distribution methods and channels are complex.
 - Benefit mandates and other regulations in some states make it difficult for carriers in the individual market to keep their prices down.
 - Medical care costs are continually rising, particularly the costs of pharmaceuticals.
- **Voluntary Nature of the Market.** The purchase of individual health insurance is voluntary, leading to the problem of "free riders," or individuals only buying into the market when they need it. As a result, the market is characterized by adverse selection and high prices.
 - There is a lack of demand for individual coverage in some segments of the population. Some individuals choose not to purchase coverage, not only because they see themselves as relatively healthy, but because they do not perceive the value of insurance. Many individuals simply assume the "safety net" will be there for them if and when they need care.
- **Lack of Subsidies.** Currently, subsidies (such as a tax credits, employer contributions, or charitable donations) to help individuals purchase insurance are limited. This dynamic contributes to the problem of risk selection. Without a subsidy, individual insurance is perceived to be too expensive for persons who don't believe they are going to use it, and, therefore, it is purchased mainly by persons who believe they will have reason to use it.

- **Instability.** There is a great deal of turn-over and instability in the market, as individuals cycle between uninsurance, small group insurance, and individual insurance.
- **Lack of Carrier Participation.** The relatively small number of carriers willing to participate in the individual market in most areas results in limited choice and less effective competition.
- **No Easy Solutions.** A fragmented and diverse market with a myriad of non-standardized product offerings and distribution channels prohibits any “quick fix” solutions.

Barriers to a Better Functioning Small Group Market

- **Voluntary Nature of the Market.** As in the individual market, participation is voluntary. Employers do not have to offer insurance (and employees do not have to accept it when offered) if they do not believe they will benefit from it. Adverse selection results when higher-risk employer groups disproportionately offer insurance coverage and higher-risk employees disproportionately accept it.
- **Lack of a Trusted Sponsor.** Although small group purchasing pools exist in many states, small employers are often unaware of them. When pools are available, small employers do not enroll in them in expected or hoped-for numbers. Health insurance purchasing pools suffer from a number of factors: lack of capital; failure to enroll enough groups to achieve economies of scale; and, lack of strong enough incentives for small employers to join (incentives potentially include employee choice of plan, stability of rates, and administrative economies for employers and employees).
- **Risk Segmentation/Inadequate Rating Reform.** Even with the small group insurance reforms passed in many states, it is still possible (in most states) for carriers to segment risk to gain an advantage in the small group market. Whether or not health-based underwriting is permitted, a myriad of other permissible rating factors allow carriers to increase rates for higher-risk groups to a point where they may be unaffordable, even within the limits of rating bands.
 - On the other hand, in states with true community rating, average prices may be too high to attract young, healthy workers, largely due to lack of age-adjustment. According to a study by the Institute for Health Policy Solutions, “New York is the only state that has implemented a pure community rating law, under which insurers are prohibited from considering age, health status, gender, industry type, or group size when establishing premium rates for a given community.”⁹ In New York, lack of age adjustment makes insurance very expensive for employer groups made up primarily of younger workers and causes young workers in mixed-age firms to reject employer-based insurance. Clearly, states must strike an appropriate balance in the use of age-rating so that both younger and older workers can remain in the market.

⁹ Curtis, R., S. Lewis, K. Haugh, and R. Forland, 1999, “Health Insurance Reform in the Small-Group Market,” *Health Affairs*, May/June 1999.

- **Affordability.** Small group coverage is more expensive than coverage for larger groups.
 - The inherent cost of selling and administering small group insurance is higher than the cost of selling and administering insurance for larger groups.
 - Benefit mandates make it difficult for carriers to hold costs down. Larger employers can avoid such mandates through self-insurance. ERISA prevents states from regulating self-insured employer plans.
 - There is significant duplication of administrative effort and added cost, with brokers, health plans, and purchasing pools performing similar and overlapping functions in some cases.
- **Structural Characteristics of the Market.** There is a great deal of turn-over among small businesses, with new groups being created and others going out of business. There is also a variability in small groups' ability to offer health insurance, depending on how well the business is performing. Finally, there is wide variation in product demand.
- **Lack of Choice.** Employees of small groups rarely have a choice among competing carriers offering plans that are close substitutes for one another. This dynamic leads to decreased competition among carriers and decreased price sensitivity among employees.
 - For the most part, carriers can avoid multiple-choice offering situations by imposing minimum participation requirements of, in many cases, 75% to 100%.
 - For most small employers, administration of a multiple-choice offering is too complex and too costly.
- **Employer Liability.** Employers are increasingly less willing to accept responsibility for making health insurance decisions for their employees. The Patients' Bill of Rights debate at the Federal level has increased their concern.
- **Unpredictability of Government Actions.** Even when state governments make subsidies available for small employers or their employees, employers are reluctant to participate due to uncertainty about continuation of such subsidies. Employers don't want to start offering insurance with the help of a subsidy, only to have the subsidy taken away after a period of time.
- **Political Will.** Small group insurance reform is not a high political priority at this time. It has been difficult for small employers to organize effective advocacy for their positions. This phenomenon is partially complicated by the fact that many small employer associations include not only purchasers of health insurance but also individuals involved in the supply side of the industry. It may be difficult for such groups to reach consensus on a position when their members have competing interests.
- **ERISA.** As more and more small employers resort to self-funding, it becomes increasingly difficult for states to regulate the coverage provided to their employees.

V. How Can Barriers be Addressed?

In this session, participants were asked to brainstorm ideas for addressing several of the most important barriers identified above; in other words, to think about how barriers to a better functioning market could be overcome. Further development and analysis of the ideas was not possible, given time constraints.

Many of the ideas discussed during this session are similar to proposals being advocated by the Presidential candidates. For further information about the candidates' proposals, see the recent issue brief published by the Employee Benefits Research Institute, "The Working Uninsured: Campaign 2000 Proposals from the Presidential Candidates," available at <http://www.ebri.org/augibforweb.pdf>.

Potential Solutions for a Better Functioning Individual Market

Participants chose to concentrate on two major areas identified above: 1) affordability of individual coverage and lack of an adequate sponsor; and, 2) the voluntary nature of the market, with many eligible employees not taking up available employer-based insurance or choosing not to enroll in individual insurance.

➤ **Lack of Affordable Coverage/Lack of Adequate Sponsor.** The group determined that the solutions to these problems may differ for different segments of the uninsured population, of which they initially identified four: 1) workers and their dependents with no employer-based insurance available; 2) individuals aged 55 and older who are retired without insurance; 3) disabled individuals in the first two years of their disability; and, 4) those losing group insurance and unable to pay the high price of COBRA premiums. A fifth segment of the uninsured population, those who are offered employer-based insurance but decline it, are discussed under the next bullet point.

1. Workers and dependents with no employer-based insurance available. For this group, flat tax subsidies (or credits) could be made available for adults, and State Children's Health Insurance Program (SCHIP) subsidies could be made available for children (i.e., SCHIP could "buy into" employer-based insurance when it is offered to the families of qualified children).

A complementary solution would be to require employers to offer opportunities to sign up for group insurance and arrange for worker payroll deductions, even if they (the employers) were unable or unwilling to contribute to such insurance. Another approach would be to expand SCHIP to adults in addition to children. A fourth solution would be to require or incent carriers to participate in the individual market. A final suggestion was that states could standardize benefit design in the individual marketplace, develop or encourage sponsoring mechanisms for individuals, and implement rating and portability rules.

2. Individuals aged 55 and older who are retired without insurance. In addition to some of the solutions above, such individuals could be allowed to voluntarily buy into Medicare (e.g., by paying higher amounts for Medicare coverage than would apply if they became eligible at age 65).

3. Individuals in the first two years of disability. Existing waiting periods between onset of disability and the effective date of Medicare coverage could be reduced or eliminated.
4. Individuals losing group insurance and unable to afford COBRA. Subsidies could be made available to help individuals pay for COBRA coverage. Alternately, COBRA rules could be modified so that employers and carriers would be required to offer options other than the current group coverage (i.e., less expensive, less comprehensive, or higher deductible plans could be offered to COBRA enrollees). Another solution for this group might be to modify Health Insurance Portability and Affordability Act (HIPAA) rules so that there would be federal rating restrictions on guaranteed HIPAA plans (which generally become available after an individual has exhausted COBRA).

➤ **Voluntary Market.** Because participation in the insurance market is voluntary, some individuals eligible for employer-based insurance (including those eligible through COBRA) do not take it up, either because it is too costly or because they do not believe they are going to need health care. According to the Center for Studying Health System Change, 20% of the uninsured have access to employer-based insurance. Viewed in another way, 5% (7.3 million) of people with access to employer-based coverage do not take it up and are uninsured.¹⁰ In addition, high uninsurance among people with access to employer-based insurance is more prevalent among the poor (those with incomes under 200% FPL), young adults (ages 18 to 34), African-Americans and Hispanics, those in fair or poor health (as opposed to in relatively good health), and those living in communities with lower average incomes (e.g., Miami versus Seattle).¹¹

These dynamics, particularly those related to income and age, can lead to risk selection and rising prices in both the individual and group markets. One potential solution to this problem would be to impose an insurance mandate and provide tax credits so that low-income employees could afford such a mandate. The federal government could provide a flat tax credit subsidy, in effect lowering the price of employer-based insurance for all workers to a point where it makes sense for even poor working families and healthy individuals to purchase it. As above, SCHIP subsidies could also be made available for dependents.¹²

One means of streamlining the administration of a mandate combined with tax credits would be to develop a system by which individuals would be automatically enrolled in employer-based coverage (with payroll withholding) unless they declined such coverage in writing and could show proof of coverage elsewhere. This system could work in a similar manner to Medicare Part B, in which individuals are automatically enrolled in coverage, and their share of premium automatically withheld from Social Security payments, unless they explicitly

¹⁰ Cunningham, P., E. Schaefer, and C. Hogan, 1999, *Who Declines Employer-Sponsored Insurance and is Uninsured?* Issue Brief #22, Center for Studying Health System Change, Washington, D.C. (available at <http://www.hschange.com/issuebriefs/issue22.html>).

¹¹ *Ibid.*

¹² This suggestion sparked a debate about equity and crowd-out. Federal rules prohibit the use of SCHIP subsidies for families currently enrolled in insurance. Therefore, low-income families who have made sacrifices to cover their children through employer-based plans would be ineligible for a SCHIP subsidy, while their co-workers who had not elected to cover their children would be eligible. There was also some concern that the availability of SCHIP subsidies might cause some employers to drop their own contributions to employer-based coverage, although it was suggested that there are several “firewall” mechanisms to prevent this from occurring.

decline such coverage. However, a mandated system, even with tax credits and automatic enrollment, would be ineffective if there were few affordable products available for small employers and individuals. As above, States could also assist individuals by standardizing benefit design, developing or encouraging sponsoring mechanisms for individuals, and implementing rating and portability rules.

Potential Solutions for a Better Functioning Small Group Market

Participants chose to concentrate on three major barriers identified above: 1) the voluntary nature of the market, 2) lack of choice among carriers, plans, and provider systems, leading to decreased price competition; and, 3) lack of an effective sponsor or purchasing group for most small employers. Participants seemed to agree that subsidies (such as tax credits) to help small groups enter the market would not be useful if rating rules were not modified to allow small employers to remain in the market, even as their employees' health status changed.

- **Voluntary Market.** Participants discussed options for encouraging more small employers and their employees to enter the market, thus creating a broader base for risk-spreading and eliminating some of the barriers for higher-risk groups. The first suggestion was that the current tax treatment of employee contributions would need to be reconfigured so that it would benefit both high- and low-income workers. One approach would be to have a flat, refundable tax credit of 30% of premium across all employees.¹³ To ensure that workers would receive the benefit of this credit in a timely manner (rather than once a year at tax time), there would be a change in the income tax withholding formula so that the credit could be “paid” throughout the year.

A second idea for addressing the problem of the voluntary market, particularly for groups that include one or more workers in poor health, would be for states to implement modified community rating, as some have done. Participants largely agreed that rating based on health status of individuals in a group should be prohibited, but that carriers should still be permitted to rate on some factors, such as age and geographic location (within limits). The goal of such a rating framework would be to bring the price of insurance within reach of high-risk groups, while not raising it so high as to exclude low-risk and/or low-wage groups.

However, a study by Len Nichols on the effects of small group reform found that, in general, regardless of the degree to which states limited health-based rating, average premiums went up, and more people lost coverage than gained it. The study's authors speculate that this increase in premiums may have been due to increased coverage among the relatively high-risk and decreased coverage among the more numerous relatively healthy.¹⁴ Other researchers also found that small group reforms have enabled high risk people to obtain

¹³ More detailed questions, such as which plan offering the 30% would be based on, would need to be discussed further. One participant suggested that the 30% should be based on the same premium as is used to calculate COBRA premiums.

¹⁴ Nichols, Len, “State Regulation: What Have we Learned so Far,” *Journal of Health Politics, Policy, and Law*, V25, N1, February 2000.

insurance if they can afford it, but they have not substantially increased or decreased the percentage of small-group employees with private health insurance.¹⁵

- **Lack of Choice among Carriers, Plans, and Provider Systems.** The group observed that one reason prices were high in the small group market, as opposed to the large group market, was lack of effective competition with employees having a choice among similar plans (offered by various carriers) or among provider groups. As a result, employees are price-insensitive. In an attempt to clarify terms (and for discussion purposes only), the group determined that in this case, “choice” did not include a choice between two benefits designs from the same carrier (e.g., an HMO and a PPO), but rather choice among similar benefit designs from non-affiliated carriers, preferably with some differentiation in terms of their provider networks. Such a choice might also cause provider groups to compete with one another for HMO business, thus improving the efficiency of the medical care system.

One suggested solution was that states and/or the federal government adopt public policies that encourage employers to provide employees with choice of health plans and carriers. For example, employer tax benefits could be conditional on implementation of such an arrangement. A supporting policy would be to restrict carriers’ ability to impose minimum participation requirements, so that two or more carriers might be offered to the same small group. However, some participants cautioned that such a policy could de-stabilize the already fragile small group market, highlighting the issue that the benefits of small group reforms must be weighed carefully against their potential to harm the market in other ways.

Some participants believed it would help stabilize the small group market if plans were more standardized, so that employers and employees could better understand their choices. Short of standardizing small group plans, states could require carriers to publish and make available plan descriptions in a standardized format.¹⁶

Participants also thought public policies should be adopted that would encourage or even assist sponsoring organizations (purchasing pools of various kinds), making it more simple for small employers to offer choice among plans and carriers.

- **Lack of a Trusted and Effective Sponsor.** It was noted that in California, few employers enroll in the purchasing cooperative PacAdvantage, but that once they enroll, they tend to renew. This dynamic points to the problem that purchasing pools are difficult to sell because they are complicated to explain, and employers do not trust and do not want to buy what they do not understand. In addition, employers are not generally aware of purchasing groups.¹⁷

¹⁵ Hall, Mark, *An Evaluation of Health Insurance Market Reforms: Summary of Findings*, Wake Forest University School of Medicine, February 1999, available on-line at: <http://www.phs.wfubmc.edu/insure>.

¹⁶ In 1997, the Colorado Legislature passed a law requiring carriers to use a “uniform health plan description form” developed by the Division of Insurance. Legislators hoped to make it simple for consumers to compare health plans. However, the plan description form is quite lengthy. Anecdotal evidence suggests that consumers do not find the forms useful (as they are more interested in whether their doctor is in a particular plan) and that brokers have to keep a stock of them for every offering, even if they are not used. (e-mail communication with Jerry McElroy, Government Relations, Kaiser Foundation Health Plan, Inc., Colorado Region).

¹⁷ A recent report published by the University of California indicates that among employers with 3 to 9 employees, only 21% were familiar with either PacAdvantage or its competitor, California Choice. Among employers with 10 to 50 employees, 33% were aware of the groups. (Schauffler, H., and E. Richard Brown, *The State of Health*

The phenomenon of purchasing pools being difficult for employers to understand has also been noted outside California.¹⁸ However, once employers get into purchasing pools, they and their employees like them. Purchasing pools, or “sponsors” could be encouraged to simplify offerings, making it easier for brokers and agents to sell the product. For example, PacAdvantage offers a choice among some 12 HMOs and several benefit levels, a choice that may be overwhelming to both employers and employees.

Participants discussed a set of conditions that might enhance public trust in purchasing groups or sponsors, recognizing that the principles might vary depending on whether there was one publicly-sponsored purchasing group or several private and competing groups. First, it might be helpful to broaden the concept of what types of entities could qualify as sponsors. Established business associations, for example, already have the trust of the business community. However, it was noted that many business associations are strongly influenced not only by buyers of insurance but also by sellers. Participants noted that the sponsor should represent the interest of the buyers. To facilitate this, there might be regulatory guidance around the governance of such groups, prohibiting conflicts of interest.

Several participants suggested that there should be regulatory guidance on issues such as the fiduciary responsibility of the sponsor and other sensitive issues, such as confidentiality of information. Finally, the group proposed that sponsors should have sufficient resources and expertise to be able to provide their members with good information about their plan offerings, including information on quality and enrollee satisfaction.

VI. Next Steps

In the final session of the roundtable, participants discussed work that could be done to address identified barriers and potential solutions. In thinking about next steps, participants agreed that it was important to thoroughly explore the trade-offs inherent in different policy options (i.e., do “improvements” in one part of the market start to “unravel” other parts?). Next steps, some of which can be carried out by the Kaiser Permanente Institute for Health Policy, and some of which may be more appropriately carried out by other parties, fell into the following categories:

- 1. Sponsorship.** Participants supported the concept of a roundtable discussion focusing on appropriate roles for sponsors. Issues to be discussed might include: types of organizations that can act as a trusted sponsor; market rules or industry activity that might make sponsors more successful in enrolling individuals and small groups; the use of e-commerce in developing sponsorship organizations; innovative means of reducing sponsors’

Insurance in California, 1999, Regents of the University of California.) In addition, enrollment in small group purchasing pools is notoriously low across the country, with most groups only reaching 1% to 2% of their target market. The exceptions appear to be the Council of Smaller Enterprises of Cleveland, Ohio (COSE), and the Connecticut Business and Industry Association’s small group purchase pools. (Wicks, E., M. Hall, and J. Meyer, *Barriers to Small Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers*, Economic and Social Research Institute, March, 2000, available on-line at: <http://www.esresearch.org/Documents/HPC.pdf>).

It would be helpful, in thinking about an ideal sponsor for small groups, to determine why the California cooperatives have had difficulty reaching their target markets, while the Connecticut and Cleveland cooperatives have been more successful.

¹⁸ This dynamic has been observed by the Institute for Health Policy Solutions in its technical assistance work with purchasing pools around the nation.

administrative costs; and, accountability for quality of care and plan performance under various sponsorship models.

2. E-Health Insurance. Analysts could explore the effect that e-commerce is having on the sale of small group and individual insurance products. Questions to be explored might include:

- Who uses health-related e-commerce sites, and for what purpose (health information, purchasing, etc.)?
- To what extent, if at all, are e-health insurance sites aggregating risk, becoming “virtual” purchasing pools?
- Do such efforts create an opportunity for significantly expanding coverage? If so, how?

The California HealthCare Foundation will release a descriptive report on health-related e-commerce sites in the near future.

3. Availability of Coverage. Under this subject area, participants suggested further exploration of the following questions:

- If tax credits are implemented, what kind of choices will or should consumers have?
- What market reforms and/or supply-side activities can ensure choices are available to individuals purchasing insurance with tax credits?
- What additional incentives can be given to carriers and delivery systems to respond to the new demand caused by tax credits (i.e., to participate in the individual market)?

4. Tax Credits. Participants wanted to further discuss how a refundable tax credit system could be operationalized and what the appropriate state/federal relationship should be. Questions included:

- Exactly what type of coverage could be purchased for a \$1,000 or \$2,000 tax credit? What does it cost to deliver a specific benefit package most efficiently, and how is “efficient” delivery defined in this case?
- How much could individuals be expected to contribute on their own?
- What rules should apply to premium rate structures charged by plans, and how can equity across plans be ensured?
- How can a tax credit system ensure that new subsidies do not replace money individuals and businesses are currently spending on health insurance? Should avoidance of crowd-out be an important policy goal?

- 5. Market Segmentation – Who are the uninsured?** More information is needed about the various segments of the population that make up “the uninsured” so that more targeted solutions can be developed. For example:
- How many of the uninsured have access to an employer-sponsored plan but don’t take it up? Why not?
 - How many are actually eligible but not enrolled in public programs?
 - How many are disabled or aged 55 and older?
 - How many are choosing to go without insurance because they don’t value it (either because of cultural reasons or because they are young and healthy)?
 - What different types of products might appeal to these different segments? What strategies might be effective in bringing various segments into the market?
- 6. The Importance of Choice.** Participants wanted to know whether enrollee satisfaction is affected by having been offered a choice of plans. Are employees who are given no choices generally less satisfied with their managed care plans than employees who are able to choose from among two or more plans? This information could help further the discussion about sponsorship and the value of sponsoring organizations.
- 7. Costs of Regulation.** To better understand the factors behind rising premium rates in the small group and individual markets, it would be helpful to have actuarial estimates of the costs health plans can expect to incur under new regulations (many arising from the Health Insurance Portability and Accountability Act), such as those concerning privacy, patient safety, mandated benefits, etc.
- 8. How do Plans Fare in Choice Models?** Many industry observers believe that when plans are offered in multiple-choice situations, particularly to small employers, plans with less-restrictive networks experience adverse selection. It would be helpful to gather data on this subject. Such data could inform a discussion of the importance of choice and the feasibility for small employers of offering choice outside of a “sponsorship” framework. It would also permit consideration of risk adjustment approaches to “level the playing field” in multiple-choice situations.
- 9. Consequences of Being Uninsured.** There is some perception among the public that uninsurance is not really a problem and that there are always safety nets for individuals who are unable to pay for medical care. To combat this perception, it would be useful to gather data on the consequences of not having insurance (such as lack of access to care) or the number of personal bankruptcies that occur as a result of being uninsured.

VII. Conclusions

As stated previously, the purpose of the roundtable discussion, “Improving the Functioning of Small Group and Individual Markets,” was to:

1. Identify barriers and explore solutions for improving the functioning of the marketplace for small group and individual health insurance; and,
2. Identify work that needs to be done to address the most important barriers and consider next steps.

While there wasn’t necessarily consensus of views, a few major issues were identified for further attention as part of broad strategies to reduce the number of uninsured small-group employees and individuals.

Most participants predicted that premiums will continue to rise and that more and more people will become uninsured unless there are policy changes. Many believed that the Federal government will address the problem of the uninsured through implementation of tax credits. While such subsidies may make insurance more affordable for some, certain “structural” characteristics of both the small group and individual markets will still need to be addressed. The major characteristics identified by the participants were:

- Lack of adequate sponsorship for small groups and individuals;
- Lack of choice among plans and carriers, leading to diminished competition among carriers and diminished price-sensitivity among consumers;
- The voluntary nature of the markets; and,
- High costs and insufficient rating reform.

Potential solutions for some of these barriers to better market functioning focused on linking consumers with sponsors or purchasing pools. For example, participants suggested that disabled individuals and early retirees without private coverage should be able to join Medicare. Participants also brainstormed ideas for helping small group purchasing pools to function more effectively and to attract more uninsured small employers. More work will be carried out in this area.

Suggestions for addressing the voluntary nature of both markets included insurance mandates, incentives (such as a flat, refundable tax credit and automatic enrollment), and direct subsidies (such as using SCHIP funds to help low-income children buy into private insurance). High costs in both markets could be addressed through further implementation of insurance rating reform and encouragement of competition among carriers through a variety of mechanisms (standardizing benefits, relaxing minimum participation rules, etc.).

While the roundtable did not provide definitive solutions to the major problems confronting the small group and individual insurance markets, it did help to identify priority areas for action and

resulted in a “road map” of future work designed to increase access to care by improving the functioning of these markets.

Appendix A: Participants List

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