

Roundtable Discussion on Health Insurance Issues

The Problem for America

- **The Lack of Access to Health Insurance is an Ongoing Concern in the United States.** In 2001, an estimated 41 million Americans – 14.6% of the population – did not have health insurance coverage.¹ The uninsured are less likely to seek adequate medical care and preventative services, placing the healthy development of themselves and their families at risk.²
- **The Majority of Americans Who Lack Health Insurance Are Working for Small Companies.** Americans who work for firms with fewer than 25 workers were half as likely to have health insurance as those who work for companies with 1,000 or more workers. This poses a major problem for America since 90% of U.S. companies are small businesses that employ fewer than 20 workers.¹ The percentage of small firms offering health insurance to employees was estimated at 61% in 2002 – a decline from an estimated 67% in 2000. These declines came almost exclusively from the smallest of the firms – those with fewer than 25 employees. In comparison, 99% of firms with 200 or more employees offered health benefits in both 2000 and 2002.³ In a recent study by the National Association of the Self Employed, 70% of respondents did not have health insurance themselves or provide it for their employees.⁴
- **The Cost of Health Coverage Is Rising.** In 2002, monthly premiums for employer-sponsored health insurance increased by 12.7% – the largest increase in 12 years – with small firms seeing an increase of 13.2% and large firms an increase of 12.5%. On average, annual premiums are \$3,060 for single coverage and \$7,954 for family coverage. Workers' share of these premiums has also risen substantially, with single coverage averaging \$454 per year (a 27% increase since 2001) and family coverage averaging \$2,084 per year (a 16% increase since 2001). Similarly, deductibles for PPO in-network providers jumped 37% to \$276, up from \$201 last year.³ With health care costs rising and a downturn in the economy, workers can expect to pay

more for coverage but get less for their money, as benefits erode.

The Problem for Women-Owned Businesses and Other Small Firms

- **Most Small Employers Are Not Offering Health Insurance Coverage Because it is Too Costly.** Eight in ten small employers (84%) who did not offer health benefits cite the high cost of premiums as a very important factor in reaching that decision. Other important reasons include not being able to qualify for group rates (57%) and administrative burdens (30%).³ Health coverage is generally more expensive on a per capita basis for smaller companies. In 2002, small firms with 3 to 9 employees paid \$285 monthly for single coverage compared to \$269 monthly for firms with 10 to 24 employees and \$239 monthly for firms with 25 to 49 employees.³ Administrative expenses for insurers of small group health plans are also higher—ranging from 33 to 37% of claims for insurers of small group health plans, versus 5 to 11% of claims for large companies' self-insured plans.⁵
- **Many Major Small Business Associations Name Health Care as Major Concern for Their Membership.** The National Association for the Self-Employed (NASE), the National Association of Women Business Owners (NAWBO), the National Federation of Independent Business (NFIB), the U.S. Chamber of Commerce and other small business organizations include access to and/or cost of health care among their 2003 legislative priorities. In a recent membership survey conducted for NAWBO, members were most likely to name association health plans among the public policy issues on which they want NAWBO to focus. Fifty-eight percent (58%) of NAWBO members who own employer firms offer health benefits to their employees.⁶
- **When Small Firms Do Offer Health Benefits, There Is Typically a Narrow Range of Choices.** Among small businesses that offer health insurance,

few provide their workers with a choice of health plans. Seven in ten (71%) firms that provide health benefits offer their workers only one plan option. The most prevalent reason cited for offering just one option is that the company gets a better deal from insurers by requiring all or most employees to be in the same plan.³

- **Women-owned Businesses Are Affected Significantly by the Lack of Affordable Health Coverage.** With an estimated 9.1 million women-owned firms in the U.S., employing 27.5 million workers,⁷ public policy regarding access to affordable health coverage is a major concern for women-owned businesses as well as other small employers. The inability of many women-owned businesses to offer health insurance could mean that an estimated 7.3 million of the uninsured are employees of women-owned firms.⁸

Proposed Solutions

A number of strategies and proposals, some of which will be addressed in the 108th Congress, have been put forth to deal with the issues of health care cost and access:

- **Association Health Plans (AHPs).** Under the President's health care proposal, AHPs can help reduce the number of uninsured by giving small businesses the same purchasing clout, federal regulatory structure, accessibility, affordability, and choice in the health care market place that large company experience. By allowing small businesses to band together across state lines through their membership in a bona fide trade association, small business owners would be able to offer affordable health benefits to employees and their families resulting from greater bargaining power, economies of scale, and administrative efficiencies.⁹ Under proposed legislation, AHPs would not be required to conform to state health insurance coverage mandates and insurance regulations—one of the major factors, many contend, that contribute to the rising cost of health coverage. Currently, labor unions, medium-sized businesses, and large companies are able to offer health benefits to their employees under one uniform federal statute known as ERISA—the Employment Retirement Security Act of 1974. This advantage saves these organizations from having to comply with different rules, regulations, and benefit mandates that exist in each of the 50 states.⁹ If the ability to offer AHPs is strengthened through legislation, small business owners could purchase health coverage through federally regulated, self-funded AHPs, thereby
- expanding the small group market. An estimated 300,000 to 8.5 million American workers and their families could gain health insurance coverage from AHP legislation.¹⁰ In June 2001, the Senate passed the Kennedy-McCain version of the Patient's Bill of Rights (S. 1052) which did not contain AHP provisions. In August 2001, the House passed H.R. 2562, a different version of patient's rights legislation, which contained AHP provisions (rolled in from H.R. 2315/H.R. 1774 in June). Just recently, H.R. 660, the Small Business Health Fairness Act, was introduced with more than 70 co-sponsors and bi-partisan support. This bill re-introduces many of the elements of previous AHP-focused legislation.
- **Medical Savings Accounts (MSAs).** Under a four-year pilot project authorized by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, MSAs were enacted although with a number of restrictions. MSAs, which are available only to self-employed persons or businesses with 50 or fewer employees, are tax-exempt personal savings accounts to be used for qualified, out-of-pocket medical expenses. To be eligible for an MSA, an individual must maintain a high deductible health plan (i.e., \$1,500 to \$2,250 for individuals and \$3,000 to \$4,500 for families). There are two health-plan options—individual and family. The allowable contribution to the MSA depends on the size of the health plan deductible chosen, and funds not spent by the end of the year may be rolled over into the next year. Many support the permanent authorization of tax-qualified MSAs with certain modifications to make them more flexible, such as varying the deductible depending on the type of expenditure and extending eligibility to all businesses. These HIPAA MSAs are often referred to as Archer MSAs, named for Rep. Bill Archer (R-Texas) who championed the MSA legislation. The Archer MSA demonstration project will end on December 31, 2003, unless it is extended or made permanent by law. The Medical Savings Account Availability Act of 2001 (S 1067/HR 1524), introduced by Senators Grassley (R-IA) and Toricelli (D-NJ) and Representatives Thomas (R-CA) and Lipinski (D-IL) would improve MSAs and make them permanent.^{11,12,13}
- **Refundable Tax Credits.** President Bush has proposed a refundable tax credit to help the uninsured purchase private health insurance coverage. In this manner, individuals could purchase health insurance that they can own and keep, even if they change jobs or their employers change plans. The credit would vary by family income and size, and provide a subsidy of up to 90% of the cost of health insurance premiums, with

a maximum credit of \$1,000 per adult and \$500 per child (for up to two children) for a maximum family credit of \$3,000. The health tax credit would be refundable, such that even those who owe no income tax would receive credit by filing an income tax return and claiming a refund against their health insurance expenses. The credit would also be advanceable, based on the individual's prior-year income, making it available whenever the individual or family seeks health insurance, and before filing an income-tax return for that year, in order to reduce the amount of the monthly health insurance premium. This proposal would also permit certain low-income individuals to purchase private insurance for themselves and their families through state-sponsored health insurance groups or high-risk pools.^{14,15}

- **Flexible Spending Accounts (FSAs).** FSAs were first authorized by Congress in 1978 and are allowed under Section 125 of the Internal Revenue Code. They enable workers to allow up to \$4,000 (pre-tax) tax-free money to spend on health care expenses—such as co-payments, deductibles, and services—not otherwise covered by their insurance, or to pay for health insurance premiums. FSAs function exactly like MSAs, except those funds not used by the end of the year are returned and cannot be carried over for future expenses. In order for workers to be allowed to take control of their health care costs, such limitations would need to be changed.⁹
- **Health Marts.** Spearheaded by Rep. Tom Bliley (R-VA), Health Marts are administrative entities or cooperatives of workers, employers, insurers, and consumers that are formed to offer more choice in employer-based health coverage. Instead of selecting a health insurance carrier for all of a company's employees, the employer would sign up with a Health Mart which, in turn, would offer workers a wide range of health coverage options (e.g., HMOs, PPO plans, MSAs, and other vehicles). Employees would then select the health insurance coverage that they prefer. Health Marts would offer multiple health plans, accept all small employers, and conform to state laws governing differences in premiums among small firms, but would be free of state mandates that require coverage of certain benefits and providers. In theory, this would allow them to offer a less costly benefit package. Health Marts are similar in many respects to Health Purchasing Cooperatives (HPCs) which have been initiated in several states, offering collective purchasing arrangements for small employers.^{16, 17}
- **Cafeteria Plans.** As its name suggests, cafeteria plans (also referred to as “Flexible Spending Plans” or “Section 125 Plans”) allow each employee to choose from among a menu of predetermined options in deciding where their benefit dollars will be spent—including medical, accident, disability, vision, dental, and group term life insurance—and the amount of the benefit. Funded through “tomorrow's earnings”, employees must estimate the anticipated cost of such expenses for the upcoming year and request to have the estimated amount redirected from wages into the plan. Benefits are paid through payroll withholding with pre-tax dollars. Such plans allow small firms to offer benefits that would otherwise be unaffordable with real tax savings to employees.¹⁸
- **Consumer-Choice Health Purchasing Groups (CHPGs).** CHPGs bring employers and consumer together for the purpose of collectively purchasing health coverage from health plans. Governed by an employer-consumer board, CHPGs provide employees of participating firms with information to compare the price, characteristics, and performance of each plan. Employees then choose a plan that best fits their needs and preferences, and the CHPG enrolls employees in the plan of their choice.¹⁹
- **Defined Contribution Health Insurance.** This strategy allows employees to select from any health plan being offered, at a cost that he or she chooses to pay, using both their employer contributions and the personal contributions that they make, instead of having the employer select plan options for their workers, as is customarily done in employer-sponsored health coverage. If the employer's contribution does not cover the full cost, the worker would supplement it with their own funds or choose a less generous plan and pay less out-of-pocket.^{20,21}
- **Health Reimbursement Arrangement (HRA).** An innovative and flexible health plan design approved last year by the U.S. Treasury and IRS (Rev. Rul. 2002-41 and Notice 2002-45), an HRA is a type of defined contribution account that may be used to pay both out-of-pocket health care expenses and health coverage premiums for employee and dependant health care, including long-term care coverage. Amounts credited to an HRA must be provided solely by the employer and cannot be financed through employee salary reductions, and any unused balances may be rolled over from year to year. These flexible plans may be provided by an employer in conjunction with a cafeteria plan as well as another health plan that

would be ordinarily financed through employee salary reduction.²²

- **High Risk Pools (HRPs).** The Trade Act legislation (H.R. 3009) passed in the 107th Congress and signed by the President in August 2002 provides up to \$100 million in federal funding for states to create high-risk pools or to fund existing ones. The Act enables offering uninsured people with pre-existing conditions access to affordable health insurance coverage. State risk pools first appeared 25 years ago and cover about 153,000 people. Currently, 30 states have enacted legislation establishing HRPs. States with well-functioning high-risk pools have virtually solved the problem of health insurance access for their medically uninsurable residents.²³

The National Women's Business Council is a bi-partisan Federal government council created to serve as an independent source of advice and counsel to the President, Congress, and the U.S. Small Business Administration on economic issues of importance to women business owners. Members of the Council are prominent women business owners and leaders of women's business organizations. For more information about the Council, its mission and activities, contact: National Women's Business Council, 409 3rd Street, SW, Suite 210, Washington, DC 20024; phone: 202-205-3850; fax: 202-205-6825; e-mail: nwbc@sba.gov, web site: <http://www.nwbc.gov>.

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² "Expanding Health Insurance: The AMA Proposal for Reform", American Medical Association, 2002. www.ama-assn.org

³ "Employer Health Benefits: 2002 Annual Survey", The Kaiser Family Foundation and Health Research and Educational Trust, 2002. www.kff.org

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⁵ "Study of the Administrative Costs and Actuarial Values of Small Health Plans" by Rose C. Chu and Gordon R. Trapnell, SBA Office of Advocacy, January 2003. www.sba.gov/advo

⁶ "2002 Membership Survey of the National Association of Women Business Owners", NAWBO, 2002. www.nawbo.org

⁷ Center for Women's Business Research. www.womensbusinessresearch.org

⁸ National Women's Business Council estimate based on the employment distribution of women-owned firms and

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¹⁵ "The Bush Health Agenda—Part II: Tax Credits for the Uninsured" by Mark McClellan, National Center for Policy Analysis (Brief Analysis No. 415), August 20, 2002.

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¹⁸ "Implementing a Cafeteria Health Plan" by T. Michael Regan, *Physicians News*, March 1998.

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