

Challenges Facing Small Employers in Purchasing Health Insurance
A Statement of
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My name is Len M. Nichols and I am the Director of the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy institute dedicated to finding practical solutions to our nation's most important problems. The range of our programs, research, and policy proposals can be found at www.newamerica.net.

Our health care system as a whole suffers from three inter-related problems: (1) low clinical value per dollar spent, (2) highly uneven quality, and (3) inequitable access to effective care. The first two problems have become so severe that many say ensuring equitable access is now beyond the reach of our political will. And so, the number and percent uninsured continues to rise, as does the share of our nation's income devoted to health spending.

Our three major health problems exacerbate each other. Poor quality coupled with large amounts of ineffective care increase costs. Even the sub-standard care received by the uninsured raises costs for health providers, the privately insured, and taxpayers alike. High cost relative to income is the single most important reason people are uninsured in the first place. And as long as 60+ million people spend time uninsured in any two-year period and outside any information system's ability to monitor their health status, health service, and pharmaceutical use, universal application of evidence-based medicine and efficient health care delivery systems will remain beyond our reach. Thus the policy stalemate continues. Our health system's problems simply cannot be solved piecemeal or in isolation; we must summon the courage to pursue comprehensive solutions. I'll return to this larger reality before closing.

The main focus for today is on a central piece of the uninsured problem: enabling more small businesses to offer health insurance to their workers. It is a high honor indeed to be invited back to testify before this Committee on this topic,¹ because I know how committed are the Chair, the Ranking Member, and all members of the Committee as well as today's guest members (Senator Durbin and Senator Lincoln) to improving insurance coverage options for small business owners, their workers and their families.

As an economist, I have studied the decisions of employers, and specifically small employers, to offer health insurance or not, as well as the general workings of small group insurance markets for the past 12 years. My research ranges from statistical analyses with nationally representative survey data gathered from employers to interviews with small employers, large employers, small business coalitions, insurers,

¹ My previous testimony to this committee was delivered on February 5, 2003.

insurance brokers, actuaries, state regulators, purchasing cooperatives, state legislators, and site visit research in conjunction with the Center for Studying Health System Change.

According to the most recent data from AHRQ, 44% of small establishments (those with fewer than 50 workers) offer health insurance, and 64 % of workers are in small establishments in firms that offer health insurance. This contrasts with 97% of large (not small) establishments and 98% of workers in large establishments.² The primary reason for this huge disparity in offer rates by firm size is well known in the research literature and in this Committee: large firms can provide health insurance to their workers far more efficiently than small firms can due to economies of scale.

These economies of scale emanate from 3 sources: purchasing and administration economies within the firm, selling economies of the insurer, and risk pool stability.

Purchasing and administration scale economies arise because the large firm can spread the fixed costs of a benefits manager or department over many workers, so the per worker cost of this crucial information gathering, processing, and dissemination function is small. Small firms cannot afford a benefits manager or department, so these tasks typically fall to the already overburdened small business owner. Health insurance is a very complicated product to research and purchase, thus the amount of effort a small business owner must invest, per worker, is relatively high. This time and information processing effort represents too high an opportunity cost for many small business owners, for their time must often be devoted to even more pressing matters related to small business survival.

Selling costs of the insurer are also largely fixed in that they do not vary with the number of employees. Since presentation and preparation time is virtually identical for small and large firms, making a sale to a firm with 10,000 workers costs less per worker than making a sale to a firm with 10 employees. These selling costs must be recouped in the premium, as must agent/broker commission rates, which are also higher for small groups, or else no one would ever bother selling insurance.

Finally, the larger the risk pool, the lower the variance of expected medical claims costs. The statistical law of large numbers is a good friend of large groups. It is theoretically possible for insurers to “make” a large group out of many small employers and for that risk pool to be stable over time, but in practice small firms are formed and go bankrupt, as well as drop and add coverage even if continuously in business, at much higher rates than large firms, so that no pool formed exclusively among small groups can be as stable as a large firm or state employee pool. In practice as well, at least above a certain minimum size, most insurers price their products with two components, one based on the firm’s own claims experience and one based on the pooled group’s own experience, so that even a one-time shock to one employee’s health costs – a single heart attack and attendant surgery or cancer therapy – can significantly affect a small firm’s premium for

² Nationally representative MEPS-IC data, AHRQ, calendar year 2002, www.meps.ahrq.gov.

years, even relative to premiums of otherwise similar small groups. This is why premium variance is higher for small firms than for large.³

These economies of scale lead to far lower premiums per dollar of actuarial value in their benefit packages for large firms when compared to small firms, and that plus the observed higher variance in premiums makes small firms naturally want to become “more like large firms” in the ways they purchase health insurance. This policy desire to enable small firms to purchase health insurance more efficiently is why we are here today. My testimony will address the pros and cons of alternative ways to facilitate this.

Currently there are two broad approaches to this worthwhile policy goal on the table: association health plans and subsidized participation in broader purchasing pools.

Association health plans would pursue the goal of more affordable insurance for small firms primarily by exempting the self-insured plans that could be marketed to members of the association from various state regulations: benefit mandates, solvency standards, state taxes, and premium rating restrictions. These exemptions alone would lower premiums a few percentage points, as CBO and others have previously indicated,⁴ but the largest gains to AHP members would more likely come from some degree of scale economies discussed above and especially from the favorable selection of health risks.

AHPs would create a kind of safe harbor from existing state insurance market laws, and as such would create a different kind of market for members than would be available to non-member small firms, and even to member firms who might initially prefer to purchase fully insured plans within the AHP. Firms with low-risk workers – young and healthy – will find the self-insured AHP product most attractive because it has no benefit mandates and no premium variance restrictions. As these firms leave the currently fully-insured market and risk pools, those risk pools would necessarily deteriorate in terms of average health risk. The only empirical question is how much premiums would rise for all but those in the self-insured AHP. Most analytic estimates are that the premium increase will not be too large, but that depends on how large the self-insured AHP grows and who exactly is able to enroll.

At this point a key policy analysis question must be asked: why would the proponents of AHPs want to create a separate market for some small firms and not others, especially when all credible analyses of this kind of legislation have always found that premiums within the self-insured AHP will be lower for low-risk firms but higher for everywhere else in each state’s small group market? I have tried to answer this question for years

³ David M. Cutler, “Market Failure in Small Group Health Insurance,” NBER working paper, October 1994; Stephen H. Long and M. Susan Marquis, “Stability and Variation in Employment-Based Health Insurance Coverage, 1993-97.” *Health Affairs* v. 18 # 6 (Nov-Dec 1999). Cutler, NBER Working Paper, ...

⁴Congressional Budget Office. “Increasing Small-Firm Health Insurance Coverage Through Association Health Plans and Healthmarts,” January 2000; Linda J. Blumberg, Len M. Nichols, and David Liska, *Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model*. Final Report 0657-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999.

now and only two rationales have come to mind. One, the proponents want to enable firms with low-risks to band together and act more like large firms when purchasing health insurance, and they simply do not worry about the fact they will harm – to an unknown and potentially large degree – the small group market as a whole. Two, at least some of the proponents may hope to enter the business of administering self-insured AHP plans or creating AHPs in general, for they see this created market opportunity as a way to fund other objectives they may have as organizations.

Both of these are perfectly normal reasons to seek specific, self-interested legislation, but they are hardly compelling public policy rationales for the nation as a whole, and certainly not for a committee as dedicated to the health of the overall small business sector as this one has always been and, I trust, remains. Indeed, it is fairly easy to see how to be true to that longstanding commitment to all small businesses in this case: enable or encourage *all* of them to act like large businesses by banding together in a truly large and powerful purchasing pool.

By having one pool within a state or perhaps multiple pools within distinct locales (since all health care and health insurance markets are ultimately local) that were open to all small businesses in particular areas, and with consistent insurance market regulations in and outside the pools, you would avoid the risk segmentation problems that self-insured AHP products invite. A majority in both houses of Congress may well think that some state legislation, e.g., some benefit mandates, are unwise public policy, because they impose more costs on all than the benefit to the few may appear to be worth. If that is the judgment of Congress, then you already clearly have the authority to repeal or override the unworthy mandates for all small firms, not just for those who happen to belong already or come to qualify for associations with the power to exclude those they do not want in their risk pool.⁵ The research literature is very clear, by the way, that benefit mandates are not nearly as costly as their opponents seem to think,⁶ but the larger point is that repealing them for some and not all firms is arguably discriminatory and certainly destabilizing for small group risk pools that are already fragile enough as it is.

Stability of the commercial and fully-insured risk pool would be threatened by regulation-exempt AHP products because initially the low-risk groups would leave to join the AHP. But if an individual firm's workers became less healthy over time, underwriting abilities preserved within the AHP would lead to higher premiums, until it might be well-advised to re-enter the commercial and regulated small group insurance market. HIPAA's guaranteed issue provisions and existing state insurance market regulations on premium variance restriction would force the insurers to accept this now higher risk group at a pooled premium rate, lower than its expected cost. Thus the commercial pool would lose healthy groups over time and then see the return of groups as their own experience deteriorated within the AHP. This is not a dynamic picture for a happy market equilibrium.

⁵ Nichols, Len M. and Linda J. Blumberg, "The Health Insurance Portability and Accountability Act: A New Kind of Federalism?" *Health Affairs*, (May-June 1998).

⁶ www.doi.tx.st.gov; CBO and Blumberg et al, op cit.

There are other dangers with AHPs related to their removal from oversight by experienced state insurance regulators, but other testimony before this Committee two years ago, from Sandy Praeger, Insurance Commissioner in Kansas and then representing the NAIC, made all the relevant points so there is no need to repeat them here.⁷

So if AHPs are not the best way to go, what sort of encouragement should legislation give to the formation of other “large firm-like” pools among small firms? Many states already have legislation for enabling purchasing pools, but few work as well as they could because states put tighter insurance market rules on competition within the pool than without. This ultimately had the effect of rendering the pools more attractive to unfavorable risks, and that, along with early but lingering attempts to limit agent/broker commissions on purchasing pool products has stymied their growth. So lesson number one, learn from those lessons: have the same insurance market rules inside the pool as outside, and make sure agents and brokers are at least indifferent between selling inside or outside the pool. Industry insiders will tell you that small group health insurance is a product that is sold and not bought, by which I mean the purchaser must be talked into it. It is not worth expending the considerable and necessary persuasive and educational effort for a sub-standard commission.

Second, while forming the purchasing pool alone could lower administrative loads and premiums for all small firms that join, subsidies would clearly entice more entry and may help stabilize the risk pool as well. Who should be subsidized? The research literature is fairly clear that the most efficient use of new subsidy dollars, whether through tax credits or direct subsidies of some kind, is to link the subsidy to low-income workers as directly as possible.⁸ Subsidizing small firms in general, as AHPs could be interpreted as doing by exempting qualified firms from state regulations and enticing favorable risk selection, is likely to “waste” subsidy dollars on higher-income workers and firms that are likely to be offering anyway and to continue offering after new laws are passed. Indeed, all analytic studies of AHPs concluded that the vast majority of likely participants are already insured.

Likewise, subsidizing low-wage workers, as opposed to low-income workers, risks wasting subsidy dollars on some low-wage workers who are married to higher-wage workers and who therefore have substantial family income. The tradeoff is that it is difficult, if not impossible, for firms to learn about or verify family income, so administrative costs might outweigh the inefficiently expended subsidy dollars.

One step toward efficient subsidies would be to offer a tax-credit to low-income workers for the purchase of group health insurance, and then eligibility for the tax-break and any necessary reconciliation would be between the IRS and the worker’s family.

⁷ Statement of Sandy Praeger, Senate Small Business and Entrepreneurship Committee, February 5, 2003.

⁸ Ferry, Danielle, Sherry Glied, Bowen Garrett, and Len M. Nichols, “Health Insurance Expansions of Working Families: A Comparison of Targeting Strategies,” *Health Affairs* v. 21 # 4 (July/August 2002); Bowen Garrett, Len M. Nichols, and Emily K. Greenman, “Workers without health insurance: Who are they and how can policy reach them?” WKKellogg Foundation Community Voices report, August 2001.

If the policy objective is to subsidize firms, however, then linking firm level tax credits to worker wages is a kind of second best solution, far more efficient than just subsidizing firms regardless of worker wages and incomes. The SEHBP bill co-sponsored by Senators Durbin and Lincoln does just this, and provides for greater tax credits the more the employer pays toward the premium. Much research concludes that the single most important factor affecting worker take-up is the out-of-pocket premium facing the worker and her family.⁹ Since tax credits to either workers or firms effectively lower the price of the premium by the credit, and since the credits proposed by Senators Durbin and Lincoln are likely to yield subsidies in the 10-50% range on top of scale economies from forming a pool, the SEHBP bill would likely increase coverage more than AHP legislation, but neither approach is going to solve the uninsured crisis facing our country, let us be clear.

In fact, recent work I have completed with the support of the California HealthCare Foundation makes clear that the fundamental health system problem we face today is that an increasing fraction of our workforce cannot afford health insurance, as we know it.

Table 1 illustrates this sad fact by reporting the ratio of family premiums to wages at different points in the wage distribution. The total family premium cost (on an hourly basis), as a percentage of wages at the 25th percentile of private sector workers' wages, rose from 33.2% to 47.1% between 1998 and 2003. Even for median wages, the family premium rises from 22.4% to 32.6%. Note then the median worker in 2003 is about where the 25th percentile worker was, in terms of health insurance purchasing power, in 1998. This illustrates how an increasing fraction of our workforce cannot afford health insurance, as we know it, for in 5 years the median worker fell to the 25th percentile worker's level of purchasing power. The average wage is higher than the median wage – earned by the person in the precise middle of the wage distribution – due to rock stars and professional athletes. A worker earning the average wage would still have had to devote 25.7% of wages to buy a family health insurance policy in 2003, and that is up from 17.9% only five years prior. This rapid decline in the power to purchase health insurance out of worker wages – either through the firm implicitly or as out-of-pocket payments -- is surely responsible for the decline in take-up and in overall ESI coverage that we have observed in recent years.

Table 1. Hourly cost of family health insurance as a percent of various hourly wage levels

	1998	2001	2003
25 th percentile wage	33.2%	38.7%	47.1%
Median wage	22.4%	27.6%	32.6%
Mean wage	17.9%	21.9%	25.7%

Source: Total – employer plus employee share -- Premiums from KFF annual surveys, various years, converted to hourly amount by dividing by 2080 = 52*40. National wages from the National Compensation Surveys, Bureau of Labor Statistics, corresponding years.

⁹Blumberg, Linda J., Len M. Nichols, and Jessica S. Banthin, "Worker Decisions to Purchase Health Insurance," *International Journal of Health Care Finance and Economics* V. 1 Number 3/4, September/December 2001.

Premiums as a fraction of the median wages of specific occupations, shown in Table 2, may illustrate the distributional nature of the affordability problem even more clearly. In California and in the nation as a whole, half of physicians would have to spend less than 7% of their wages to buy a family health insurance policy, whereas half of all cooks would have to spend more than 50% of their wages to do the same. It is hard to imagine employers of workers making in the \$8-10 range being willing to pay 45-50% more than that for health insurance in addition, or those workers being willing to trade half their earnings for health insurance as we know it. Therefore far bolder solutions than either AHPs or SEHBPs are required.

Table 2. Family health insurance premium costs as a fraction of median wages, 2002.

	US		CA	
	Median hourly wage	Family premium / median wage	Median hourly wage	Family premium / median wage
Physician	\$60.10	7.3%	\$62.21*	7.5%
History professor	\$27.63	15.8%	\$31.74	14.6%
Licensed practical nurse	\$16.18	26.9%	\$18.31	25.3%
Secretary	\$15.00	29.1%	\$14.55	31.9%
Bank teller	\$ 9.93	43.9%	\$10.34	44.9%
Carpenter	\$18.00	24.2%	\$20.49	22.6%
Cook	\$ 8.75	49.8%	\$ 9.68	47.9%

Source: National and California premiums from the MEPS-IC. National and California wages from the US Bureau of Labor Statistics. *US physician data are for general internists. The median wage for that specialty was not reported for California, so the roughly comparable 25th percentile of psychiatrist wages was used instead.

I will close my written testimony with a reminder about the three inter-related problems of our impressive but flawed health care system: low clinical value per dollar, highly uneven quality of care, and inequitable access to care. To avoid ever-increasing uninsured rates, and we know that a disproportionate share of the uninsured are connected to the workforce of small firms, you on this Committee and we as a nation must tackle all three problems simultaneously in a comprehensive reform. Our political system may not be ready for this conversation just yet, but support for responsible policy debate is growing around the country.¹⁰ The fundamental dynamic of an increasing percentage of our workforce being unable to afford health insurance as we know has been noticed all over our country.

Although certain details of a comprehensive solution have yet to be addressed, the principle and central elements of a feasible path to a far better health care system are increasingly clear. The guiding principle is universal coverage in exchange for universal

¹⁰ Nichols, Len M. et al, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning in 12 Communities," *Health Affairs* (March-June 2004).

responsibility.¹¹ The elements center on an individual mandate to purchase private insurance coverage with continued employer and increased social responsibility for financing the subsidies that will make the mandate feasible. There must also be effective cost-containment mechanisms that will substantially lower the rate of health care cost growth, so that the public subsidy guarantee and continued employer participation will be politically feasible. There are promising experiments around the country but assembling these initiatives into a cohesive cost-containment strategy is a task not yet completed, and it is one my New America colleagues and I will undertake in the next two years.

In the meantime however, perhaps our most important next step is to begin to acknowledge as a nation that access to health care is fundamentally a moral issue: the Institute of Medicine has clearly interpreted the research literature to tell us that one of the consequences of lack of insurance is thousands of premature deaths every year.¹² This should be just as unacceptable to us as deaths from smoking, drunk driving, medical errors, and acts of terrorism here and abroad. Over five thousand years of various scriptural traditions call upon us all quite clearly to pursue justice and enhance the life chances of all our fellow human beings. Once we agree to stop accepting the morally unacceptable, then maybe we will be ready to talk about how, rather than whether, to reform our entire health care system, being ever mindful of the essential role small employers will always have in our economy and our health insurance opportunities.

¹¹ Calabrese, Michael and Laurie Rubiner, "Universal Coverage, Universal Responsibility: A Roadmap to Make Coverage Affordable for All Americans,"

http://www.newamerica.net/Download_Docs/pdfs/Pub_File_1443_1.pdf

¹² *Hidden Costs, Value Lost: Uninsurance in America*. Institute of Medicine, 2003.