A Compendium of State and Local Initiatives to Expand or Retain Employer-Based Coverage

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I. INTRODUCTION

Many states and some local communities are experimenting with programs to expand access to employer-based coverage. Recognizing that there are a variety of reasons that workers are uninsured, these programs take different approaches that target those reasons. Many programs target employers that do not offer coverage—the most common reason that workers lack employer-based coverage.

Most programs to expand employer-based coverage offer a subsidy, either to induce employers to begin offering coverage or to assist the significant number of uninsured workers who cannot afford their share of the premium even when offered coverage. Typically, these programs target workers or children at family income levels that also would qualify them for coverage from Medicaid or the State Children’s Health Insurance Program (SCHIP).

Very few programs rely solely on unsubsidized approaches to expand coverage, although several take a “hybrid” approach, combining subsidies with unsubsidized strategies to expand group coverage. Unsubsidized strategies may include authorizing the sale of one or more limited-benefit insurance products (stripped of state-mandated benefits) or the development of purchasing pools to help streamline the purchase of insurance for small employers and provide additional coverage options for workers. Small firms (with fewer than 50 employees)—which have difficulty affording coverage and also may find the market for insurance difficult to navigate—are the usual targets for these strategies.

This report reviews major state and local programs that attempt to expand or retain employer-based coverage. State and local programs that subsidize employer and/or employee premiums are summarized in Tables I.1 and I.2 (below). State and local programs that rely on features other than a premium subsidy are summarized in Table I.3.
<table>
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<tr>
<th>Program and date opened</th>
<th>Estimated employer-based enrollment</th>
<th>Firm Size</th>
<th>Current offer status</th>
<th>Is wage level a basis for the subsidy?</th>
<th>Must be Uninsured?</th>
<th>Qualifying Level of Income</th>
<th>Is the product available to individuals?</th>
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<td><strong>Target Population</strong></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Employer Share Only Subsidized</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kansas:</strong> Small Employer Tax Credit (1999)</td>
<td>400 businesses</td>
<td>2-50 Employees</td>
<td>Does not offer</td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>No</td>
</tr>
<tr>
<td><strong>Maine:</strong> Small Employer Tax Credit (for dependents) (1999)</td>
<td>Never more than 13 employers</td>
<td>&lt;5 Employees</td>
<td>Any</td>
<td>No</td>
<td>n/a</td>
<td>n/a</td>
<td>No</td>
</tr>
<tr>
<td><strong>Pennsylvania:</strong> Health Insurance Premium Payment (HIPP) program (1994)</td>
<td>22,725 enrollees</td>
<td>Any</td>
<td>Offers</td>
<td>No</td>
<td>n/a</td>
<td>Worker or child must be Medicaid-eligible</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Oregon:</strong> Family Health Insurance Assistance Program (FHIAP) (1997)</td>
<td>9,643 group enrollees</td>
<td>Any</td>
<td>Offers</td>
<td>No</td>
<td>Yes</td>
<td>&lt;185% FPL</td>
<td>4,706 individual enrollees</td>
</tr>
<tr>
<td><strong>Maine:</strong> Dirigo Choice (2005)</td>
<td>3,600 small group lives</td>
<td>1-50</td>
<td>n/a</td>
<td>No</td>
<td>No</td>
<td>&lt;300% FPL</td>
<td>4,500 individual and sole-proprietors have enrolled</td>
</tr>
<tr>
<td><strong>Rhode Island:</strong> Rite Share (2001)</td>
<td>6,000 enrollees</td>
<td>Any</td>
<td>Offers</td>
<td>No</td>
<td>n/a</td>
<td>Individual Rite Care option</td>
<td>Individuals are eligible for a limited benefit product</td>
</tr>
<tr>
<td><strong>Utah:</strong> Covered At Work (2003)</td>
<td>43 enrollees</td>
<td>Any</td>
<td>Offers</td>
<td>No</td>
<td>Premiums must exceed 5% of income</td>
<td>&lt;150% FPL</td>
<td>Individuals are eligible for a limited benefit product</td>
</tr>
<tr>
<td><strong>Employee and Employer Share Subsidized</strong></td>
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</tr>
<tr>
<td><strong>New York:</strong> Healthy New York (2001)</td>
<td>27,000 small-firm employees</td>
<td>2-50 Employees</td>
<td>Does not offer</td>
<td>30% of employees must earn $33,000/year or less</td>
<td>No</td>
<td>n/a for small employer product</td>
<td>Individuals are 56% of total enrollment; sole-proprietors are 18%</td>
</tr>
<tr>
<td><strong>Massachusetts:</strong> Insurance Partnership/ Premium Assistance Program (1999)</td>
<td>19,000 lives</td>
<td>1-50 Employees</td>
<td>n/a</td>
<td>Employer subsidy available only for eligible employees</td>
<td>No</td>
<td>&lt;200% FPL</td>
<td>Parents with income below 133% FPL may enroll in MassHealth Standard</td>
</tr>
<tr>
<td>Program and date opened</td>
<td>Estimated employer-based enrollment</td>
<td>Employer eligibility</td>
<td>Employee eligibility</td>
<td>Target Population</td>
<td></td>
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<tr>
<td><strong>Washington:</strong> Basic Health Plan (1993)</td>
<td>6,300 lives</td>
<td>2 or more</td>
<td>n/a</td>
<td>No</td>
<td>No</td>
<td>&lt;200% FPL</td>
<td>Individuals are 98% of total enrollment</td>
</tr>
<tr>
<td><strong>New Mexico:</strong> State Coverage Insurance Program (2005)</td>
<td>Unknown percentage of estimated 2,000 total enrollment</td>
<td>1-50</td>
<td>Does not offer</td>
<td>No</td>
<td>Yes</td>
<td>&lt;200% FPL</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Idaho:</strong> Access to Health Insurance (2005)</td>
<td>229 lives</td>
<td>2-50</td>
<td>Does not offer</td>
<td>No</td>
<td>Yes</td>
<td>&lt;185% FPL</td>
<td>No</td>
</tr>
<tr>
<td><strong>Oklahoma:</strong> Premium Assistance Program (2005)</td>
<td>Unknown</td>
<td>1-25</td>
<td>n/a</td>
<td>No</td>
<td>No</td>
<td>&lt;185% FPL</td>
<td>No</td>
</tr>
</tbody>
</table>

Sources:  
(1) Kansas Small Employer Tax Credit: Correspondence with Craig Van Alst, Kansas Insurance Department (November 3, 2005).  
(2) Maine Small Employer Tax Credit: Correspondence with Gerard Jerome, Maine Revenue Services, 11/14/05.  
(3) Pennsylvania HIPP program: Personal conversation with Veronica Ressler, Pennsylvania Department of Public Welfare (11/9/05).  
(4) Oregon’s Family Health Insurance Assistance Program (FHIAP): Program Website, "Enrollment Statistics, October 24, 2005."  
(7) Utah: Covered At Work: Personal Correspondence with PNC Covered at Work Outreach Coordinator (11/09/05).  
(8) Idaho Access to Health Insurance: Personal Correspondence with Phyllis Stephenson (11/15/05).  
(10) Massachusetts Insurance Partnership/ Premium Assistance: Personal correspondence with Peter Terry (November 5, 2005).  
(11) Research Triangle Institute, "Employer Subsidies for Health Insurance Premiums: Massachusetts’ Unique Experiment” (September 30, 2004).  
(13) New Mexico State Coverage Insurance Program: Correspondence with Mari Spaulding, SCI Program Coordinator (November 4, 2005).

Note:  
n/a indicates that the provision is not applicable.

a New Jersey and Wisconsin have very small Medicaid-based premium assistance programs for families, similar to the Rhode Island program. Missouri, Iowa, Texas and Virginia have Medicaid HIPP programs covering children similar to the Pennsylvania program but with much smaller enrollment.
b Subsidy must be used to buy employer coverage if the employer offers and contributes.
c Eligible individuals with an employer offer of coverage must use Rite Share.
### Table 1.2

**Subsidized Local Programs**

<table>
<thead>
<tr>
<th>Program and date opened</th>
<th>Estimated current enrollment</th>
<th>Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Firm size Current offer status Is wage level a basis for the subsidy?</td>
<td>Employer eligibility</td>
</tr>
<tr>
<td><strong>Employee and Employer Share Subsidized</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wayne County, MI: HealthChoice (1994)</td>
<td>4,000 subscribers</td>
<td>At least 3 who qualify for coverage Does not offer</td>
</tr>
<tr>
<td>Muskegon County, MI: AccessHealth (1999)</td>
<td>1,150 lives</td>
<td>Groups of 2 or more Does not offer</td>
</tr>
<tr>
<td>Duval County, FL: JaxCare (2004)</td>
<td>300 lives</td>
<td>3 or more employees Does not offer</td>
</tr>
<tr>
<td>Sacramento County, CA: SacAdvantage (2002)</td>
<td>89 subsidized lives</td>
<td>2-50 Does not offer</td>
</tr>
<tr>
<td>Cabell County, WV: OUCH Program (2002)</td>
<td>78 lives</td>
<td>Any size Does not offer</td>
</tr>
</tbody>
</table>

**Sources:**
1. HealthChoice Wayne County, MI: Correspondence with Vicki Hertel (November 4, 2005).
3. JaxCare Duval County, FL: P. Galewitz, “Local Governments Find Ways to Assist with Care for the Uninsured,” Palm Beach Post (July 31, 2005).
5. Offering the Uninsured of Cabell County Healthcare (OUCH) Program in Cabell County, WV: Correspondence with Lanie Masilamani, OUCH Project Director and Clinic Administrator (November 7, 2005).

**Notes:**
- n/a indicates that the provision is not applicable.
- At least six additional communities have introduced “three-share” programs similar to those in Muskegon and Wayne Counties but enrollment to date is either very small or the program has closed.
<table>
<thead>
<tr>
<th>Program and date opened</th>
<th>Estimated employer-based enrollment</th>
<th>Target population</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATE PROGRAMS</strong></td>
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</tr>
<tr>
<td><strong>Arizona:</strong> HealthCare Group of Arizona (1988)*</td>
<td>17,000 lives</td>
<td>Sole proprietors and firms with 2-50 employees and do not offer coverage</td>
<td>A public-private partnership that offers health plans to small employers on a guarantee issue basis. Employers have the option of paying some, all or none of the premium.</td>
</tr>
<tr>
<td>West Virginia: Small Business Plan (2005)</td>
<td>About 500 enrollees</td>
<td>Firms with 2-50 employees, Does not offer coverage</td>
<td>A public-private partnership that offers a high deductible health plan to small businesses that do not offer coverage. The program uses the state's Public Employees Insurance Agency’s negotiated discounts to benefit from lower insurer administrative fees and lower provider reimbursement rates.</td>
</tr>
<tr>
<td>Connecticut: Municipal Employee Health Insurance Program (2004)</td>
<td>236 lives</td>
<td>Firms with 2-50 employees</td>
<td>Firms with 50 or fewer employees may join the State's Municipal Employee Health Insurance Program to benefit from the lower administrative cost of a large group. Small-employers are a separate risk pool in the program.</td>
</tr>
<tr>
<td>Oregon: Alternative Group Plan (adults) and Children’s Group Plan (2005)</td>
<td>Fewer than 100 lives</td>
<td>Firms with 2-50 employees, Does not offer coverage</td>
<td>Small employers that do not offer coverage may participate in the Alternative Group Plan (a limited-benefit, high-deductible plan that covers adults only) and/or the Children’s Group Plan (offering more comprehensive coverage for children). Employers may contribute as little as $50 per employee per month in either program. FHIAP-eligible employees (see Table 1) may apply the FHIAP subsidy to pay their share of the premium for children’s coverage.</td>
</tr>
<tr>
<td>Colorado: Multiple Employer Welfare Arrangement (MEWA) Pilot Program (2003)</td>
<td>One association offers a plan</td>
<td>Any</td>
<td>As a pilot program, Colorado allows the formation of Multiple Employer Welfare Arrangements or MEWAs, with the intent that employers will be able to band together to bargain effectively with health plans. MEWAs must include at least 2 firms and at least 100 employees and dependents.</td>
</tr>
<tr>
<td><strong>LOCAL PROGRAMS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NYC and Suburban Areas: HealthPass (1999)*</td>
<td>12,059 lives (7/2003)</td>
<td>Firms with 2-50 employees</td>
<td>A conventional purchasing alliance. The Mayor’s office provides a small subsidy for administration.</td>
</tr>
</tbody>
</table>


* Healthcare Group received a state-subsidy in some years of operation but it is not now subsidized.

* The HealthPass program staff are not authorized to release current enrollment numbers.
The discussion that follows describes these programs along several dimensions. In Section II, we review the programs’ target populations. In Section III, we consider the majority of programs that offer subsidies and describe how these subsidies are designed and financed. In Section IV, we review unsubsidized strategies that some programs use exclusively or in combination with subsidies to expand coverage, and then turn to a discussion of hybrid approaches in Section V. The final section reviews the rationale for an employer-based strategy to expand coverage and the features that more successful programs have in common. We conclude with a proposed list of the initial design questions that may help to establish both the priorities and constraints within which such a program might operate in Pennsylvania.

A number of very small current state programs are not separately reviewed in this report, due not only to their smaller enrollment but also to having many features in common with the programs that are described; we have attempted to identify these smaller programs in the table notes. Finally, where helpful, the report also refers to unique features of selected closed or proposed programs. These programs are summarized in Appendix A.
II. THE TARGET POPULATION

Employer-based coverage programs may use either firm or worker characteristics to target coverage. All programs that subsidize the employer’s share of the health insurance premium restrict the sorts of firms that are eligible to participate. If the program subsidizes only the worker’s share of the premium, the eligibility criteria typically focus on the worker’s characteristics. Many programs have criteria for both worker and firm eligibility, and in addition require that the coverage offered meet certain benefit criteria.

The population eligible for the program may be broader than the program’s target population. For example, uninsured workers may comprise the program’s target population but, for reasons of operational simplicity or equity (treating similarly situated persons similarly), the program may be open to other workers as well, regardless of their coverage status.

In this section, we describe the firm and worker characteristics often used to define the eligible population. These characteristics typically include firm size, whether the firm offers coverage, and whether the worker is currently insured. In addition, the programs may specifically include or exclude dependents from coverage.

A. FIRM SIZE

Most programs that subsidize the employer’s portion of the premium limit the size of firms eligible to participate—typically to firms with 50 or fewer employees, but sometimes to much smaller firms. Many also restrict participation to firms that do not offer (and have not recently offered) coverage. In Pennsylvania, as in other states, the vast majority of firms that do not offer coverage are very small—typically having fewer than 10 employees.\(^1\) Consequently, restricting

\(^1\) The 2003 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) for Pennsylvania.
eligibility to firms that do not offer coverage focuses the program predominantly, if not exclusively, on very small firms. For example:

- Healthy New York enrolls low-wage firms that do not offer coverage, with 2 to 50 employees, yet the average size of enrolled firms is just 3 employees.²

- AccessHealth in Muskegon County, Michigan permits non-offering firms of any size (excluding sole-proprietors) to participate yet the average firm has just 3 to 4 employees.

B. WORKERS WITHOUT AN EMPLOYER OFFER OF COVERAGE

Most uninsured workers are not offered employer coverage. When employers are asked why they do not offer coverage, they characteristically state two primary reasons: the coverage costs too much, and/or they believe that their employees do not need it (Fronstin 2003). Therefore, programs that target these workers focus on improving the affordability of coverage to employers and on marketing to educate employers about the importance of coverage. For example:

- The Kansas Small Employer Tax Credit is a refundable tax credit available to small, non-offering employers that begin to cover to their employees. The credit is intended to reduce employers’ after-tax cost of coverage.

- The Healthy New York program is available to small employers that have not offered coverage in the past year. It uses reinsurance coupled with a lean benefit design to reduce the cost of coverage—by up to 40 percent, compared to competing plans in the small group market (Swartz 2005). In addition, employers may contribute as little as half of the premium for single coverage, an amount well below the market standard.³

- In the “three-share” programs of Muskegon and Wayne Counties in Michigan, the employer, the employee, and the program each pay approximately 1/3 of a premium

² Uninsured workers and sole-proprietors under 250 percent of the Federal Poverty Level (FPL) can also enroll in Healthy New York as individuals if they do not have an employer that sponsors insurance.

³ In 2003, New York employers with 50 or fewer workers contributed 85 percent of the premium on average for single coverage. However, a significant portion of these employers (64 percent) offered at least one plan where the employer paid 100 percent of the premium for single coverage. Excluding these employers, the remaining employers paid an average of 59 percent of the premium for single coverage (2003 Medical Expenditure Panel Survey-Insurance Component [MEPS-IC] for New York).
that is itself slightly below the commercial market average. Employers in this program pay a much smaller share of premium than they would for commercial coverage (Fronstin 2005).

C. INELIGIBLE WORKERS IN FIRMS THAT OFFER COVERAGE

Nationally and in Pennsylvania, 15 to 20 percent of uninsured workers are employed in firms that offer coverage, but the worker is ineligible to participate. Workers in this situation typically are satisfying a waiting period for coverage after they are hired, or they work in job categories (part-time, temporary, or seasonal) that are permanently ineligible. Programs to expand employer-based coverage rarely target these workers.

While programs that subsidize commercially available insurance may have little choice but to follow standard industry practice regarding eligibility for coverage, those that sponsor a non-commercial product may have the flexibility to adopt non-standard eligibility rules. Some of these programs have a standard for minimum hours worked that may be below the industry standard. For example:

- In Oregon, the Alternative Group Plan for adults and the Children’s Group Plan both permit small-firm employees who work at least 17.5 hours per week to participate.
- JaxCare, a small program operated out of Jacksonville, Florida, permits employees working just 15 hours per week to participate in the program.

D. WORKERS WHO DECLINE COVERAGE

Approximately 20 percent of uninsured workers decline an offer of coverage for which they are eligible, typically deterred by the amount of premium they are required to contribute.

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4 Nationally, 43 percent of ineligible workers cite insufficient time on the job as the reason for being ineligible (Garrett 2004). This suggests that some workers may lack coverage for only short periods. Another 37 percent claim that they don’t work sufficient hours or weeks in the year to qualify for coverage. (Employer plans typically require minimum job tenure and/or minimum hours worked to avoid adverse selection from workers who may take a job solely to obtain coverage and leave when their immediate need for coverage is satisfied.) Other ineligible workers (20 percent) cite various other reasons for ineligibility.
Programs that target these workers attempt to lower costs to employees, and may not address the employer cost of coverage at all. In general, these programs serve larger numbers of eligible workers in states that where employer offer of coverage is high, and the amount of program subsidy available to employees is significant. For example:

- Maine’s Dirigo Choice program enrolls groups of 1 to 50, and pays as much as 100 percent of the employee’s share of the premium, calculated on a sliding-scale basis relative to family income. Opened in April 2005, an estimated 3,600 small-group employees are enrolled. An additional 4,500 individuals and sole-proprietors are also enrolled with another 3,000 wait-listed.\(^5\)

- Rhode Island’s RIté Share and Pennsylvania’s Health Insurance Premium Payment (HIPP) program are premium assistance programs for Medicaid- or SCHIP-eligible workers and their dependents. Funded with Medicaid or SCHIP dollars, these programs pay all or much of the employee contribution to premium, when it is less expensive than direct Medicaid or SCHIP coverage. RIté Share has enrolled approximately 6,000 parents and children. Pennsylvania’s HIPP program (the largest of all the Medicaid or SCHIP based premium assistance programs) has enrolled over 22,000 Medicaid-eligible adults and children.

- In contrast to these programs, Utah’s Covered at Work program has enrolled just 43 lives in nearly two years of operation. This program offers workers with family income below 150 percent of FPL a premium subsidy worth up to $50 per month. Employees must pay a $50 annual fee to enroll in the program. It is not known what factors may be contributing to the program’s low enrollment.

**E. SOLE PROPRIETORS**

Whether to include sole proprietors without employees (sometimes called “groups of one”) in a program to expand coverage for workers is a key consideration. It is generally assumed that including sole proprietors makes the program more vulnerable to adverse selection. However, subsidizing coverage may reduce adverse selection, if the subsidy is sufficient to encourage relatively healthy individuals to buy and maintain coverage.

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\(^5\) Dirigo Choice capped individual enrollment (including sole proprietors) in the first year of program operation. This cap has recently been lifted.
Several programs allow sole proprietors to participate, and in each of these programs, they enroll in disproportionate numbers. For example:

- In the Massachusetts’ Insurance Partnership program, 62 percent of the participating employers are sole proprietors without employees (RTI 2004). This population is generously subsidized: sole proprietors may receive not only the “employer” subsidy (via the Insurance Partnership), but also the “employee” subsidy available through the state’s Premium Assistance program.

- Sole proprietors and other self-employed individuals enrolled in Healthy New York enrollees equal the number of workers enrolled through small groups.

To include coverage for sole proprietors but reduce the impact of adverse selection, some programs restrict enrollment to an annual open enrollment period:

- Maine’s Dirigo Choice restricts sole proprietors (as well as others eligible to enroll as individuals) to an annual open enrollment period. As noted above, Dirigo Choice also capped the number of individuals and sole proprietors who could participate in the first year of the program.

F. DEPENDENTS

Employer-based subsidy programs vary widely in their coverage of dependents. Some programs do not subsidize or offer coverage for dependents, citing limited subsidy funds and the greater availability of Medicaid and SCHIP coverage for children. For example:

- New Mexico’s State Coverage Insurance program offers subsidized coverage all small firms that do not offer coverage and to low-income workers in these firms. However, coverage is only available to the worker and not their dependents. Having recently opened (July 2005), program officials were unable to estimate total small

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6 Uninsured, self-employed workers make up about 15 percent of all uninsured workers (PA DOI, 2004). Compared to other workers, they are disproportionately likely to be uninsured. In most states, sole proprietors without employees must buy coverage in the individual market at higher premiums and with less favorable benefits than group coverage.
group enrollment but believed total enrollment (including individuals) might represent 2,000 lives.\textsuperscript{7}

- Utah’s Covered at Work program subsidizes the coverage of workers and spouses but not children.

Other programs emphasize the coverage of children. This emphasis may be more common when the programs use Medicaid or SCHIP dollars as a funding source, but it is not unique to such programs:

- Pennsylvania’s HIPP Program, financed with Medicaid dollars, pays for the least amount of adult coverage necessary to enroll eligible children. Children account for 70 percent of total enrollment in the program.
- The Massachusetts’s Premium Assistance Program, financed with Medicaid and SCHIP dollars, subsidizes families more generously than individuals. More than half of all contracts (56 percent) are family coverage.
- Maine enacted a small employer tax credit in 1999 that subsidizes dependent coverage only. Possibly owing to rather complicated eligibility rules, take-up of the credit has been very low ever since it was enacted (never totaling for than 13 firms).

G. HEALTH INSURANCE STATUS

Some coverage programs require that participants be uninsured not only at the time of application, but also for a significant period (typically one year) before enrolling in the program. The latter provision is intended to increase the target efficiency of the program (the net increase in persons with coverage per program dollar) by deterring insured individuals and families from dropping existing coverage in order to qualify for subsidized coverage. The phenomenon of individuals dropping private coverage in favor of publicly subsidized coverage commonly is called “crowd out.”

\textsuperscript{7} In addition to small groups, the plan is also available to individuals willing to pay the employer and employee portions of the premium.
While crowd out provisions are relatively easy to structure for programs that enroll individuals, they can be a major deterrent to enrollment in a program for employers. Many employers would not want to participate in a program that treats similarly situated workers differently, depending on whether they purchased insurance in the prior period. Recognizing this problem, programs often consider insurance status only at the employer level, if even then.

State coverage programs vary across the board in their consideration of current insurance status. For example:

- Healthy New York does not require that workers in eligible small businesses be uninsured, but it does require that the business itself not have offered coverage for the past 12 months.
- New Mexico’s State Coverage Insurance program, as well as most of the local programs that subsidize the employer and employee premium shares, require the worker to have been uninsured and also preclude employers that have recently offered coverage from participating.
- Idaho’s Access to Health Insurance permits only small employers that do not offer coverage to participate. Moreover, the program subsidizes the employee’s share of the coverage only if the eligible (low-income) employee has been uninsured.

Alternatively, some programs do not consider the insurance status of either the firm or the worker. For example, neither the Massachusetts Premium Assistance Program, Maine’s Dirigo Choice program, nor Washington’s Basic Health Plan consider insurance status. Nevertheless, a large proportion of program enrollees were uninsured before enrolling in the program:

- Massachusetts’ Premium Assistance program estimates that 57 percent of program enrollees were previously uninsured.
- In Maine’s Dirigo Choice program, nearly 40 percent of enrollees were previously uninsured.
III. APPROACHES TO DESIGNING SUBSIDIES

Programs that use a subsidy-based approach can structure the subsidy in a number of different ways. Some consider family income in determining eligibility for the subsidy, the amount of the subsidy, or both. Others consider only worker wage levels.

Programs that use commercial health insurance products may subsidize the cost of coverage directly (paying a portion of the insurance premium) or indirectly (for example, by providing reinsurance). Some programs subsidize one non-commercial plan created specifically for the program. These variations are described in greater detail below.

A. THE BASIS FOR SUBSIDY

Most programs that subsidize employee coverage consider family income to determine eligibility. This approach may maximize equity (workers with similar family incomes all are eligible) as well as target efficiency (low-income workers are less likely to afford health insurance when it is offered). However, it creates operational complexity for employer-based programs: neither employers (who know only the employee’s wage) nor insurers can easily administer programs that base subsidies on family income. Instead, a third-party (the state government or local program office) typically must determine which workers are eligible for the subsidy as well as whether the employer is eligible.

Programs designed to encourage employer-based coverage typically target workers with family incomes below 200 percent of FPL. Most employees who benefit from these programs have income between 100 percent and 200 percent of FPL. For example:

- Rhode Island targets RItShare subsidies to workers with family income below 185 percent of FPL. However, premium assistance is cost-effective primarily for families with incomes from 100 percent to 185 percent of FPL. These workers are more likely both to work for an employer that offers coverage and to be eligible for coverage.
• In an unusual approach, the JaxCare program in Duval County, Florida, required eligible workers to have family income of at least 150 percent of FPL, but not more than 200 percent of FPL, to be eligible for subsidized coverage. The lower income threshold was eliminated in June of 2005.

Reflecting differences in ability to pay among individuals below 200 percent FPL income range, many programs have multiple subsidy levels scaled to family income:

• Maine’s Dirigo Choice, Washington’s Basic Health Plan, RIte Share, the Massachusetts Premium Assistance program, New Mexico’s State Coverage Insurance Program and Oregon’s Family Health Insurance Assistance Program (FHIAP) all scale the employee’s subsidy to family income.

Rarely, both the employer and employee are subsidized on the basis of the employee’s family income. The result can be a relatively complex structure of subsidies that is difficult for the employer to anticipate. For example:

• SacAdvantage has three different subsidy levels depending on worker income. Because the employee and the employer split the post-subsidy premium cost, the varying subsidy amounts also affect the employer’s cost to participate in the program. Because employers do not know their employees’ family incomes, they cannot predict with certainty their share of the cost. This uncertainty might deter some small employers from enrolling.

Among programs that offer a subsidy, only Healthy New York and the three-share programs in Michigan consider the firm’s entire wage profile—not individual workers’ family income—in determining eligibility for enrollment and, therefore, the subsidy:

• Healthy New York serves employers that do not offer coverage and that employ low-wage workers: at least 30 percent of their employees must earn less than $33,000 per year (an amount that is adjusted annually). By law, insurers that offer the Healthy New York product determine the eligibility status of small firms that apply for coverage.8

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8 Any licensed insurer may sell the Healthy New York product, but HMOs are required to sell it. To date, only HMOs have sold Healthy New York coverage.
• Muskegon County’s AccessHealth program only serves firms that do not offer coverage and have a median wage of $11.50 per hour.

• Wayne County’s HealthChoice program also serves only firms that do not offer coverage, and in which 50 percent of employees who qualify for coverage earn $14.50 per hour or less.

B. TOTAL PREMIUM REDUCTION

Programs that pay a subsidy directly to the plan to reduce the total premium make the subsidy “invisible” to both the employer and the employee. Such programs can make it easier for employers and employees to understand their cost to participate, and they greatly simplify monthly premium payments for participants. For example:

• Idaho’s Access to Health Insurance program sends a subsidy per covered enrollee and dependent directly to the insurer. The plan then invoices the employer for the rest of the cost. The employer must pay at least 50 percent of the invoiced amount, and the employee pays the balance.

• The “three-share” programs in Muskegon and Wayne counties, MI (as well as SacAdvantage in Sacramento, CA) take a similar approach. The simplicity of the employer interface with the program and the predictability of employer cost are regarded as very important to the Michigan programs’ having successfully recruited small employers (Neuschler 2004).

C. REIMBURSEMENT OF PREMIUMS

Several programs, including Oregon’s Family Health Insurance Assistance Program (FHIAP) and Utah’s Covered at Work program, require that the worker pay her full share of the premium. The worker is then reimbursed up to the amount of the subsidy. This approach can be administratively cumbersome, and it can create serious cash-flow problems for low-income workers. Nevertheless, at least one program—RItShare—believes that it has increased enrollment significantly by removing employer involvement from the subsidy payment process (Silow-Carroll 2004).
Programs that reimburse premium contributions have use various approaches to minimize administrative and worker cash flow problems:

- Dirigo Choice provides an "EBT Card" to workers who qualify for a subsidy. Like a debit card, the EBT card is loaded with their subsidy amount on the same day that the premium contribution is taken out of their paycheck—effectively reimbursing them instantaneously.

- In Massachusetts, the Insurance Partnership and Premium Assistance programs send the combined amount of the employer and employee subsidy directly to employers that participate in the Insurance Partnership. As a condition of participating in the Insurance Partnership, the employer must adjust payroll withholding for the employee by the amount of the employee subsidy. If the worker’s employer does not participate in the Insurance Partnership, the check is then sent to the worker.

- Pennsylvania’s HIPP program (which subsidizes only the employee share of the premium) pays the employee’s premium subsidy directly to the employer whenever possible. If the employer is unwilling to accept the check directly or the payroll system cannot accommodate this method of payment, the check is sent to the employee and the employee makes the premium payment. In order to reduce cash flow problems for these enrollees, the program tries to time the checks so that they arrive when the premium is due. However, this effort sometimes results in the program inadvertently sending a check to individuals who are no longer covered by their employer.

D. EMPLOYER TAX CREDITS

Many states have explored the possibility of using tax credits to subsidize coverage.9 Two states currently provide a state tax credit to employers, subsidizing their cost of offering coverage. However, the low take-up in these programs suggests that they are not effective in expanding coverage:

- Kansas uses a refundable employer tax credit to encourage employers that have not offered coverage to begin doing so. Established in 1999 at $35 per eligible enrolled employee, Kansas doubled the credit to a maximum of $70 per eligible enrolled employee for the 2004 tax year. The value of the tax credit declines over time and is eliminated entirely after five years. Take-up of the tax credit has been very low,

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9 Such a credit increases the tax advantages that the federal tax code and all state tax codes already give to expenditures for group health insurance. Both employer and employee expenditures for group coverage typically are exempt from individual income taxation and from FICA.
potentially due to the low level of the credit. However, available research suggests that even doubling the size of the credit may not significantly increase coverage among small-firm workers (Reschovsky 2001).

- Maine has a small employer tax credit designed to subsidize the provision of dependent coverage. Take-up of this credit is even lower than Kansas. No more than 13 firms have applied for the credit in any given tax year. This may be due to a lack of publicity and some complexity in the rules qualifying an employer for the credit.

To our knowledge, no states have explored use of individual tax credits to subsidize the employee’s share of employer-sponsored group coverage. However, at least one state is considering using the state income tax code to compel individuals (who can afford to do so) to buy coverage:

- Massachusetts is considering legislation that would penalize taxpayers who do not purchase coverage by removing their eligibility for the personal exemption in calculation of their personal income tax liability to the state. Either group or nongroup coverage would qualify individuals for the personal exemption.

E. SUBSIDIZED REINSURANCE

Two states have developed reinsurance programs to subsidize the cost of coverage to small firms. These programs pick up part of the cost of claims for the highest-cost individuals who enroll in the program:

- Healthy New York is the largest example of this type of approach. Healthy New York reimburses insurers for 90 percent of claims between $5,000 and $75,000. In combination with a somewhat lean benefit package, the reinsurance feature helps keep premiums approximately 40 percent below the market level for “typical” small group coverage (Swartz 2005).

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10 Parenthetically, many states have enacted conforming legislation with respect to holding funds in a Health Savings Account (HSA), giving individuals who put funds in an HSA the same tax advantages at the state level as at the federal level.

11 Other states—including Maryland—have considered a similar provision in the past, but did not enact it.

12 A number of states operate self-supporting small group reinsurance programs intended to stabilize the small group market but not necessarily to lower the cost of group coverage (Chollet 2004).
• Louisiana (see Appendix A) has a HIFA waiver application pending CMS review. The waiver program would subsidize reinsurance to cover losses from $3,000 to $90,000 for small employers that have not offered coverage in the past 6 six months.

F. SOURCES OF SUBSIDY FUNDS

Subsidized programs to expand employer coverage have financing from many different sources. In order to finance the substantial subsidies needed to change employer offer and employee take up of coverage, many rely on more than a single source of funds.

1. State General Revenues or Tax Expenditures

Several programs are completely or partially funded directly from general state revenues or as foregone revenues (called tax expenditures). The Washington Basic Health Plan is wholly funded from state general revenues; the Kansas Small Employer Tax Credit is funded as foregone general revenues. The Massachusetts Insurance Partnership and Healthy New York both rely partially on state funding. Such use of “state-only” funds offers the maximum flexibility to the state in tailoring the program to its own economic and fiscal circumstances—compared, for example, to use of Medicaid or SCHIP funds.

2. Medicaid/SCHIP funds

Several states use Medicaid or SCHIP funds to support a premium assistance program. The federal Centers for Medicare and Medicaid Services (CMS) operate three systems of waivers that provide opportunities to fund such programs (two of them named for the section of federal statute authorizing the waivers): Section 1906 waivers (also called Health Insurance Premium Payment, or HIPP, waivers); Section 1115 demonstration waivers; and Health Insurance Flexibility and Accountability (HIFA) waivers. States may apply for any of these types of waivers, all of which in effect allow the state to use funds that it would receive for its traditional
Medicaid or SCHIP programs in nontraditional ways. The Pennsylvania HIPP program operates under such a waiver.

Depending on the waiver program used, however, the funds may carry more or fewer restrictions on how the state is able to design the program. Several programs have relatively creative and/or complex designs—largely or entirely transparent to enrollees—to accommodate federal funding rules:

- Independent of (and prior to) the development of Dirigo Choice, Maine obtained an 1115 waiver to expand coverage to parents of SCHIP-eligible children and to low-income adults without children. That waiver achieved the relatively broad eligibility for Maine’s combined program, called MaineCare, that was critical in the development of Dirigo Choice: many of Maine’s low-income workers are MaineCare-eligible. Dirigo Choice enrolls eligible employees and dependents in MaineCare (if they wish to obtain a full subsidy against the employee contribution and high deductibles that the program requires) and pays the state share of cost (SCI 2005b).\(^\text{13}\)

- In Massachusetts, the Insurance Partnership and Premium Assistance programs use both Medicaid and SCHIP funding. Subsidies to employers that have not previously offered coverage are eligible for the federal Medicaid match. Subsidies to all other participating employers are paid with state-only funds. Subsidies paid to workers who are covering their previously uninsured children qualify for federal SCHIP match, and subsidies to all other workers participating in the Premium Assistance program qualify for federal Medicaid match.

- Similarly, Rhode Island’s RIteShare program is financed from a combination of Medicaid and SCHIP funds. Eligible individuals with an employer offer of coverage may not enroll in RIte Care, but must enroll in RIte Share instead.

- New Mexico’s State Coverage Insurance program uses SCHIP funding to support coverage for childless adults as well as adults with children who participate in the program. New Mexico is the only state to have secured SCHIP funds to support childless adults.

\(^\text{13}\) MaineCare-eligible individuals who do not have an offer of employer coverage are ineligible to enroll in Dirigo Choice.
3. Disproportionate Share Hospital (DSH) Funds

Several communities leverage Medicaid disproportionate-share hospital funds to fund their programs. For example:

- Maine’s 1115 waiver used DSH funds to finance expanded MaineCare eligibility for childless adults, to 125 percent of FPL—one aspect of the broad eligibility for MaineCare that helped to make the Dirigo Choice plan feasible.

- Michigan law permits counties that operate hospitals to establish local non-profit organizations—such as the AccessHealth plan—to provide care for the uninsured. Because the premium contributions that employers make to AccessHealth are viewed as reducing the county’s uncompensated care burden, they can be used to generate Federal match under the DSH program. The process by which this takes place involves a relatively complex series of intergovernmental transfers between the county hospital and the state (Fronstin 2005). However, AccessHealth does not rely on the upper payment limits that have drawn increasing Congressional and CMS scrutiny of the states’ creative uses of DSH funds.

4. Assessments on Insurers

Some states have used insurer assessments to fund programs intended to expand group coverage. This source of financing, however, must obviously be used with care: to the extent that the assessment is passed forward into higher health insurance premiums, it could reduce the affordability of private coverage in the larger market. Examples of approaches that attempt to minimize the impact of such assessments include the following:

- Maine’s Dirigo program was initially capitalized with a one-time appropriation from the state’s general revenues. However, the program requires ongoing funds to support not only subsidies to low-income workers and their families, but also the program’s quality and system-wide cost initiatives. Those funds are to be obtained from an assessment on insurers’ gross premium revenue. Called a savings offset payment, the assessment is triggered only if the program proves that it has forced at least that amount of savings in private health care costs—including reductions in bad debt and charity care associated with under- or uninsured patients. Carriers are expected to negotiate with providers to extract those savings and reflect them in premium levels. The assessment, which by law may not exceed 4 percent, may not be passed forward as a net increase in premiums.
• Idaho’s new program, Access to Health Insurance, also is funded with a tax on health insurance premiums. However, enrollment in this program is capped at 1,000 participants.

5. Tobacco Settlement Funds and Taxes

Tobacco settlement funds have provided seed money for several programs (for example, SacAdvantage), and in some states they have provided some operating capital. However, the states have been more likely to use tobacco settlement funds to provide coverage unrelated to employers (such as Pennsylvania’s AdultBasic program) than to encourage broader employer-based coverage.

At least two employer-based programs currently rely on tobacco taxes (not settlement funds) to partially fund subsidies for coverage:

• Healthy New York relies partially on tobacco tax revenues for its funding.
• When Montana’s Small Business Health Insurance Program begins enrollment (anticipated in 2006), it will subsidize premiums for coverage purchased through the program. The subsidy will be funded with tobacco tax monies (See Appendix A.)

6. Provider Discounts

While programs that expand coverage probably reduce providers’ uncompensated care burden, it can be difficult to recover “windfall” gains from providers (Maine’s Dirigo Choice assessment on insurers is one such attempt). Nevertheless, programs that are local in their focus have had considerable success in recruiting providers to accept reduced rates payment or to donate services—especially if the providers feel the program is narrowly targeted and their financial exposure is limited. For example:

• AccessHealth in Muskegon County reimburses providers at Medicare rates plus 10 percent. While providers consider these rates still to be below average, they are nonetheless very supportive of the program, and almost all local providers participate. The program has a policy of prompt payment to providers and covers only local care.
• Both the very small Offering the Uninsured of Cabell County Healthcare (OUCH) program in West Virginia and the JaxCare program in Duval County, Florida rely on provider discounts to offer affordable coverage. JaxCare, in particular, relies on the donation of hospital services to subsidize coverage.
IV. NON-SUBSIDY APPROACHES

Some states have explored approaches to employer-based coverage that do not rely on subsidies. These approaches include waiving benefit mandates to allow the sale of limited-benefit plans to small groups (or sponsoring such plans) and encouraging the development of small-employer purchasing pools.

A. LIMITED-BENEFIT PLANS

In varying degrees, all states have specific benefits that must be included in all group coverage sold in the state. However, at least 10 states have enacted legislation to waive some or all of these mandated benefits, permitting the sale of limited-benefit plans to small employers. Legislators in these states hope insurers will develop lower-priced but still attractive products that will encourage more small employers to offer coverage and more employees to afford the coverage when offered.

However, experience has shown that carriers are reluctant to offer these products, and when they are offered, enrollment is very low. State officials have reported that these products are not much less expensive than conventional coverage, and that they have little appeal for business owners who prefer comprehensive coverage for themselves (Friedenzohn 2004). For example:

- Oregon’s Alternative Group Plan is a limited-benefit product available only to small employers that do not offer coverage. The Alternative Group Plan covers only adults and has a very lean plan design intended to be about 30 percent less expensive than $1,000-deductible commercial plans offered in the market. Offered through a large HMO and the state’s large Blue Cross Blue Shield plan, fewer than 100 workers have enrolled in the product since it was launched in January 2005.14

14 Oregon also developed a more comprehensive small-group plan to cover children—the Children’s Group Plan. The plan is intended to offer firms the opportunity to provide comprehensive coverage for children of their workers even if they cannot afford to cover their employees. Employers may offer the Children’s Group Plan only or together with the adult plan.
B. POOLING ARRANGEMENTS

Many states and localities have experimented with small employer purchasing pools. While these pools have been successful in offering small groups both administrative convenience and a choice of plans, there is no evidence that they reduce premiums. As a result, most evaluations have concluded that purchasing pools alone do not expand coverage (Long and Marquis 2001).

While some states that sponsor health insurance programs use a purchasing pool concept, none currently rely on this strategy alone. Nevertheless, the ease of enrollment that these plans offer and the attractiveness of their benefits may lead some employers and workers to participate when they otherwise might remain uninsured. For example:

- HealthPass in New York City is believed to have enrolled at least 12,000 lives (Taylor, 2004). HealthPass attracts very small firms: the median group size is just 5 employees. Nearly two-thirds (64 percent) of participating firms report that they did not offer coverage at the time of application, and 56 percent of HealthPass enrollees report that they were uninsured for 12 months prior to enrolling in HealthPass (Rosenberg, 2003).

C. STATE-NEGOTIATED HEALTH PLAN

A few states have explored ways to leverage the administrative services and purchasing power of the state employee’s health plan to provide more attractive coverage options for small employers. Each of these programs pools the medical risk associated with small employer enrollment separately from the public employee group, so they offer no particular advantage with respect to the medical cost of the plan—although all are too new to evaluate claims experience.

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15 From 1993 to 1999, the State of California sponsored the Health Insurance Plan of California (HIPC), a purchasing pool for groups of 2 to 50 employees. In accordance with its authorizing statute, operation of the pool was transferred to a private entity in 1999. The Pacific Business Group on Health currently operates the pool as PacAdvantage.

16 By comparison, a somewhat larger number of workers enrolled through a small group in Healthy New York (68 percent, compared to 56 percent in HealthPass) report that they would have been uninsured if they had not enrolled in the program.
However, the intent of the programs is to offer (potentially substantial) economies of scale in administrative services and marketing:

- West Virginia recently launched a Small Business Plan for uninsured business with 2 to 50 employees. This program combines a high-deductible benefit design with reduced administrative fees and provider payment rates that the state’s Public Employees Insurance Agency negotiates. The program is expected to achieve premiums that are 20 percent less than market levels. Mountain State Blue Cross/Blue Shield (the state’s largest insurer) currently offers this product. Approximately 100 firms have enrolled.

- In Connecticut, companies with 1 to 50 employees (as well as other nonprofit organizations that do business with the state) may join the Municipal Employee Health Insurance Program (MEHIP), a state-administered insurance program for municipal employees. However, MEHIP coverage appears to be more expensive than the market, potentially related to the programs’ more comprehensive benefit designs (Kaminski 2005).

D. INDIVIDUAL AND EMPLOYER MANDATES

Some state policy makers view an individual mandate as the most effective way to accomplish large increases in coverage. However, to make such a requirement realistic could require substantial change in individual insurance regulation—ensuring that affordable coverage is available to everyone. In states with an individual income tax, enforcement of such a mandate would likely occur through the tax system—for example, denying a personal exemption for individuals who remain uninsured.

The states also have explored the potential for mandating that employers provide coverage. At present, only Hawaii has such a mandate. In place for more than 30 years, Hawaii’s employer mandate is generally credited with having achieved a much higher rate of coverage in Hawaii than otherwise would have occurred (Kronick 2004).
In other states, the federal Employee Retirement Income Security Act (ERISA) prohibits the state from requiring employers to offer health insurance as a benefit.\textsuperscript{17} However, there is a growing consensus among state policy makers that a carefully crafted “play or pay” strategy could survive an ERISA challenge. Such a strategy might offer employers that provide coverage an offset against a fee that they otherwise would be required to pay into a state coverage program.\textsuperscript{18} However, there is little confidence that a simple mandate could succeed without some source of subsidy to the smallest employers, especially, that do not now offer coverage.

\textsuperscript{17} Enacted in 1974, ERISA exempts employee benefit plans from state regulation (although the states retain authority to regulate the business of insurance). Hawaii’s mandate requiring employers of all sizes to provide coverage for their workers was in place at the time ERISA was legislated, and was grand fathered into the federal law. Hawaii’s law requires that the worker’s contribution to that coverage be limited to 1.5 percent of wages. Nevertheless, 10 percent of Hawaiians under age 65 are uninsured due to the absence of a qualifying workforce connection.

\textsuperscript{18} This approach was taken in California and enacted as The Health Insurance Act of 2003 (also known as S.B. 2). The law ultimately was repealed by referendum, with a narrow majority.
V. COMBINING SUBSIDIES WITH NONSUBSIDY APPROACHES

Some subsidy programs use one or more of the non-subsidy approaches described above to reduce the cost of coverage available through the program. Obviously, efforts to reduce program cost minimize the amount of the subsidy that the program requires. However, minimizing program cost also is essential to encouraging broad participation by employers and employees (some who may not be subsidized at all) and the wide pooling of risk needed to stabilize the program.

A. SUBsidIZED SMALL-EMPLOYER PURCHASING POOLS

Combining subsidies with a small employer purchasing pool can facilitate administration of the subsidy and reduce the overall cost of coverage. For example:

- SacAdvantage subsidizes coverage available through PacAdvantage, the small employer purchasing pool in California. In addition to subsidized coverage, program participants benefit from PacAdvantage’s streamlined enrollment processes and the wide range of PacAdvantage products. Currently, PacAdvantage offers primary coverage through eight major carriers, with a wide selection of optional dental and vision plans.

- Montana’s Small Business Program is developing a new state-operated purchasing pool for very small businesses (with 2 to 5 employees) in which all employees (except the owner) are paid less $75,000 per year. The pool will offer premium incentives for employers and, for employees, premium assistance scaled to family income. The program expects to begin enrollment in 2006, when its funding (derived from state’s tobacco tax) reaches a sufficient level. (See Appendix A.)

But not all programs that combine subsidies with small employer purchasing pools emphasize the choice of plans that historically has been the hallmark of employer purchasing pools. For example:

- Maine’s Dirigo program negotiates with commercial health insurers to underwrite the two Dirigo Choice products. Both products are identical, with the exception of the
deductibles: the high-option product has a $1250 deductible, and the low-option product has a $1750 deductible. The subsidies available to employees, sole proprietors, and other individuals below 300 percent of FPL reduce both the premium they must pay and the amount of the deductible. Dirigo Choice relies on strong enrollment, active disease management, and system-wide cost control—as well as the ability to retrieve system-wide cost savings through an assessment on insurers—to manage the pooled risk of small groups, sole proprietors, and individuals enrolled in the program.

B. COMBINING MANDATES AND SUBSIDIES

While employer and/or individual mandates may have great potential for expanding coverage among the currently uninsured, they immediately beg the question of affordability. Two recent examples of such mandates are to be found in California and in Massachusetts. Both clearly attempt to ensure that the mandated coverage is affordable to employers and to low-income employees:

- In 2003, California enacted an ambitious mandate, imposing a “pay-or-play” mandate on employers of 50 or more employees that subsequently was repealed (by a narrow margin) in referendum. The Health Insurance Act (more commonly known by its bill number, S.B. 2) required employers of 200 or more employees also to cover dependents. Smaller employers (with 10 to 49) were mandated to provide coverage only if the state passed a tax credit to help pay for coverage (a prospect widely considered unlikely); the legislation did not address very small employers. SB2 authorized a system of subsidies for Medicaid-eligible workers and for workers with incomes under 200 percent of FPL. S.B. 2 also called for a new state-operated plan to cover workers whose employer preferred to “pay” rather than provide coverage directly.

- The Massachusetts legislature is considering two similar proposals designed to move the state closer to universal coverage. One proposal, initiated by the Governor, would require Massachusetts’s residents to purchase insurance coverage if they can afford to do so. The Governor’s proposal would encourage the development of new lower-cost small group insurance products (probably with high deductibles), and the state would subsidize premiums for lower-income workers who are not eligible for Medicaid.

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19 For unsubsidized participants, both plan designs are HSA-qualified.

20 Had SB2 been fully implemented, it is estimated that the program would have covered 26 percent of the uninsured population in California (about 1.4 million people). The remaining uninsured Californians either were not in a working family or the worker’s employer was too small to be subject to the mandate.
The Speaker of the House has introduced a competing proposal that would assess a payroll tax on businesses of 10 employees or more that do not insure their workers.
VI. DISCUSSION

Nearly half of all U.S. workers currently are covered through their own employer; including dependents, about 3 of every 5 Americans under age 65 have coverage from an employer plan. While it is true that employer-based coverage has been eroding for most of the past two decades, it remains the largest source of private coverage in the country.

Aside from the general appeal of building on a system that most Americans accept, many state and local programs that have attempted to expand coverage focus on employer-based coverage for a number of very practical reasons:

- By capturing employer contributions to coverage, state programs can reduce the subsidy needed to expand coverage effectively.
- Employer groups offer an opportunity to pool risk broadly. The potential for adverse selection is a much greater problem for programs that enroll individuals.
- A significant body of federal and state law has contributed to a relatively stable group insurance market. Federal HIPAA protections (incorporated into nearly every state’s insurance laws) support a “level playing field”—with guaranteed issue of every small-group product and standard portability rules—that most states have not matched in their individual markets.
- Federal law offers much greater tax advantages to workers for group coverage, compared to coverage that they might buy individually.
- Some administrative functions that greatly simplify worker participation—such as enrollment and payroll deduction of the employee’s contribution to premium—are routine for most employers.

Nevertheless, building on employer coverage has some potential disadvantages relative to conventional public coverage. In particular:

- Federal rules make it very complex for states to use Medicaid or SCHIP funds to subsidize employer-based coverage. Strategies that cannot use these sources of funds forego federal matching funds, making the program much more costly to the state. Nevertheless, Pennsylvania has been unusually successful in using Medicaid funds
for this purpose and probably would want, at minimum, to coordinate its HIPP program with a broader strategy to expand coverage.

- Commercial insurance plans typically pay providers much higher rates than public programs. Providers are very reluctant accept discounted rates from private insurance plans.

State programs to expand employer-based coverage have attempted to address these problems in different ways. The largest such program—Healthy New York—does not use federal funding; the program is operated independent of the state’s Medicaid and SCHIP programs. Similarly, Maine’s Dirigo Choice plan does not rely directly on federal funding. Dirigo Choice brokers MaineCare coverage, enrolling employees and their dependents when they are eligible and requesting full relief from both the employee’s share of premiums and the program’s high deductibles. Dirigo Choice pays the state share of funding required to draw the federal match, the program itself does not use federal funding.

All of the programs—both state and local—reflect a broad agreement that the cost of commercial insurance to small groups is the most important factor discouraging coverage. However, only local noncommercial plans have based cost savings on free or discounted care from providers who serve patients enrolled in the program. The state programs have been more likely to rely on use of managed care. For example, Healthy New York requires HMOs to participate, and until recently, Arizona’s Health Care Group relied exclusively on managed care plans that contracted with the state’s Medicaid program.

State programs that subsidize coverage probably have the potential to cover more workers than programs that attempt to reduce cost without a subsidy. However, even subsidized programs have had varied success in reaching their target populations. Those that enrolled relatively large numbers of employers and/or employees have a number of features in common (Neuschler 2004):
• They make cost to employers and employees predictable.

• They have a sense of permanence—employers must have confidence that the program will exist for the long term.

• They offer attractive benefits, appealing to both business owners and low-income workers.

• They are simple to the user—the program is easy to understand and applying for the program is streamlined.

Finally, evaluations of more successful programs often point to the importance (and difficulty) of the extensive outreach and insurance education required to recruit small employers that do not offer coverage.

Finally, any state that would consider a program to expand access to employer-based coverage must address a series of initial program design questions that include at least following:

• What population will the program target? Firms that do not offer coverage? Uninsured workers in firms that offer coverage? All employees in qualifying firms, or only low wage/income employees? Sole proprietors? Part-time and/or temporary workers?

• Is it acceptable that eligibility be wider than the target population, or is crowd out a concern?

• Is a very narrow or limited benefit design acceptable? Will a limited benefit design compromise the appeal of the program over time?

• Is it necessary that the program to use SCHIP or Medicaid funds? How much state or local funding will be available to the program?

• Will providers accept reduced payment rates for the population served by the program?

• Will the program be organized statewide or regionally/locally?

Answering these questions will help to identify both the critical priorities of the program and its essential constraints. The answers will determine both the size of the program and the program’s relationship (if any) to existing public and private programs. Ultimately, they may also determine public perceptions about the program’s value and permanence.
REFERENCES


APPENDIX A

SUBSIDIZED STATE AND LOCAL PROGRAMS—CLOSED, PENDING, OR PROPOSED
TABLE A.1
CLOSED STATE PROGRAMS

<table>
<thead>
<tr>
<th>Program and dates of operation</th>
<th>Estimated employer-based enrollment</th>
<th>Employer Eligibility</th>
<th>Employee Eligibility</th>
<th>Is subsidized product available to individuals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Small Employer Tax Credit (1989-1995)</td>
<td>At its peak, 32,000 employees</td>
<td>1-25 employees</td>
<td>Credit varied by whether the employer previously offered</td>
<td>No</td>
</tr>
</tbody>
</table>

**Only Employer Share Subsidized**

<table>
<thead>
<tr>
<th>Program and dates of operation</th>
<th>Estimated employer-based enrollment</th>
<th>Employer Eligibility</th>
<th>Employee Eligibility</th>
<th>Is subsidized product available to individuals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State Health Insurance Partnership (1996-2003)</td>
<td>Enrollment capped at 1100 firms. In 1999, the waiting list peaked at 300 firms.</td>
<td>1-50 employees</td>
<td>Does not offer</td>
<td>Low-wage firms given preference</td>
</tr>
</tbody>
</table>


Note: n/a indicates that the provision is not applicable.
<table>
<thead>
<tr>
<th>Program and dates of operation</th>
<th>Estimated employer-based enrollment</th>
<th>Target Population</th>
<th>Is subsidized product available to individuals?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Montana Small Business Program</strong>&lt;br&gt;(January 2006)</td>
<td>Expected to help 7,000-8,000 workers in the first year</td>
<td><strong>Employer</strong>&lt;br&gt;Firm size: 2-5 employees <strong>Current offer status</strong>&lt;br&gt;Premium incentive for employers that do not currently offer; tax credit for those that offer</td>
<td><strong>Employee</strong>&lt;br&gt;All employees (except owner) must earn less than $75,000 per year <strong>Is wage level a basis for subsidy?</strong> No restriction &lt;200% FPL for premium assistance</td>
</tr>
<tr>
<td><strong>Arkansas Safety Net Benefit Program (pending CMS approval of HIFA waiver)</strong></td>
<td>Aims to cover 55,000 low-income employees and their dependents</td>
<td><strong>Small employers (not specified)</strong>&lt;br&gt;No offer in past 12 months</td>
<td><strong>n/a</strong>&lt;br&gt;Must be ineligible for state employee’s coverage and Medicaid</td>
</tr>
<tr>
<td><strong>Louisiana LaChoice (pending CMS approval of HIFA waiver)</strong></td>
<td>Estimated 3,000 adults</td>
<td><strong>Small employers (not specified)</strong>&lt;br&gt;No offer in past six months</td>
<td><strong>Not specified</strong>&lt;br&gt;Not specified</td>
</tr>
</tbody>
</table>


**Note:** n/a indicates that the provision is not applicable.
## TABLE A.3

**CLOSED LOCAL PROGRAMS**

(Employee and Employer Share Subsidized)

<table>
<thead>
<tr>
<th>Program and dates of operation</th>
<th>Estimated employer-based enrollment</th>
<th>Firm size</th>
<th>Current offer status</th>
<th>Is wage level a basis for subsidy?</th>
<th>Must be uninsured?</th>
<th>Income basis for subsidy?</th>
<th>Is subsidized product available to individuals?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOCUS, San Diego, CA (1999-2004)</strong></td>
<td>216 businesses with 1,699 employees (capped)</td>
<td>2-50</td>
<td>Must not offer</td>
<td>Any wage level</td>
<td>Must be uninsured</td>
<td>&lt;300% FPL</td>
<td>No</td>
</tr>
<tr>
<td><strong>Small Business Health Insurance Program, New York City, NY (1998-2001)</strong></td>
<td>123 businesses</td>
<td>2-50</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>No</td>
</tr>
<tr>
<td><strong>Denver Community Voices, Denver, CO (1998-2002)</strong></td>
<td>21 businesses</td>
<td>2-50</td>
<td>No offer in previous 90 days</td>
<td>Indirectly: net annual business income less than $50,000</td>
<td>n/a</td>
<td>n/a</td>
<td>No</td>
</tr>
<tr>
<td><strong>MaineCare, two communities in Maine (1989-1994)</strong></td>
<td>2,000 enrollees</td>
<td>1-15 employees</td>
<td>Must not offer</td>
<td>n/a</td>
<td>n/a</td>
<td>&lt;200% FPL eligible for premium assistance</td>
<td>No</td>
</tr>
</tbody>
</table>


Note: n/a indicates that the provision is not applicable.