Advancing the Health of Ohioans
Through Informed Policy Decisions

Small Employer, Big Crisis: Health Insurance Affordability, Small Market Reforms, & Policy Challenges

12:00 p.m. Welcome & Opening Remarks – William D. Hayes, Ph.D., President, Health Policy Institute of Ohio

12:05 p.m. Presentations:

Paul Fronstin, Ph.D., Senior Research Associate with the nonpartisan Employee, Benefit Research Institute (EBRI)

Len Nichols, Ph.D., Director of the Health Policy Program, New America Foundation

Katherine Swartz, Ph.D., Professor of Health Policy & Management, Harvard School of Public Health (HSPH)

1:30 p.m. Questions & Dialogue

2:00 p.m. Concluding Remarks – William D. Hayes, Ph.D.

The Sad and Woeful State of the Small Group Market

Paul Fronstin, Ph.D.
Director, Health Research & Education Program
Employee Benefit Research Institute

Health Policy Institute of Ohio
July 14, 2006

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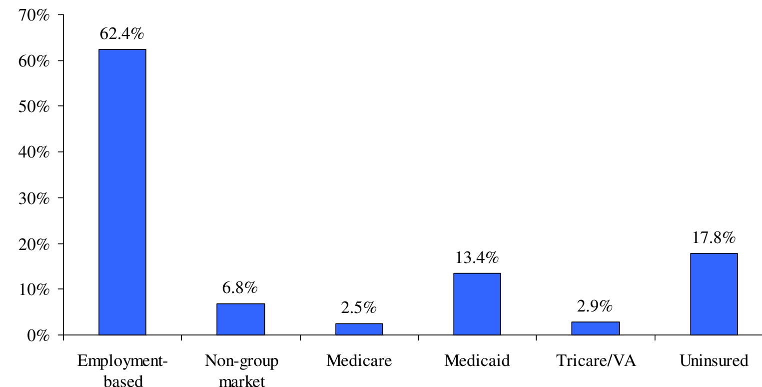
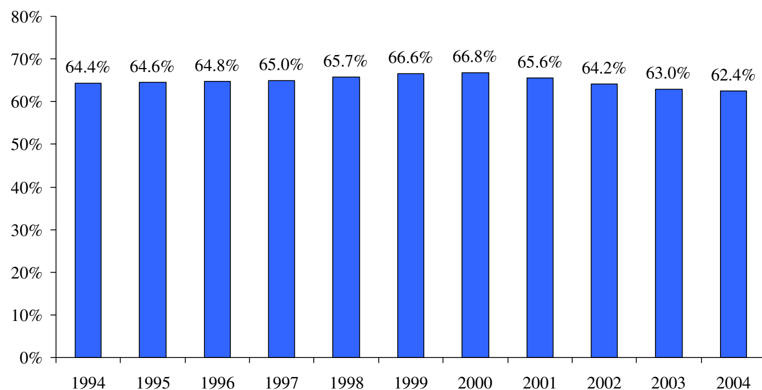
Sources of Health Coverage, Nonelderly, 2004



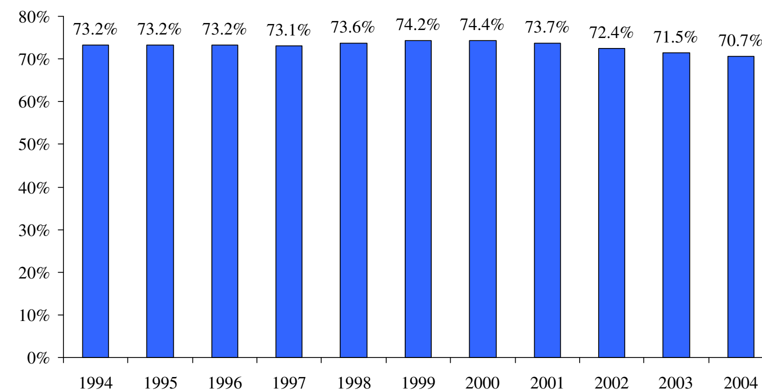
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2005 Supplement.

Percentage of Nonelderly With Employment-Based Coverage, 1994-2004



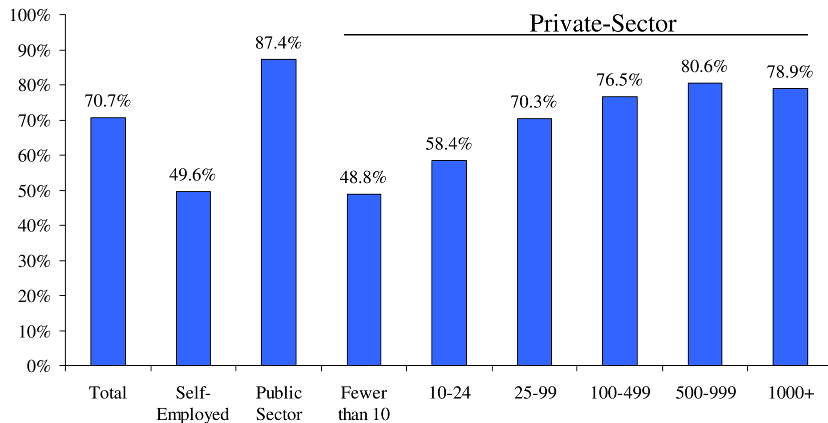
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995-2005 Supplements.

Percentage of Workers With Employment-Based Coverage, 1994-2004



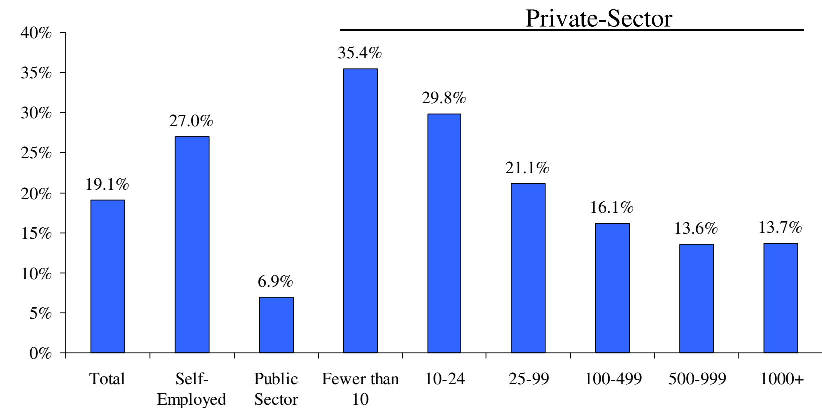
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995-2005 Supplements.

Workers Ages 18-64 with Employment-Based Coverage, by Firm Size, 2004



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2005 Supplement.

Uninsured Workers Ages 18-64, by Firm Size, 2004



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2005 Supplement.

Change in Probability of Having Employment-Based Coverage, by Firm Size, 2000 & 2004

	2000	2004	% Change
Self-Employed	53.8	49.6	-8%
Fewer than 10	54.2	48.8	-10%
10-24	63.5	58.4	-8%
25-99	72.3	70.3	-3%
100-499	79.8	76.5	-4%
500-999	80.7	80.7	0%
1000+	82.2	78.9	-4%
Public Sector	88.0	87.4	-1%

Change in Probability of Being Uninsured, by Firm Size, 2000 & 2004

	2000	2004	% Change
Self-Employed	23.9	27.0	13%
Fewer than 10	31.5	35.4	12%
10-24	26.5	29.8	13%
25-99	19.6	21.1	8%
100-499	13.9	16.1	16%
500-999	13.0	13.6	4%
1000+	11.4	13.7	20%
Public Sector	6.3	6.9	8%

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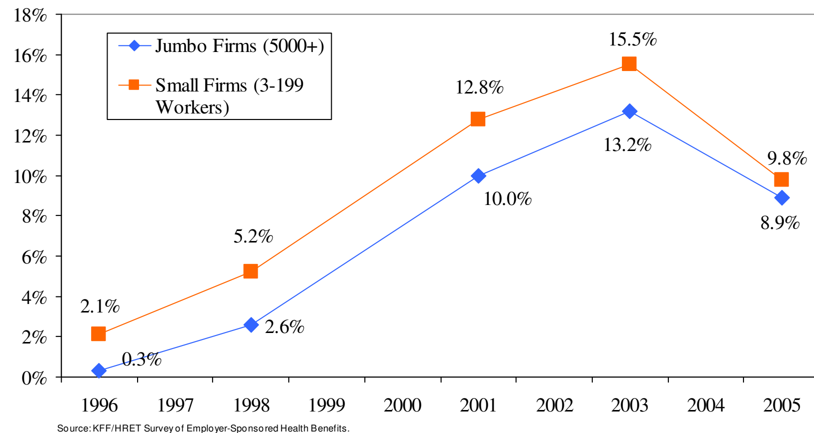
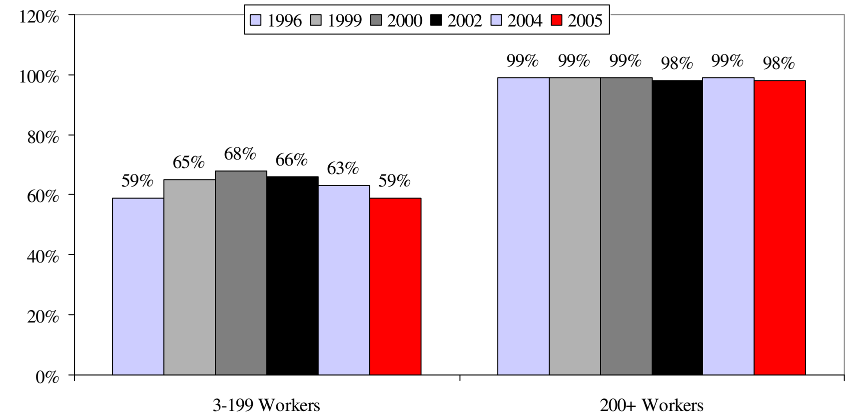
Premium Increases by Firm Size, 1996-2005



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits.

EBRI Employee Benefit Research Institute

Percentage of Firms Offering Health Benefits, by Firm Size, 1996-2005



Source: KFF/HRET.

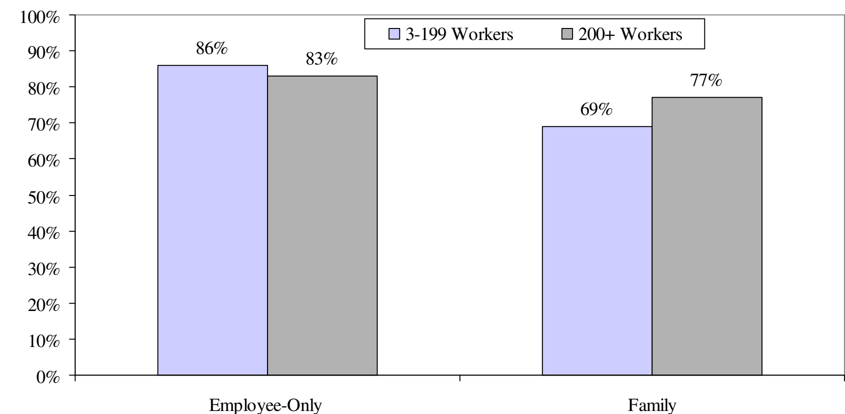
EBRI Employee Benefit Research Institute

Average Premiums, by Firm Size, 2005

Source: KFF/HRET.

EBRI Employee Benefit Research Institute

Percent of Premium Paid by Employer, by Firm Size, 2005



Source: KFF/HRET.

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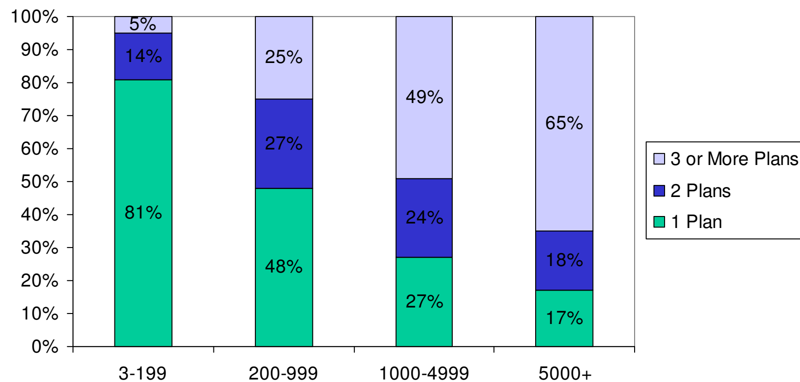
Choice of Plan, by Firm Size, 2005



Source: KFF/HRET.

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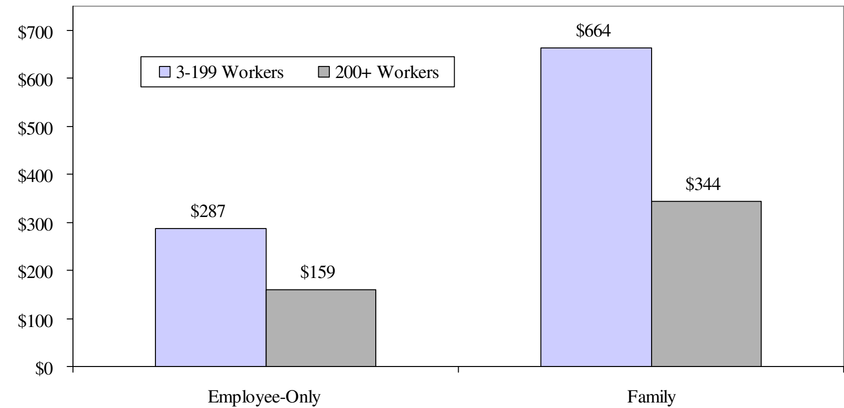
Average Deductibles, by Firm Size, 2005



Source: KFF/HRET.

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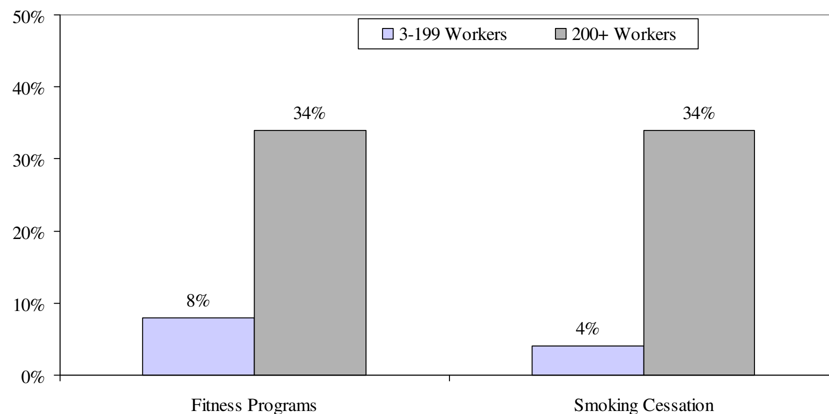
Percent of Employers Offering Wellness Programs, by Firm Size, 2005



Source: KFF/HRET.

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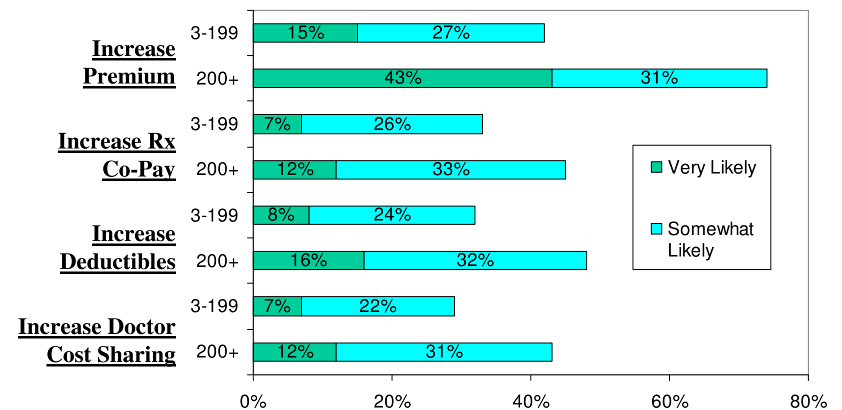
Likelihood of Employers Making Changes in 2006, by Firm Size



Source: KFF/HRET.

Consumerism

- A very big idea.
- Much bigger than health accounts.
- Starting with health accounts.

Consumerism: Potential & Concerns

Potentials

- Lower costs
  - Reduction in use
  - Use of lower cost services
- Better engaged consumer
- More satisfied consumer
- Better health outcomes/more appropriate care
- Improve affordability

Concerns

- Low health literacy
  - Reduce necessary care
  - Induce demand for unnecessary care
- Lack of tools & resources to make decisions
- Impact on high cost users uncertain
- One-time savings

Evidence So Far

Full Replacement HRA Study
(McKinsey & Company, 2005)

- CHDP consumers are more engaged than "traditionally insured" in decision making
- Make decisions that *may* drive sustained decline in trend
  - Forego less serious care
  - Shop for most cost effective care when they can
  - Take greater responsibility for health and wellness
- Seek information to compare treatments, not providers
- Are no more likely than employees in traditional plans to seek quality info
- Are less satisfied than with previous plans

EBRI/Commonwealth Survey Respondent Profile

		Comprehensive (n=1061)	HDHP (n=463)	CDHP (n=185)
Age	21 to 34	29%	17%*	21%*
Education	High school graduate or less	32	8*	5*
	College graduate or some graduate work	23	38*	46*
	Graduate degree	11	17*	21*
Household Income	$150,000 or higher	4	3	9*

Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.
*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

EBRI/Commonwealth Survey Respondent Profile

		Comprehensive (n=1061)	HDHP (n=463)	CDHP (n=185)
Self-Rated Health Status	Excellent/very good	45%	47%	57%*
	Obese	36	33	26*
	Smokes cigarettes	23	14*	14*
	No regular exercise	24	15*	16*
Firm Size	Self-employed with no employees	2	9*	8*
	2-49	15	31*	38*
	50-199	9	9	8
	200-499	10	7	5*
	500 or more	55	37*	36*

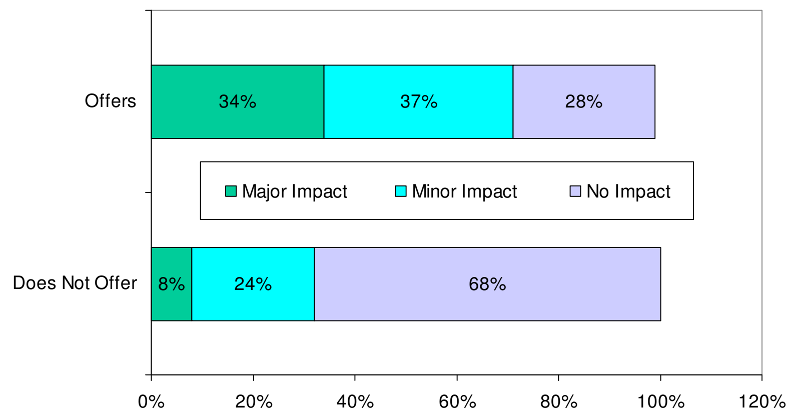
Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.
*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005

EBRI/Commonwealth Survey Summary of Findings

- CDHP enrollees more likely to exhibit cost conscious decision making.
- Lower satisfaction with CDHPs.
- CDHP enrollees more likely to avoid of delay needed care.
- Larger financial burdens associated with CDHPs.
- Lack of information to make informed decisions.
- Lack of trust in insurers to provide information.
- Less choice of health plan among CDHP enrollees.

Impact of Offering or Not Offering Coverage on Overall Success of Small Business, 2002

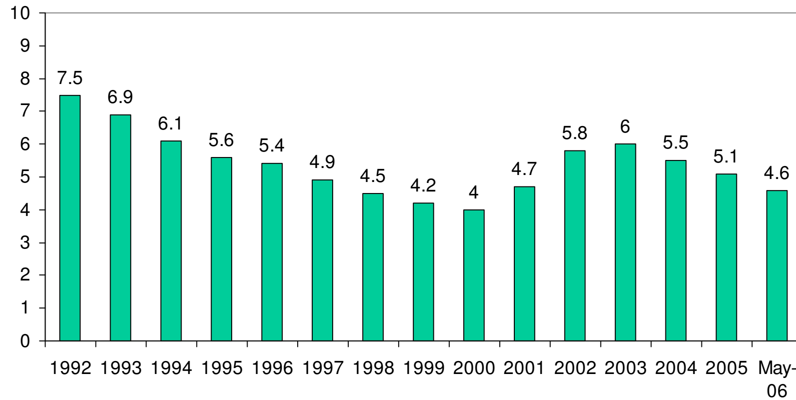


Source: EBRI 2002 Small Employer Health Benefits Survey.

Impact of Rising Costs Among Small Business in 2002

- 19% changed health benefits to reduce costs in 2002.
- 43% reported that the cost of health benefits affected some other aspect of business.
  - Reduced or eliminated pay, raises, or bonuses.
  - Reduced other benefits.
  - Delayed equipment and other purchases.
  - Froze hiring or laid off workers.

National Average Unemployment Rate, 1992-2006



Source: BLS.

Conclusion

- Short term challenge to address rising health costs.
- Short term challenge gets more complicated if unemployment rate reaches 4%.
- National health insurance debate starts in 2010, new system in 2018.

Small Employers and Health Insurance: IS There a Better Way?

Len M. Nichols, Ph.D.
Director, Health Policy Program
New America Foundation

Health Policy Ohio Forum
Columbus, Ohio
July 14, 2006

Overview

- A little (more) background
- Some useful distinctions
- Policy options on the table
- Refined options for Ohio
- Longer term solutions

Fundamental Fact of Health Insurance Economics (FFHIE)

- Distribution of health spending skewed
- Top 1% of people → 30% of spending
- Top 10% of people → 70% of spending
- Top 20% of people → 80% of spending
- Bottom 50% of people → 3% of spending
- Mean spending 5 times median spending
- Mean spending 20 times 25th percentile $

Why We Regulate Health Insurance

- FFHIE → Insurance is about pooling risk
- FFHIE → Risk selection more profitable than managing care or improving the delivery system
- Voluntary purchase → selection is key issue
- Competing views of "Just" risk pools
  - Libertarian vs. Communitarian
- Regulation is about forcing pooling beyond what *laissez faire* market would offer

Problems with Health Insurance

- Asymmetric Information
- Adverse Selection
- Moral Hazard
- Stinting

- POLICY is about making tradeoffs among these, in pursuit of desired and attainable equity

Why is Employment-Based Group Insurance So Prevalent in US?

- Tax Preferences

- Economies of Scale
  - Risk pooling
  - Administrative
  - Bargaining power vs. insurers/providers

- Econs of scale alone → Making workers "whole" is more expensive than offering, for employers of most workers, still

Some Useful Distinctions

- Affordability vs. Cost

- Managing care/delivery system re-engineering vs. selecting risks

- Competition vs. number of competitors

- Size vs. market power

Competing Policy Visions

- New Wild West, with tax breaks
  - Individual consumers will drive efficiency

- Musty Cocoon of Single Payer
  - Elite control will drive efficiency

- Brave New World
  - Mandates, smart regulation, combined buying power will drive efficiency

Policy Options On the Table

- Repeal benefit mandates
- Allow AHPs
- Allow SBHPs (Enzi-Nelson)
- Enhance tax advantages of HSAs/non-group insurance
- Tax credits for the purchase of insurance in certain ways

Benefit Mandates

- Add 3-7% to costs
- Limit variation in product design
- Can be socially efficient
- Can protect providers more than patients

AHPs

- Want to extend large group advantages to small employers
  - Inter-state size not going to help bargaining power in local health provider markets
  - Most un-regulated large firms already offer benefit mandates
  - Risk pooling rules are tighter in 48 states than in AHP vision; would help some, hurt others, especially those left in residual small group market
  - Would empower "TPA" of nationwide AHP

Enzi's SBHPs

- Designed to meet objections to AHPs
- Three kinds of supporters
  - NFIB
  - Individual trade associations
  - Insurers intent on aggressive underwriting
- Last group inserted provisions that made it unattractive for those who prefer pooling for all

President's Proposals

- Encourage non-group purchase of HSA-eligible insurance
  - Premium + OOP from HSAs deductible
  - Payroll tax credit for HSA contribution
- Support passage of AHPs + federal override of state regulation of insurance markets
- Malpractice reform
- HIT and transparency exhortations

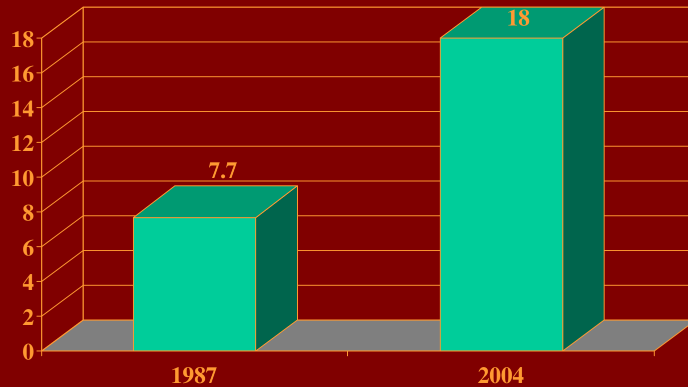
Refined Options for Ohio

- Turbo-charged purchasing pools
  - COSE everywhere
  - DEFINE small group + individual markets to be ONLY in pools, a la Massachusetts
  - Use state-employees as base group
  - Have same rules inside as outside
  - Define terms of competition
    - Geographic, product markets are not accidents
  - Consider 3-share models for lower income workers

Longer Term Solutions

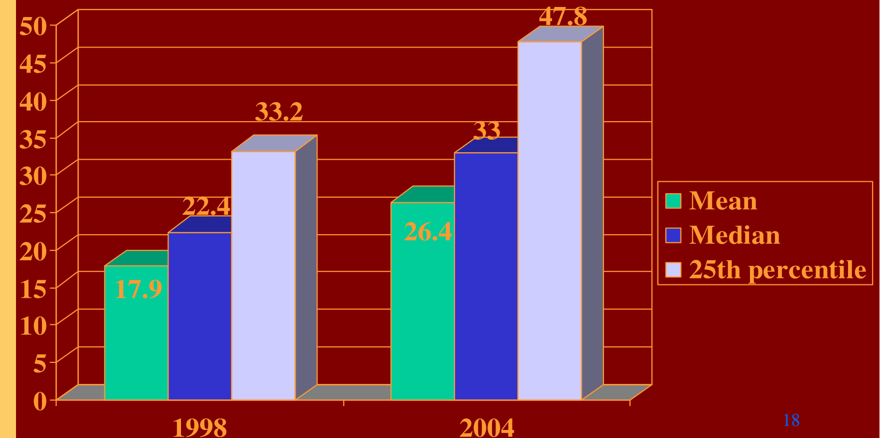
- Our main 3 problems are linked
  - Low value per dollar
  - Uneven and low average quality
  - Inequitable access
- Linkages → incremental solutions will not work

Percent of median family income required to buy family health insurance



Source: Author's calculations, using KFF and AHRQ premium data, CPS income data.

Family health insurance premium as percent of wages



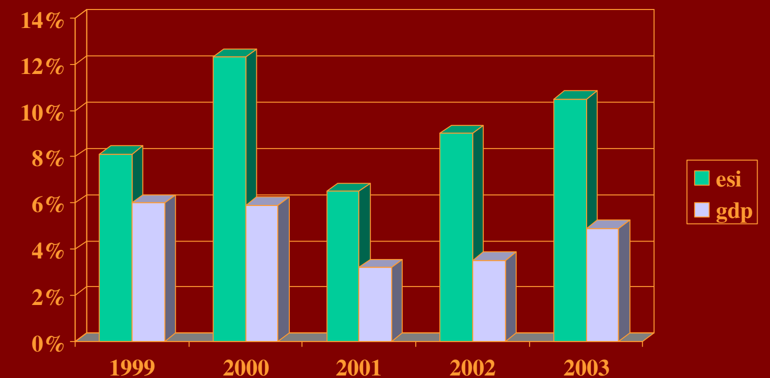
Source: author's analysis of KFF premium data, BLS wage data

Labor Market Realities

Occupation	Family premium/Median wage
Physician	7.9%
History professor	14.8%
Secretary	30.9%
Carpenter	25.6%
Cook	50.0%

Source: KFF premium and BLS wage data, 2004.

Premium Payments v. GDP Growth Rate



Source: NIPA, BEA/Commerce Dept.

Result of our incremental approaches

- *Health insurance as we know it is out of reach of a growing share of our workforce*

Myths That Impede Progress

- Uninsured get all the care they need, or deserve
- Entrenched interests are so strong that reform of our system is impossible
- I can take care of myself, regardless

What Do We Need?

- Political Space to Begin the Conversation
  - Moral case
- Proof we are all in the same community
  - Economic case
- Delivery system "culture of value"
- Credible policy design
  - 3 dimensions of credibility
    - Stakeholders, politicians, people

Moral Case

- Feed the Hungry
  - Gleaning, the community, and the stranger
- Health care joins food as an indispensable commodity
- IOM clarifies that the lack of health insurance leads to excess death
- Therefore, to deny insurance is to deny food
- Stewardship over health care resources is also essential

Economic Case

- Health costs are reducing wages, profits, investments
- Jobs are being lost due to lack of competitiveness
- Middle class preponderance is not guaranteed

Health System Culture of Value

- Information infrastructure to support quality improvement
- Malpractice safe harbors and value-enhancing incentives (for all)
- Comparative technology assessment as countervailing power between medical technology and coverage/use decisions
  - Raise the bar at the FDA
  - Raise the bar for procedural interventions as well

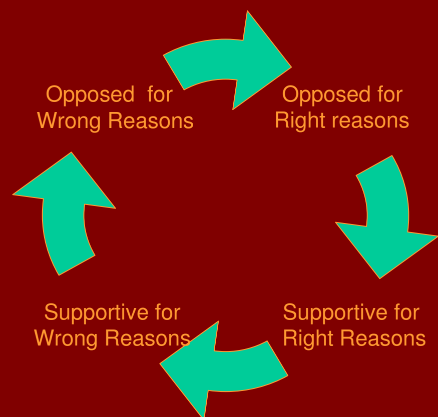
Credible Policy Design

- Individual and Shared Responsibility
  - Individual mandate
  - Employer and government roles
    - Subsidies + dedicated revenue source as budget limit
    - Purchasing pool
  - Market rules to prevent excess segmentation
  - Preservation of liberty and choice
- Culture of Value
  - Evidence-based limits on collectively financed benefits

Creative Partial Solutions

- No inpatient coverage
  - Utah, West Virginia*
- Limited inpatient coverage
  - Arkansas, New Mexico, Tennessee**
- Combination partial coverage + account
  - South Carolina
- Piggyback on state's purchasing power
  - West Virginia
- Universal but limited coverage
  - Massachusetts and Vermont

Health Reform Politics



Pew Typology: Support for government guarantee of health insurance, even if taxes must be raised

Pew Center for Research on People & the Press: 2005

Coalitions of the Willing

- Those who care about their fellow citizens
- Employers who shrink from the future they see
- Governors and state legislators who shrink from the futures they see
- Providers who want to lead
- Workers who know access has cost and value
- Politicians who want to lead

The Role of Reinsurance in Reducing the Number of Uninsured

Katherine Swartz, Ph.D.
Harvard School of Public Health

Health Policy Institute of Ohio
July 14, 2006

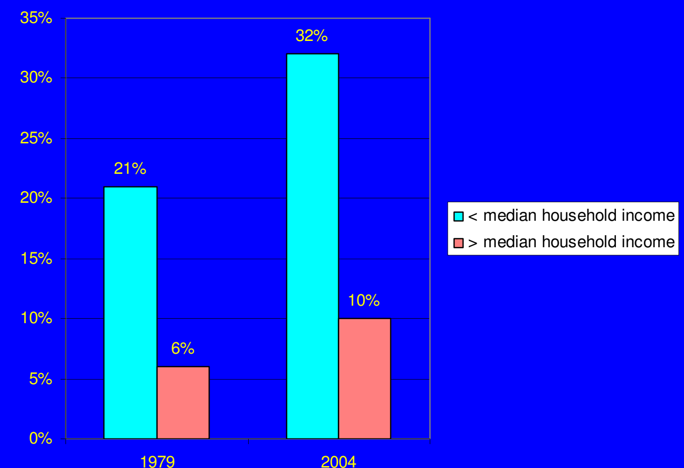
Outline of Presentation

- Case for Reinsurance: more uninsured who can buy in individual/small group markets
- Reinsurance basics – design options
- Reinsurance needs to be part of a package of policies to reduce uninsured – by itself, it cannot reduce uninsured numbers

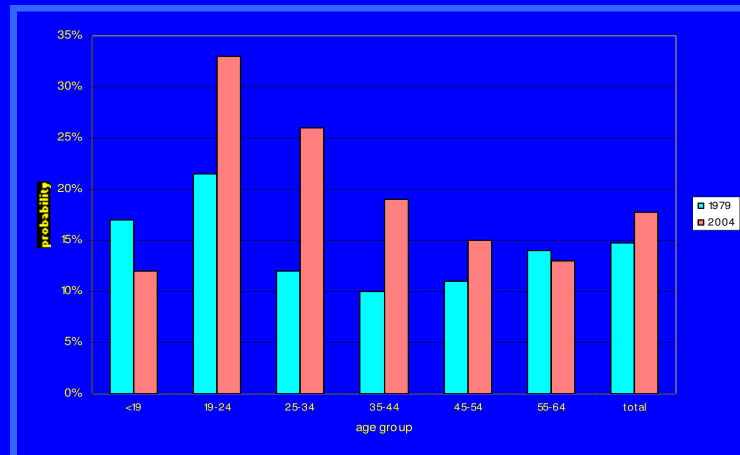
Who Lacks Health Insurance?

- 45.5 million Americans in 2004 – 2 million more than in 2002, almost all of whom lost employer-based coverage
- 13.75 million (30%) had middle-class incomes
- Poor and near-poor need government help with subsidies; reinsurance might help middle-class workers

Probability of Being Uninsured by Middle-Class Income for Adults, 1979 and 2004



Probability of Being Uninsured by Age, 1979-2004



Changes in Economy

- Manufacturing to service jobs – manufacturing dropped from 22% of all jobs to 11% since 1979
- % of private sector workers in firms with < 50 employees increased from 37% to 43% between 1979 and 2002
- Changes in employer-employee relationships – cost of health care an incentive

Implications of Changes

- Increasingly a middle-class problem due to changes in economy and employer-employee relationships
- We're not going back to old economy
- Need to increase access to small group and individual insurance markets

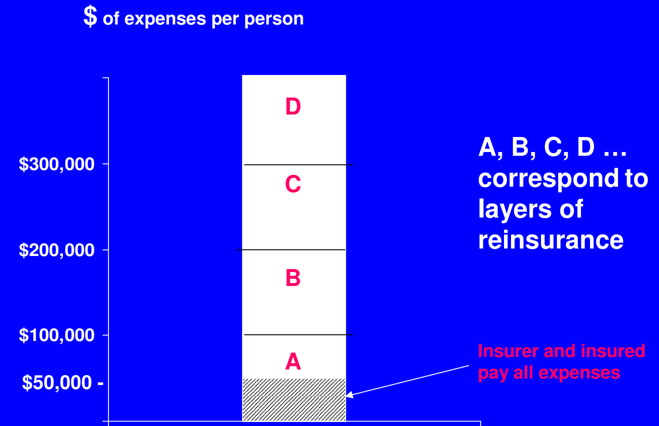
Competition in Small Group and Individual Markets

- Lack of perfect information causes insurers to fear 2nd risk: adverse selection
- Competition in terms of how best to avoid risk or to charge higher premiums for expected higher risk

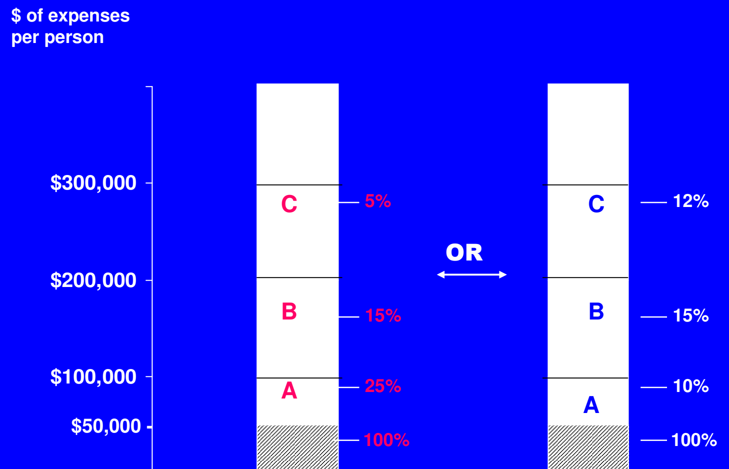
Reinsurance Basics

– Insurance for insurers
– Sold as layers of coverage above threshold
– Cost-sharing between reinsurer and originating insurer → originating insurer retains portion of risk
– Excess of loss vs aggregate loss designs; Excess-of-loss reinsurance aligns incentives to reduce selection

Layers of Reinsurance



Risk Sharing by Layers of Reinsurance: % of Risk Retained by Insurer



What Determines Cost?

- Number of potential enrollees
- Threshold and range of expenses to be covered – layers of coverage – and where the range is in distribution of medical costs
- % of risk (costs) retained by originating insurer in layers
- Relevant medical expenses

Why Excess-of-Loss Design?

- Objective is to reduce insurers' incentives to avoid adverse selection → reduce their risk
- Aligns incentives for insurers to manage individuals' medical care
- Aggregate-loss reinsurance does not address risk of extremely-high-cost individuals

Which Markets to Include?

- Small group and individual markets – not large group
- Goal is to address insurers' concerns with potential for adverse selection → want them to reduce use of selection mechanisms and lower premiums

Estimates of Costs

- Estimates at the national level run from $5B to $20B for the small group and individual markets with $50,000 threshold
- Urban Institute estimate for MA: state to cover 75% above $35,000; only for individual and small group mkts:

  $446 million - $632 million depending on voluntary vs required purchase

Financing Mechanisms

- Note: goal is to reduce insurers' concerns about adverse selection and expand coverage
- Need new funds – not fees or taxes on insurers
- Broad tax base desired – extremely high medical costs are due to random events

Lessons from New York

- **Healthy New York has reduced premiums relative to direct-pay market by more than 50%**
- **> 110,000 enrollees currently; >250,000 enrolled since 2001**
- **Stop loss pool not exhausted in either 2003 or 2004**

Other States

- Arizona has not used excess-of-loss
- Massachusetts' had reinsurance in Senate proposal; still being considered
- Vermont has reinsurance in new bill
- Expectation is that premiums would be reduced by 10-30% depending on design parameters chosen

Reinsurance Is One Part of Policy Package to Reduce Uninsured

- **Will reduce premiums and will increase availability of insurance for people now turned down – but not a panacea for all uninsured**
- **Need other subsidies for low-income workers so their coverage increases**

Bottom Line

- **Need for small group and individual market insurance never been greater – and is growing, especially among adults younger than 45**
- **Need to address insurers' concern with adverse selection in these markets**
- **Gov't sponsored reinsurance could do this – and stabilize markets by lowering premiums, bringing in healthy adults**