National WOMEN'S BUSINESS Council

Research Report

Access to Affordable Health Coverage for Women-Owned Businesses: A Summary of Key Issues and Policy Options

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FOREWORD

The inability to secure affordable health care for employees is a critical and growing concern of many women business owners. It is estimated that 60% of the 41 million uninsured Americans reside in families with members employed by small businesses. Thus, an estimated 7.3 million of the uninsured are employees or families of employees of the 9.1 million women-owned firms in the U.S.

The National Women's Business Council (NWBC) believes that a review of current research and other information can provide critical information to finding a solution to this critical problem. This review explores the ability or inability of women business owners and other small business owners to secure affordable health care. Also examined are associated costs and the extent of existing health care coverage for employees. In addition to reviewing the existing state of health care, this report analyzes alternative strategies and proposals that have been put forth to deal with the issues of health care cost and access.

The National Women's Business Council is a bi-partisan Federal government council created to serve as an independent source of advice and counsel to the President, Congress, and the U.S. Small Business Administration on economic issues of importance to women business owners. Members of the Council are prominent women business owners and leaders of women's business organizations.

The National Women's Business Council is committed to:

- conducting research on issues of importance to women business owners and their organizations;
- communicating these findings widely;
- connecting the women's business community to public policy makers; and

- providing a platform for change in order to expand and improve opportunities for women business owners and their enterprises.

This research was prepared under contract for the National Women's Business Council by Westover Consultants, Inc., a woman-owned business headquartered in Silver Spring, MD. For more information about the Council, its mission and activities, contact: National Women's Business Council, 409 3rd Street, SW, Suite 210, Washington, DC 20024; phone: 202-205-3850; fax: 202-205-6825, e-mail: nwbc@sba.gov

INTRODUCTION

There are a significant number of Americans without health insurance. According to the U.S. Census Bureau, an estimated 41 million Americans in 2001—14.6% of the population—did not have health coverage. Reducing the number of uninsured represents a far-reaching, national issue that the Executive Office, Congress, state legislators, health care researchers, public policy analysts, and others have struggled with, especially over the last decade. Most disconcerting is the irony that the majority of the uninsured are working people who contribute daily to the health of the Nation's economy. These unprotected individuals tend to work for small businesses with fewer than 20 employees, a sector of the economy that accounts for 90% of all U.S. companies. Considering that small firms are about half as likely as larger ones to provide health insurance coverage to their workers and their families, the health care crisis becomes even more apparent. Women-owned businesses, one of the fastest-growing sectors of the small business community, are impacted significantly by this critical issue, which bears directly on their ability to survive, thrive, and grow.

Although most people would agree that no American should go without health insurance or needed medical care, there is less agreement on the best way to reach this goal. A number of possible solutions have emerged, some of which will be addressed through legislation in the 108th Congress. Other strategies are already available to both small and large companies to boost access to affordable health coverage and increase choice. This report reviews selected Internet research and other documents that explore both proposed and existing health coverage options for the small business community, including women entrepreneurs. In sum, this assembled information should prove to be a useful guide for those confronting one of the most formidable challenges to successful small business ownership in the 21st century.

EXECUTIVE SUMMARY

The Problem for America

- **The Lack of Access to Health Insurance is an Ongoing Concern in the United States.** In 2001, an estimated 41 million Americans – 14.6% of the population – did not have health insurance coverage.[1] The uninsured are less likely to seek adequate medical care and preventative services, placing the healthy development of themselves and their families at risk.[2]

- **The Majority of Americans Who Lack Health Insurance Are Working for Small Companies.** Americans who work for firms with fewer than 25 workers were half as likely to have health insurance as those who work for companies with 1,000 or more workers. This poses a major problem for America since 90% of U.S. companies are small businesses that employ fewer than 20 workers. The percentage of small firms offering health insurance to employees was estimated at 61% in 2002 – a decline from an estimated 67% in 2000. These declines came almost exclusively from the smallest of the firms – those with fewer than 25 employees. In comparison, 99% of firms with 200 or more employees offered health benefits in both 2000 and 2002.[3] In a recent study by the National Association of the Self Employed, 70% of respondents did not have health insurance themselves or provide it for their employees.[4]

- **The Cost of Health Coverage Is Rising.** In 2002, monthly premiums for employer-sponsored health insurance increased by 12.7% – the largest increase in 12 years – with small firms seeing an increase of 13.2% and large firms an increase of 12.5%. On average, annual premiums are $3,060 for single coverage and $7,954 for family coverage. Workers' share of these premiums has also risen substantially, with single coverage averaging $454 per year (a 27% increase since 2001) and family coverage averaging $2,084 per year (a 16% increase since 2001). Similarly, deductibles for

PPO in-network providers jumped 37% to $276, up from $201 last year.[3] With health care costs rising and a downturn in the economy, workers can expect to pay more for coverage but get less for their money, as benefits erode.

The Problem for Women-Owned Businesses and Other Small Firms

- **Most Small Employers Are Not Offering Health Insurance Coverage Because it is Too Costly.** Eight in ten small employers (84%) who did not offer health benefits cite the high cost of premiums as a very important factor in reaching that decision. Other important reasons include not being able to qualify for group rates (57%) and administrative burdens (30%).[3] Health coverage is generally more expensive on a per capita basis for smaller companies. In 2002, small firms with 3 to 9 employees paid $285 monthly for single coverage compared to $269 monthly for firms with 10 to 24 employees and $239 monthly for firms with 25 to 49 employees.[3] Administrative expenses for insurers of small group health plans are also higher– ranging from 33 to 37% of claims for insurers of small group health plans, versus 5 to 11% of claims for large companies' self-insured plans.[5]

- **Many Major Small Business Associations Name Health Care as Major Concern for Their Membership.** The National Association for the Self-Employed (NASE), the National Association of Women Business Owners (NAWBO), the National Federation of Independent Business (NFIB), the U.S. Chamber of Commerce and other small business organizations include access to and/or cost of health care among their 2003 legislative priorities. In a recent membership survey conducted for NAWBO, members were most likely to name association health plans among the public policy issues on which they want NAWBO to focus. Fifty-eight percent (58%) of NAWBO members who own employer firms offer health benefits to their employees.[6]

- **When Small Firms Do Offer Health Benefits, There Is Typically a Narrow Range of Choices.** Among small businesses that offer health insurance, few provide their workers with a choice of health plans. Seven in ten (71%) firms that provide health benefits offer their workers only one plan option. The most prevalent reason cited for offering just one option is that the company gets a better deal from insurers by requiring all or most employees to be in the same plan. [3]

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

Proposed Solutions

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

- **Association Health Plans (AHPs).** Under the President's health care proposal, AHPs can help reduce the number of uninsured by giving small businesses the same purchasing clout, federal regulatory structure, accessibility, affordability, and choice in the health care market place that large company experience. By allowing small businesses to band together across state lines through their membership in a bona fide trade association, small business owners would be able to offer affordable health benefits to employees and their families resulting from greater bargaining power, economies of scale, and administrative efficiencies.[9] Under proposed legislation, AHPs would not be required to conform to state health insurance coverage mandates and insurance regulations—one of the major factors, many

contend, that contribute to the rising cost of health coverage. Currently, labor unions, medium-sized businesses, and large companies are able to offer health benefits to their employees under one uniform federal statute known as ERISA—the Employment Retirement Security Act of 1974. This advantage saves these organizations from having to comply with different rules, regulations, and benefit mandates that exist in each of the 50 states.[9] If the ability to offer AHPs is strengthened through legislation, small business owners could purchase health coverage through federally regulated, self-funded AHPs, thereby expanding the small group market. An estimated 300,000 to 8.5 million American workers and their families could gain health insurance coverage from AHP legislation.[10] In June 2001, the Senate passed the Kennedy-McCain version of the Patient's Bill of Rights (S. 1052) which did not contain AHP provisions. In August 2001, the House passed H.R. 2562, a different version of patient's rights legislation, which contained AHP provisions (rolled in from H.R. 2315/H.R. 1774 in June). Just recently, H.R. 660, the Small Business Health Fairness Act, was introduced with more than 70 co-sponsors and bi-partisan support. This bill re-introduces many of the elements of previous AHP-focused legislation.

- **Medical Savings Accounts (MSAs).** Under a four-year pilot project authorized by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, MSAs were enacted although with a number of restrictions. MSAs, which are available only to self-employed persons or businesses with 50 or fewer employees, are tax-exempt personal savings accounts to be used for qualified, out-of-pocket medical expenses. To be eligible for an MSA, an individual must maintain a high deductible health plan (i.e., $1,500 to $2,250 for individuals and $3,000 to $4,500 for families). There are two health-plan options—individual and family. The allowable contribution to the MSA depends on the size of the health plan deductible chosen, and funds not spent by the end of the year may be rolled over into the next year. Many support the permanent authorization of tax-qualified MSAs with certain modifications to make them more flexible, such as varying the deductible depending on the type of

expenditure and extending eligibility to all businesses. These HIPAA MSAs are often referred to as Archer MSAs, named for Rep. Bill Archer (R-Texas) who championed the MSA legislation. The Archer MSA demonstration project will end on December 31, 2003, unless it is extended or made permanent by law. The Medical Savings Account Availability Act of 2001(S 1067/HR 1524), introduced by Senators Grassley (R-IA) and Toricelli (D-NJ) and Representatives Thomas (R-CA) and Lipinski (D-IL) would improve MSAs and make them permanent.[11,12,13]

- **Refundable Tax Credits.** President Bush has proposed a refundable tax credit to help the uninsured purchase private health insurance coverage. In this manner, individuals could purchase health insurance that they can own and keep, even if they change jobs or their employers change plans. The credit would vary by family income and size, and provide a subsidy of up to 90% of the cost of health insurance premiums, with a maximum credit of $1,000 per adult and $500 per child (for up to two children) for a maximum family credit of $3,000. The health tax credit would be refundable, such that even those who owe no income tax would receive credit by filing an income tax return and claiming a refund against their health insurance expenses. The credit would also be advanceable, based on the individual's prior-year income, making it available whenever the individual or family seeks health insurance, and before filing an income-tax return for that year, in order to reduce the amount of the monthly health insurance premium. This proposal would also permit certain low-income individuals to purchase private insurance for themselves and their families through state-sponsored health insurance groups or high-risk pools.[14,15]

- **Flexible Spending Accounts (FSAs).** FSAs were first authorized by Congress in 1978 and are allowed under Section 125 of the Internal Revenue Code. They enable workers to allow up to $4,000 (pre-tax) tax-free money to spend on health care expenses—such as co-payments, deductibles, and services—not otherwise covered by their insurance, or to pay for health insurance premiums. FSAs function exactly

like MSAs, except those funds not used by the end of the year are returned and cannot be carried over for future expenses. In order for workers to be allowed to take control of their health care costs, such limitations would need to be changed.[9]

- **Health Marts.** Spearheaded by Rep. Tom Bliley (R-VA), Health Marts are administrative entities or cooperatives of workers, employers, insurers, and consumers that are formed to offer more choice in employer-based health coverage. Instead of selecting a health insurance carrier for all of a company's employees, the employer would sign up with a Health Mart which, in turn, would offer workers a wide range of health coverage options (e.g., HMOs, PPO plans, MSAs, and other vehicles). Employees would then select the health insurance coverage that they prefer. Health Marts would offer multiple health plans, accept all small employers, and conform to state laws governing differences in premiums among small firms, but would be free of state mandates that require coverage of certain benefits and providers. In theory, this would allow them to offer a less costly benefit package. Health Marts are similar in many respects to Health Purchasing Cooperatives (HPCs) which have been initiated in several states, offering collective purchasing arrangements for small employers.[16, 17]

- **Cafeteria Plans.** As its name suggests, cafeteria plans (also referred to as "Flexible Spending Plans" or "Section 125 Plans") allow each employee to choose from among a menu of predetermined options in deciding where their benefit dollars will be spent—including medical, accident, disability, vision, dental, and group term life insurance—and the amount of the benefit. Funded through "tomorrow's earnings", employees must estimate the anticipated cost of such expenses for the upcoming year and request to have the estimated amount redirected from wages into the plan. Benefits are paid through payroll withholding with pre-tax dollars. Such plans allow small firms to offer benefits that would otherwise be unaffordable with real tax savings to employees.[18]

- **Consumer-Choice Health Purchasing Groups (CHPGs).** CHPGs bring employers and consumer together for the purpose of collectively purchasing health coverage form health plans. Governed by an employer-consumer board, CHPGs provide employees of participating firms with information to compare the price, characteristics, and performance of each plan. Employees then choose a plan that best fits their needs and preferences, and the CHPG enrolls employees in the plan of their choice.[19]

- **Defined Contribution Health Insurance.** This strategy allows employees to select from any health plan being offered, at a cost that he or she chooses to pay, using both their employer contributions and the personal contributions that they make, instead of having the employer select plan options for their workers, as is customarily done in employer-sponsored health coverage. If the employer's contribution does not cover the full cost, the worker would supplement it with their own funds or choose a less generous plan and pay less out-of-pocket.[20,21]

- **Health Reimbursement Arrangement (HRA).** An innovative and flexible health plan design approved last year by the U.S. Treasury and IRS (Rev. Rul. 2002-41 and Notice 2002-45), an HRA is a type of defined contribution account that may be used to pay both out-of-pocket health care expenses and health coverage premiums for employee and dependant health care, including long-term care coverage. Amounts credited to an HRA must be provided solely by the employer and cannot be financed through employee salary reductions, and any unused balances may be rolled over from year to year. These flexible plans may be provided by an employer in conjunction with a cafeteria plan as well as another health plan that would be ordinarily financed through employee salary reduction.[22]

- **High Risk Pools (HRPs).** The Trade Act legislation (H.R. 3009) passed in the 107th Congress and signed by the President in August 2002 provides up to $100 million in federal funding for states to create high-risk pools or to fund existing ones. The Act

enables offering uninsured people with pre-existing conditions access to affordable health insurance coverage. State risk pools first appeared 25 years ago and cover about 153,000 people. Currently, 30 states have enacted legislation establishing HRPs. States with well-functioning high-risk pools have virtually solved the problem of health insurance access for their medically uninsurable residents.[23]

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SECTION 1.0: THE PROBLEM FOR AMERICA

This section describes the high number of uninsured adults in the Nation who work for small companies and examines their characteristics, reasons for lacking coverage, and some consequences of being uninsured. The surging cost of health insurance is also addressed.

1.1 The High Number Of Uninsured Americans

The number of Americans without health insurance in this country is significant. According to the Census Bureaus' 2001 Current Population Survey, an estimated 14.1% of the population, or 41 million Americans, lacked health coverage.[1] The number of uninsured Americans steadily increased from the late 1980s to the end of the 1990s. In 1999, the Census Bureau reported a decline in the share of Americans without health coverage for the first time in 12 years. At that time, an estimated 15.5% of the population was uninsured during the year, compared with 12.9% in 1987 and 16.3% in 1998.[1] Despite expansion of existing Government health care programs, especially Medicaid, and the creation of new programs, like the State Children's Health Insurance Program (SCHIP), the number of uninsured has remained stubbornly high. The problem has persisted through periods of both economic prosperity and recession.[2]

Data from the National Center for Health Statistics (NCHS) corroborate Census statistics on the high number of uninsured. In the initial quarter of 2002, the proportion of uninsured persons was 14.3%, a slight increase from 14.1% in 2001. NCHS reports that the proportion of Americans without health insurance decreased over the period 1997-2001, from 15.4% in 1997 to 14.1% in 2001.[3] The number of persons without health coverage tends to grow as unemployment increases, which—considering the recent upturn in unemployment—is bound to exacerbate the current health care crisis. Reflecting the economic downturn that

began early in 2001, the annual average unemployment rate climbed from 4.0% in 2000 to 4.7% in 2001 to 5.8% in 2002. [4]

1.2 The High Number Of Uninsured Workers

Working Uninsured in Small Firms. Most insured Americans obtain their health insurance coverage through the work place. In 1997, over three-quarters (75.9%) of the employed population received health insurance coverage through their own employer or another person's employer, as reported in the Census Bureau's Survey of Income and Program Participation (SIPP).[5] Among the unemployed in 1997 and those not in the work force, 33.2% and 45.2% respectively, received employment-based coverage through a spouse or former employer.[5]

Although employers are the Nation's portals for employee health coverage, most of the uninsured are working adults who contribute daily to America's growth and prosperity. The Census Bureau reports that in 1997 small businesses were less likely than larger businesses to offer health insurance benefits to their workers and cover them. About one-half (52.1%) of workers in firms with fewer than 25 employees were offered health coverage through their current employer, with only one-third (33.8%) choosing to receive such coverage. These rates increased with firm size to the point that over three-fourths (78.2%) of employees in firms with 25-99 workers were offered health insurance, with over half (53.3%) accepting it. Nearly all (91.6%) workers in companies with 500 to 999 employers were offered health insurance benefits, with two-thirds (66.3%) accepting coverage.[5]

Small companies are not only less likely than large companies to offer health insurance coverage to their employees and cover them; when they do, health insurance choices can be quite limited. "Larger companies were more likely to offer a choice of several health insurance plans, to cover part-time workers, and to offer long-term care" than smaller companies.[5]

The Kaiser Family Foundation, in its 2001 National Survey of Small Businesses, queried a random sample of 805 business owners and other executives with three to 24 employees regarding their health insurance benefits and practices. The study found that only 60% of these offered health insurance coverage. The availability of coverage varied substantially by firm size and other characteristics. Generally, the smaller the firm, the less likely it was to offer health insurance, with only 56% of small businesses with three to nine employees offering coverage, compared with 72% of small businesses with 10-24 employees.[6]

In a sample survey of 300 small businesses nationwide, the National Association of Health Underwriters (NAHU) found that nearly three-fourths (72%) of small businesses in America currently offer some type of health insurance coverage to their workers. The businesses that make coverage available have significantly higher average sales volumes ($2.2 million) and more benefits-eligible employees than those that do not offer coverage ($1.2 million).[7]

Characteristics of the Uninsured. An analysis by the Institute of Medicine (IOM) of the National Academies provides insight into the characteristics of persons who lack health coverage. IOM conducted an extensive review of 130 research studies that examined the health insurance status of non-elderly adults and its effect on health-related outcomes. Although the uninsured are found in all segments of the U.S. population, the IOM identified three personal characteristics that are closely related to having coverage: health status, race and ethnicity, and socioeconomic status. Non-Hispanic workers are more likely to be covered than either African Americans or Hispanics, and men are more likely to be covered than women. The IOM suggests that some racial and ethnic disparities in the use of appropriate health care services and in rates of morbidity and mortality would likely be reduced with increased minority access to health insurance coverage.[8] As for reasons for lack of coverage, The Commonwealth Fund cites three primary reasons. First, health insurance premiums are so costly and the income

of most uninsured people is so low that they cannot afford to purchase health coverage.[9] In 2000, the worker's share of the average health insurance premium for a single employee under age 65 was $2,424 and a family policy cost $6,348.9[9] This means that for nearly one-half of the uninsured population, the cost of health coverage exceeded 25% of family income.

Second, over 90% of people with private health insurance obtain it through their place of employment.[9] However, the majority of uninsured workers do not have the option of securing employment-based health coverage either directly or through a family member, mainly because the business does not offer it.[9] Third, working adults often cannot qualify for public insurance programs because eligibility criteria are stringent, especially if the worker has no children. For example, although children in families with incomes below 100 percent of the Federal poverty guidelines are eligible for Medicaid in all states, an adult who earns $4,000 annually would not even qualify for Medicaid in most states.[9] Thus, in broad terms, the majority of the uninsured are low-income people without access to employment-based coverage or public coverage.

Employee Access to Coverage. Not all employees are offered coverage equally, and many do not accept coverage that is available to them. Offers of company health insurance and take-up rates by workers vary by industry and occupation. "Workers in the educational service industry and the manufacturing industry were the most likely to be offered health insurance—92% and 90.7%, respectively," as were workers in the transportation, communication, and public utilities industries (89%) and in the public relations and administration industry (88.7%). In contrast, employees in the agriculture, mining, and construction industries (57.3%) and the repair and recreational service industries (58.3%) were the least likely to be offered health insurance.[5]

In terms of occupations, persons who worked as architects, technicians, scientists, and medical workers were the most likely to be offered health

insurance (92.8%), "followed by managers and administrators (89.5%). Farm, construction, and mining workers were the least likely to be offered (55.5%) health insurance".[5] Similarly, the likelihood of accepting the option of health insurance varied by occupation. "For example, mechanics, repairers, and precision workers were not the most likely to be offered health insurance, but they were one of the most likely to be covered if health insurance was offered." [5]

Although employers provide opportunities for many workers to become insured, in 1997 nearly one-half (46.4%) of workers who were eligible to participate in their employer's health insurance plan elected not to do so. Either coverage was too expensive or they received it through another source.[5] Nearly one in ten (9.3%) employed persons had public, privately purchased, or military-related health insurance. The General Accounting Office (GAO) reports similar findings: About one in three employers (36%) with fewer than 10 employees offered health insurance coverage to their workforce, although these businesses represented about 61% of small firms.[10]

The National Association of Health Underwriters has found that about one-half of the small employers that offer health insurance report that "all of their eligible employees take the company's health insurance." If employees do not, it is because the majority (79%) have coverage elsewhere. Nonetheless, there are still others (18%) who for cost or financial reasons do not accept coverage.[7]

Additionally, the less an employee earns, the less likely she or he is offered health insurance coverage. Workers receive offers of coverage in 48% of businesses with an average employee wage of under $2,200 per month, compared with a 72% offer rate among businesses with an average employee wage exceeding this amount. Similarly, businesses that employ workers in positions that primarily require a college degree are more likely to offer coverage than businesses with jobs that usually require a high school diploma or less.[8]

1.3 The High And Rising Cost Of Health Care

In a national sample survey of more than 2,000 employers of all sizes, the Kaiser Family Foundation and the Health Research and Educational Trust (Kaiser/HRET) extensively explored the cost of health coverage. In 2002, health insurance premiums for employment-based coverage increased by 12.7%, the largest increase since 1990. This was the sixth consecutive year that the rate of increase grew faster than the prior year's. In fact, "premium increases in 2002 exceeded the overall rate of inflation by 11 percentage points."[11] The researchers attribute the high rate of premium growth for job-based coverage primarily to increasing medical claims expenses.[11]

Double-digit increases in health premiums were noted for all types of health plans. Premiums rose for health maintenance organizations (HMOs) (13.3%), indemnity plans (12.7%), preferred provider organization (PPOs) plans (12.7%), and point-of-service (POS) plans (11.9%). Firms with three to 199 workers witnessed premium increases of 13.2%. This figure slightly exceeded that of firms with 200 or more workers, which experienced premium increases of 12.5%. The largest premium increases (14.9%) were found among firms with 10-24 employees. For all firms, there was slight geographic variation in premium increases across the country, ranging from 12.5% in the South and Northeast to 13.2% in the Midwest.[11]

In 2002, the average monthly cost for health premiums for single and family coverage was $255 and $663, respectively, for the combined employer and worker share. The annual cost of premiums that year reached $3,060 for single coverage and $7,954 for family coverage. For firms with three to 199 workers, these annual costs were higher for single coverage ($3,100) but lower for family coverage ($7,737). The smallest of these firms paid higher premiums for single coverage than did any other firm size group. Employers of three to nine workers paid $3,419 annually for single coverage, while employers of 10-24 workers paid

$3,233.[11] Thus, small business owners who may be among those least able to afford health coverage are facing the highest premiums.

1.4 The Human Costs Of Being Uninsured

National figures on the number of uninsured do not reveal the real consequences to America of so many citizens living without health insurance. According to the American Medical Association (AMA), the uninsured are less likely to seek adequate medical attention and preventive services, which inevitably places the healthy development of themselves and their families at risk.[12] Similarly, the Institute of Medicine (IOM) reports that individuals without health insurance are more likely to have poorer health and die prematurely than those who are insured.[8]

Furthermore, the IOM reports a number of other adverse health consequences for uninsured persons. For example, uninsured adults do not receive the care recommended for the prevention and treatment of chronic diseases, such as timely eye examinations to avert blindness or foot examinations to prevent amputations in diabetics. They also lack access to medications critical to the management of life-threatening conditions such as hypertension or HIV disease. They receive fewer diagnostic and treatment services after a severe injury or heart attack, increasing the risk of death.[8] Similarly, uninsured adults are more likely to forego recommended cancer screening tests (e.g., mammograms, clinical breast examinations, Pap tests, and colorectal screenings), delaying diagnosis and increasing chances of premature death. Notably, uninsured women with breast cancer have a 30%-50% higher risk of dying from this condition and are less likely to receive breast-conserving surgery than are women with private health coverage.[8]

Going without health insurance has different consequences depending on a person's age, general health status, and the length of time uninsured. Individuals between 55 to 65 years old and low-income adults are especially susceptible to

deteriorating health without health coverage. Population-based studies that monitored non-elderly adults over an extended period found that individuals who were uninsured when the study began had a 25% higher risk of dying than persons with private health insurance. This pattern held true for deaths from heart attack, cancer, traumatic injury, and HIV infection.[8] The long-term effects of these and similar findings can only be staggering, given that an estimated 40% of the uninsured are without health insurance coverage for a period of 18 months or more.[13] Besides increased morbidity and mortality, treatment in hospital settings often depends upon insurance status, IOM research shows. For example, uninsured patients with traumatic injury are less likely to be admitted to a hospital, to undergo needed surgical procedures, and to receive physical therapy.[8]

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SECTION 2.0: THE PROBLEM FOR WOMEN-OWNED BUSINESSES AND OTHER SMALL FIRMS

This section examines the role of small companies in the economy and the response of the small business community, including women entrepreneurs, to the lack of affordable health coverage. It also explores reasons why small firms are generally not providing coverage and how those who do offer it are struggling to maintain it.

2.1 The Importance Of Small Business To The Economy

The crucial role that small businesses play in the American economy cannot be overstated. In 2001, there were an estimated 22.4 million small businesses in the country, accounting for virtually all (99%) of America's employers and employing just over one-half (53%) of the private work force. President Bush makes clear the importance of the small business sector: “Small businesses have always been the backbone of our economy. They perennially account for most innovation and job creation, and not just when our economy is robust and growing. Small businesses have sustained the economy in weaker times as well, and put us back on the track to long-term growth. It is vital that we work together to give small businesses the climate they need to thrive.”[1]

Without access to affordable health insurance by a much greater proportion of small firms, the gap between the uninsured and the insured is likely to widen as the small business sector continues to grow. In the period 1998-1999, the number of small firms—inclusive of those both with and without employees—continued to rise, with a large share of the total and growth stemming from an increase in sole proprietorships. The number of small businesses with paid employees rose from 5.5 million in 1997 to 5.8 million in 1999, an increase of 5 percent.[1] Non-employer businesses, too, played a key role in small business growth. This category of firms includes, for example, businesses that are operated by one or more individuals and can range from home-based enterprises

to mom-and-pop stores to independent contractors. According to the Census Bureau, non-employer firms increased by 2.3% between 1999 and 2000, from 16.2 million to 16.5 million. Non-employer enterprises accounted for 70% of all businesses, although they contributed a relatively small but growing share of the overall sales and receipts generated by the small business sector.[2]

2.2 Barriers To Small-Firm Health Coverage

High health insurance costs and limited choice of health plans pose a formidable challenge to small business owners. Most small business owners surveyed who do not offer health insurance coverage cite cost as the primary barrier. In the Kaiser Family Foundation survey, nearly three-fourths (72%) of small firms surveyed did not offer coverage for this reason. Other reasons, although less important, for not taking up coverage included the availability of health insurance from a spouse or other family member (43%), administrative burden (34%), and the ability to attract high-quality employees without it (32%).[3]

The majority (67%) of small business owners surveyed are dissatisfied with the high and increasing expense of health insurance coverage, with many suggesting that rising costs could cause them eventually to shift more of the premiums cost to the employee or to pursue other alternatives. Among small firms that offer coverage, about 28% indicate that they have changed health insurance plans in the last two years, mostly for cost reasons. Finding and keeping affordable health insurance poses such a challenge for many small businesses that about one-third (35%) of those that offer it say that they will probably have to increase the share of costs that is borne by their employees if health insurance premiums continue to rise. About 37% of firms indicated that they will likely switch to a defined contribution approach in the next five years.[3]

Despite the importance of cost as a deciding factor in whether to offer health insurance coverage, not all employers are as aware as one might expect of the

actual price of coverage. In the Kaiser survey, nearly one-third (29%) of small business owners who did not offer health insurance benefits overestimated how much it would cost them, projecting that that an average monthly premium for a single employee would cost $264, compared with the actual average cost of $227. In any event, most of these business owners felt that the most they could pay would be about $110 monthly toward the premium and their employees would be able to contribute only about $89 monthly.[3]

In a 2001 survey conducted by the National Association of Health Underwriters (NAHU), most small employers (59%) that offered health insurance benefits were satisfied with their company's health plan and felt that their workers were satisfied with it too. Employers were not as satisfied, however, with the limited range of health insurance plans available to them.[4]

Surveys conducted at regional and state levels support many of the findings of national surveys and studies. The Plattsburgh-North Country Chamber of Commerce, which represents about 2,000 businesses in upstate New York, released data in 2001 from its third annual small business survey. Health insurance cost and access were among the top three concerns of the overwhelming majority (68%) of surveyed small business owners with 10 or fewer employers. More than one-half (54%) of the respondents represented family-owned businesses; 19% were women-owned firms; and 4% were minority-owned businesses.[5]

The Ohio-based Council of Smaller Enterprises (COSE), the Nation’s largest local small business association, found that nearly 70% of its members believed health care costs to be "the most important short-term issue they face.”[6] COSE warns that "premiums can become so expensive that they threaten some employers' ability to offer health care benefits at all, resulting in an increased number of uninsured.”[6] The organization has been recognized by both the Bush and Clinton administrations for its pioneering work in health care group

purchasing models, which has resulted in coverage to 13,000 small firms in the northeast Ohio area.[6]

2.3 Small-Firm Commitment To Its Work Force

Many small firms offer health insurance to their workers, despite the high cost, because they feel it is the right thing to do. According to the Census Bureau, the smaller the business that offers coverage, the higher the proportion of covered employees whose health care premiums are paid entirely by the firm. Approximately 44% of covered employees in businesses with fewer than 25 workers had their entire premium paid by their employer, compared with just 29.4% of covered employees in large firms with 1,000 or more workers.[7]

In the NAHU study, nearly one-half (45%) of small employers that offered health insurance required that their employees pay part of the premium, which averaged about 42% of the total cost, or approximately $44 monthly. Most employees (64%) paid an additional amount to include a family member, which averaged around $168 monthly for a spouse and $249 monthly for a spouse and children.[4]

Despite the tendency of smaller firms who offer health coverage to pay a higher proportion of the premium than larger firms do, this trend could be slowed in the future given the weakened national economy. In evaluating the response of business owners to surging health coverage costs, market and health policy experts at a 2001 Wall Street Roundtable forecast that premium cost-sharing with employees is inevitable and will increase. Higher deductibles and co-payments are also likely to occur. In addition, there may be an increased application of coinsurance in which patients pay a percentage of their medical bill instead of a predictable fixed-dollar amount.[8]

Premium cost-sharing is already a reality for many employers, as shown in the 2002 Employer Health Benefits Survey conducted by the Kaiser Family

Foundation and the Health Research and Educational Trust (Kaiser/HRET). "In 2002, employee contributions for single and family coverage increased substantially in nominal dollars—contributions for single coverage grew almost 27% while contributions for family coverage grew by 16%. The fact that worker contributions have increased in 2002 after remaining stable or declining in prior years is likely due to employer's greater willingness to pass along cost increases given the weaker economy and lower demand for labor."[9] Researchers warn that this pattern could affect employees in several ways. "Workers may seek less expensive options, or, if the employee's share of the premium is high enough, may choose not to accept health insurance coverage."[9]

Higher premium cost-sharing can also affect a company's talent pool. "Of the firms that increased the amount employees pay for coverage this year, 41% report that it was somewhat harder to attract and retain workers compared to 23% of firms who did not increase the amount employees pay."[9]

In addition to paying a greater share of health care premiums, employees are experiencing higher cost-sharing for health plan deductible and copayments. "In PPOs, deductibles increased from $201 in 2001 to $276 in 2002. Deductibles for single coverage in conventional plans also increased significantly—from $195 to $270 this year." [9] In addition, the percentage of workers enrolled in HMOs with a $5 copayment decreased from 11% in 2001 to 5% in 2002, as the share of workers with a $20 copayment jumped from 2% to 11%. Although higher co-payments and deductibles save costs, researchers point out that they may also discourage use of needed services, particularly among lower income persons.[9]

2.4 Access To Health Insurance In Women-Owned Companies

A Visible and Growing Presence. With an estimated 9.1 million women-owned firms in the U.S., employing 27.5 million workers, public policy regarding access to affordable health coverage is a major concern for women-owned

businesses as well as other small employers.[10] The inability of many women-owned businesses to offer health insurance could mean that an estimated 7.3 million of the uninsured are employees of women-owned firms.[11]

In 1999, women represented just under one-half (46%) of the American labor force, the highest labor participation rate in the world. Women also played a significant role in the decision-making process in the work place. Of the 20.7 million people in 1999 who occupied executive, administrative, and managerial positions, 46%, or 9.4 million, were women. Of these women, about 6% were under the age of 25, about 30% were between 35 and 44, and only 2.6% were age 65 or older.[7]

Large Representation in Service Industries. Although women-owned businesses operated in all industrial categories in 2002, fully half (53%) were in the service sector. Approximately 16% of these firms were in retail trade; 9% were in finance, insurance, and real estate; 3% were in construction; and 12% fell into an unclassified category. The wholesale trade, retail trade and service industries accounted for 65.9% of total revenues.[10] Almost two-thirds (64.3%) of the total revenues generated by women-owned businesses were derived from the wholesale and retail trade and service industries. In the 2002 Kaiser/HRET survey, the highest increases in health insurance premiums (13.9%) were experienced by businesses in the service sector and by state and local governments. Businesses in the retail industry encountered the second highest rate increase in premiums that year (12.2%).[9]

The experiences of women business owners in accessing affordable health coverage support many of the research findings of national small business surveys described earlier. This was apparent at the Roundtable on Affordable Health Care for women business owners, hosted by NWBC in February, 2003. During that meeting, a diverse panel of women entrepreneurs, business association executives, and other stakeholders raised awareness of how the lack

of access to affordable health coverage is affecting their companies, employees, and constituents. Women business owners expressed a sincere commitment and willingness to provide health insurance coverage despite its high cost because of a moral obligation to their work force. Some of the businesses represented at the Roundtable paid anywhere from 80%-100% of employee coverage.[12]

Upon starting a business, many women entrepreneurs cannot afford to provide health insurance coverage at all, although they tend to offer this benefit as their business grows. In a recent survey of the 8,000-member National Association of Women Business Owners, over one-half (58%) of employer firms offered health insurance coverage.[13]

Even companies that are able to purchase insurance are hit routinely with the high cost of coverage year after year. As a result, many women entrepreneurs for the first time are considering increasing premium cost-sharing with employees, paring down coverage, or dropping benefits altogether. The lack of access to affordable health coverage is also considered to be a key factor in creating an uneven playing field for women entrepreneurs in attracting and maintaining employee talent.[12]

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SECTION 3.0: PROPOSED SOLUTIONS FOR BUSINESS OWNERS

In this section we discuss a variety of approaches for increasing access to affordable health coverage by small business owners.

3.1 Strategies For Accessing Affordable Health Coverage

Concern in the past decade about the high number of uninsured has prompted policymakers and other stakeholders to explore ways to improve access to affordable health coverage by the self-employed and other small businesses. After facing multiple years of double-digit increases in health insurance premiums, business owners are especially motivated to identify alternative ways to manage surging health care costs for themselves and their work force. Employees, too, in response to the effects of this prolonged crisis (e.g., increased cost-sharing, pared-down coverage, higher deductibles, or even loss of coverage altogether), have awakened to a new era in the management of their own health care. Consumers everywhere are discovering the need to be more aware and savvy about how to spend their health care dollars. They are searching for products that permit more consumer choice in what they will buy, from whom they will buy it, and how much they will spend.

As the small business community awaits the outcome of pending national legislation, there are a number of health coverage programs already available that offer small business owners flexibility, options, and control in their health care spending. Accordingly, this section reviews association health plans, medical savings accounts, refundable tax credits, state high-risk pools, defined contribution accounts, cafeteria plans, flexible spending accounts, health reimbursement accounts, small group purchasing cooperatives, and health marts. For each program, we provide a general description, discuss recent legislative activity (if any), and highlight other key information of interest to small firms. (Additional details on each approach can be obtained by referring to the Topical Resource List in the Appendix.)

3.2 Association Health Plans

Description. One of the most significant pieces of health-related small business legislation before the 108th Congress is the expansion of association health plans (AHPs) beyond the state level. An AHP is a group health plan that is sponsored by a business, professional, and/or trade association offering medical benefits to all its members.[1] Many view AHPs as a major part of the solution to the current health care crisis in America. Under the President's health care proposal, AHPs would help decrease the high number of uninsured by giving small businesses the same advantages enjoyed by large companies. These enhancements include purchasing clout, economies of scale, Federal regulatory structure, accessibility, affordability, and choice in the health care market.

By banding together across state lines through a bona fide association, AHPs may help level the playing field for small firms by allowing them to exploit lowered administrative costs that should result in less expensive health insurance premiums. The interstate operations of AHPs would exempt them from state health insurance coverage mandates and, instead, subject them to Federal law.[2] Some contend that state mandates are one of the principal cost-drivers in the rising price of health coverage. Currently, labor unions, medium-sized businesses, and large companies can offer health benefits to their employees under one uniform Federal statute known as ERISA, the Employment Retirement Security Act of 1974. This law exempts such organizations from having to comply with different rules, regulations, and benefit mandates in each of the 50 states.[2] As proposed, AHPs could either purchase coverage directly from insurance companies or could self-insure (i.e., pay claims from association funds), if they cover sufficient numbers of participants. AHPs that self-insure would be subject to solvency requirements so that sufficient monies would be available to pay claims when presented.

The U.S. Department of Labor (DOL) would be the Federal agency responsible for oversight of AHPs if the legislation is passed by Congress and signed into law. The agency would certify AHPs, confirming that sponsoring associations are bona fide and not formed solely for the purpose of marketing insurance. AHPs would have to meet strict requirements designed to protect participants and foster financial solvency. The DOL would establish a separate fund to guarantee that outstanding participant claims would be paid if, for some reason, the AHP became insolvent.[2]

Some AHPs currently exist at the state level, and a number of small businesses now offer health coverage through programs sponsored by trade and professional associations. These health programs are considered multiple employer welfare associations (MEWAs) that, under current Federal law, are subject to state insurance laws and regulations.[2] If the ability to offer AHPs is strengthened through pending legislation, business owners could purchase health insurance at more affordable rates, thereby expanding the small-group market.

Legislative Activity. AHP legislation has been introduced a number of times in the Congress. While the White House and the House of Representatives have generally supported AHPs, the Senate has primarily opposed them. Many Senators have been unwilling to alienate state insurance commissioners, who would have to relinquish some authority if AHPs become subject to a Federal regulatory structure and DOL oversight.[3] In June 2001, the Senate passed the Kennedy-McCain version of the Patient's Bill of Rights (S. 1052), which did not contain AHP provisions. In August 2001, the House passed H.R. 2562, a different version of patient's rights legislation, which included provisions for AHPs (rolled in from H.R. 2315/H.R. 1774 in June), as well as medical savings accounts.[4]

In May 2001, Representatives Ernie Fletcher, M.D. (R-KY), and Cal Dooley (D-CA) introduced the Small Business Health Fairness Act (H.R. 1774). The same bill was introduced in the Senate (S. 858) by Senator Tim Hutchinson (R-AR) and was cosponsored by Senator Christopher Bond (R-MO), the ranking member of

the Senate Small Business Committee. In February 2003, Rep. Ernie Fletcher and 96 cosponsors proposed the Small Business Health Fairness Act of 2003 (H.R. 660), which would give AHPs an ERISA preemption.[3,5] A month later in the Senate, incoming Small Business Committee Chairperson Olympia J. Snowe (R-ME) introduced the same bill (S. 545) with six cosponsors.[5]

Other Considerations. One of the most favorable arguments in support of AHPs is that small firms would experience lower health insurance premiums because of savings from lower health plan administrative costs. This would, in turn, enable more small firms to offer health insurance to their work force. In a study released in 2003 by the Actuarial Research Corporation for the SBA, the high administrative costs of health plans designed for small businesses were explored. Researchers found that the administrative costs for insurers of small business group health plans ranged from 33% to 37%, in contrast to 5% to11% of claims for larger companies. Furthermore, sales, underwriting, and operating expenses were all higher for the small health plans.[6] A Congressional Budget Office study of potential AHP impacts on small-group premiums and coverage found that small firms would pay premiums that were, on average, about 13% lower than what they otherwise would have paid. The reduction stems partly from exemption from state health coverage mandates and partly from "a net shift to the new plans of firms with relatively low expected health costs."[7]

AHPs have the overwhelming support of most major business associations for small firms, including those that primarily serve women- and minority-business owners.[8] Micro-businesses (i.e., firms with 0-10 employees) face an especially difficult challenge gaining access to affordable health coverage in terms of premiums and plan choice. For these, the smallest of small businesses, AHPs are especially attractive. In 2002, the National Association for the Self-Employed (NASE)—the nation's leading business association and resource for the self-employed and micro-businesses—conducted a random survey of 2,000 small business owners. This study explored different parameters relative to owners'

current health care insurance and their views on AHPs, MSAs, and health care tax credits.[1]

Reported findings were based on data received from 600 of these businesses. Approximately three out of four of the small business owners surveyed indicated that they would be “very” or “somewhat likely” to participate in an AHP if doing so would result in less expensive insurance (78%) coverage, greater choice in health care benefits for themselves and their workers (75.1%), and less administrative burden (72.7%). Thus, if AHP legislation currently pending in Congress becomes law, it should reduce the extraordinarily high proportion of self-employed and micro-businesses that currently do not offer health insurance coverage (70.3%) and have never offered it (88.3%). About three in seven (42.3%) of the survey respondents belong to a business, professional, and/or trade association. Over half (50.5%) of the businesses that were not members of an association indicated that they would be “very” or “somewhat likely” to join an association in order to receive AHP benefits. Respondents in the 2002 NASE survey are well-established firms, having been in business for an average of 17.2 years, with an average of three employees and average gross revenues in 2001 of $341,000.[1]

The chief opponents of AHP legislation are the Nation’s health plans, led by Blue Cross/Blue Shield organizations nationwide—the largest insurers in the small-group market—and some labor unions and consumer groups.[9,10] Opponents cite insurance fraud as an area of major concern. However at the recent Roundtable on Affordable Health Care, Secretary of Labor Elaine Chao provided reassurance that the DOL, as the lead Federal agency fighting insurance fraud, will tightly regulate insurance fraud through its newly named Employee Benefit Security Administration (EBSA). EBSA recovered nearly $9 million last year attributed to health plan fraud.[8]

The other key argument against AHPs is that they would foster “cherry picking,” or selection of only the healthiest persons for plan participation. The legislation,

however, contains numerous provisions intended to prevent this practice. AHPs must comply with the Health Insurance Portability and Accountability Act (HIPAA), which prohibits group health plans from excluding high-risk individuals or businesses with a history of high claims. The legislation also limits the ability of AHPs to alter the premiums of lower and higher cost employers or direct potentially higher cost participants to the individual insurance market.[11]

3.3 Medical Savings Accounts

Description. Medical savings accounts (MSAs) are tax-exempt arrangements that were established for the self-employed and businesses with 50 or fewer workers. This strategy allows individuals to set aside monies for routine, out-of-pocket health care expenses and to build up savings for future medical expenses.[1] Currently, MSAs are available as part of a congressionally approved four-year demonstration project (authorized by HIPAA) that ends on December 31, 2003, unless extended or made permanent by law. If not, only individuals who previously had MSAs and employees of previously participating employers will be allowed to continue to make contributions to an MSA. These HIPAA MSAs are often referred to as Archer MSAs, named for Rep. Bill Archer (R-TX) who championed the bill.[12,13,14]

There are two health plan options—individual and family—and the allowable contribution to the MSA depends on the size of the health plan deductible chosen. To be eligible for an MSA, an individual must maintain a high-deductible health insurance policy (i.e., $1,500 to $2,250 for individuals and $3,000 to $4,500 for families). Monies can be contributed to an MSA throughout the year, or the participant can elect to make a lump sum payment at the beginning of the year. All MSA contributions are 100% deductible, and any unused funds can be carried forward to the next year, earning interest all the while.[12,13,14] By expanding and making MSAs permanent, as well as by removing enrollment limits, new

legislation could allow many individuals with a high-deductible health plan to participate.[15]

Legislative Activity. As with AHPs, legislation on MSAs has been introduced in Congress on several occasions. In 2001, as noted above, House-approved patients' rights legislation (H.R. 2562) contained provisions for MSAs.[4] The Medical Savings Account Availability Act of 2001 (S. 1067/H.R. 1524) introduced by Senators Charles Grassley (R-IA) and Robert Toricelli (D-NJ) and Representatives Bill Thomas (R-CA) and Bill Lipinski (D-IL) proposed to improve MSAs and make them permanent.[12,13,14] In February 2003, Rep. Ron Paul (R-TX), along with cosponsor Rep. Ginny Brown-Waite (R-FL), introduced the Medicare Medical Savings Account Expansion Act of 2003. In its present form, the legislation would make MSAs permanent and eliminate the ceiling for the number of enrolled businesses.[5]

Other Considerations. The small business community generally views MSAs favorably. In NASE's 2002 small business survey, information on MSAs was collected from self-employed persons and micro-businesses. Only two in seven (28.3%) of the survey respondents were aware of MSAs prior to the survey, and practically none of these business owners (only 1.8%) currently had an MSA for themselves or their employees. However, after learning about MSAs through the survey questionnaire, nearly half (42.6%) were open to the idea, with 6.8% indicating they were "very interested" and 35.8% noting they were "somewhat interested". In fact, about one quarter of surveyed entrepreneurs (26.8%) said they were "very" or "somewhat likely" to establish an MSA policy for their work force, and over one-third (33.6%) indicated that they would personally contribute to an MSA if the business offered one to its employees. An overwhelming majority (79.2%) of business owners felt that MSAs should be made available to all individuals and employers and not limited to the self-employed and small firms with 50 or fewer workers.[1]

3.4 Refundable Tax Credits

Description. In 2002, President Bush proposed a refundable tax credit to those persons lacking access to employer-based coverage so that they could purchase private health insurance. Individuals could obtain coverage that they can own and keep, even if they lose or change jobs. The size of the credit would vary by family income and size, and provide a subsidy of up to 90 percent of the cost of health insurance premiums. There would be a maximum credit of $1,000 per adult and $500 per child (for up to two children) for a maximum family credit of $3,000. The credit would be refundable even for taxpayers who owe no income tax. Such persons would file an income tax return and claim a refund against their health insurance expenses. The credit would also be advanceable on the basis of the individual's prior-year income. This feature would enable persons who, for example, may not have enough cash readily available to meet monthly premiums to receive an advance through the tax credit system. In addition, certain low-income persons could purchase private coverage for themselves and their families through state-sponsored health insurance groups or high-risk pools.[16,17] Refundable tax credits would have special appeal to the individual insurance market. As it is currently structured, this market provides coverage to a broad mix of people with different life circumstances. These include the self-employed, workers in businesses where health coverage is not offered, individuals outside the labor force, persons who have exhausted their COBRA coverage after leaving an employer, and early retirees who are too young to qualify for Medicare.[18]

Legislative Activity. The 108th Congress is currently considering legislation that would extend a tax credit to individuals to purchase health insurance. In February 2003, Rep. Mark Kennedy (R-MN) introduced a bill (H.R. 583) in the House along with 107 cosponsors that would allow individuals a refundable credit against income tax for this purpose. The bill would also establish state health insurance safety nets.[5]

Other Considerations. The business community generally supports refundable tax credits as an important component of a viable solution to the health coverage crisis. In a Kaiser Foundation survey the overwhelming majority (89%) of small employers favored tax credits to help purchase private health insurance for their workers. Three in four small employers supported tax credits or other financial assistance to help employees purchase health insurance on their own.[19]

Under President Bush's health care tax credit proposal, an individual would receive a maximum $1,000 tax credit per adult to purchase health insurance. It is important to know whether there are low-cost health insurance policies available that can be purchased with the credit. Research conducted by the Health Research and Educational Trust suggests that there are a number of low-cost plans available for younger and healthier adults, although older adults would have great difficulty finding high-quality health coverage at this price. About one-quarter of the plans on the market for a healthy 27-year old male cost $816 annually. In contrast, only one-quarter of healthy 55-year old males can get a policy for under $2,184 per year.[20] Researchers at the Center for Studying Health Systems Change raise similar concerns based on their national Community Tracking Survey. Their data show that health insurance premiums for older persons and for those in declining health are more costly than for other groups.[21]

3.5 State High-Risk Pools

Description. For many individuals who lack employer-based health coverage but have extensive medical expenses, obtaining coverage in the individual insurance market is not an affordable option. In most states, insurers can refuse coverage to "high risks" because of a current or preexisting medical condition. State high-risk pools, which first appeared 25 years ago, help insure those who have been denied private coverage in the individual market. In 2001, 29 states maintained high-risk pools, although enrollment was limited and covered only an estimated 113,000 individuals.[22] Such pools now operate in 30 states and cover about

153,000 persons. Most of the states also use their pools to comply with HIPAA provisions relating to individuals leaving employer group coverage. Some enroll Medicare-eligible persons in their high-risk pool for supplemental coverage.

Legislative Activity. The Trade Act legislation (H.R. 3009) signed into law in August 2002 provides up to $100 million in Federal funding for states to create high-risk pools or to fund existing ones. In March 2003, Representative Edolphus Towns (D-NY) and 17 cosponsors introduced the State High Risk Pool Funding Extension Act of 2003 (H.R. 1110) to continue the current funding of high-risk pools at the state level. Also in March, Representative Mark Udall (D-CO) introduced an amendment to the Public Health Service Act that would enable high-risk pools to receive reductions in prices charged for prescription drugs.[5]

Other Considerations. Some research shows that high-risk pools have had a limited impact on making heath coverage more available and affordable to otherwise uninsurable persons. Often, state risk pools have long waiting lists, exclude new participants, and charge higher health insurance premiums relative to income. They also require large deductibles and copayments, restrict annual and lifetime benefits, and may impose preexisting-condition exclusions to reduce adverse selection.[22] State high-risk pools operate at a loss because the amount of medical claims paid is typically higher than the amount of insurance premiums collected. Nonetheless, some states (e.g., Kentucky, Oregon, Washington, and Wisconsin) have found innovative ways to finance their high-risk pools by broadening their revenue bases.[22] States with well-functioning high-risk pools have made major strides in increasing access to health insurance for their medically uninsurable residents.[23]

3.6 Defined Contribution Accounts

Description. A defined contribution account (DCA) is an account that an employer establishes on behalf of an employee to pay health care expenses. The

employer credits the account a certain amount that the employee can use to pay for medical expenses. DCAs may also be used to pay for health-related expenses that are typically not covered in traditional health plans, such as some vision correction procedures. When utilized in combination with an existing health plan, a DCA arrangement can provide funds to cover out-of-pocket expenses and deductibles.[24,25]

Legislative Activity. Legislation pertaining to DCAs has been particularly active in the past two years. In the 107th Congress alone, one bill in the House (H.R. 3657) and three in the Senate (S. 1919, S. 1992, and S. 2032) were introduced to permit improved disclosure, diversification, access, and accountability for DCAs. In January 2003, Senator Thomas Daschle (D-SD) proposed legislation (S. 9) advancing further improvements to DCAs in the 108th Congress.[5]

Other Considerations. DCAs present some uncertainty that should be carefully considered. "Under current law, there is some risk that DCAs will be treated like flexible spending accounts, including the use-it-or-lose-it rule. This effectively prevents amounts from being carried over from year to year." [24,25]

3.7 Cafeteria Plans

Description. As its name suggests, a cafeteria plan (also referred to as a "flexible spending plan," "flexible benefits plan," or "Section 125 plan") allows employees to design their own benefits package. Workers can select different types and levels of benefits that are funded with nontaxable employer dollars. Employees are allotted a certain predetermined number of credits, dollars, or points that they can use to purchase benefits. Individuals can pick from a menu of predetermined benefit options to best meet their needs and those of their families.[26]
The types of benefits that can be carried by a cafeteria plan are typically those that would not result in taxable income to employees if they were provided outside such a plan. Examples include health insurance, dental insurance, life insurance,

accidental death and dismemberment coverage, disability coverage, and vacation leave. The only exception to this rule of thumb is group life insurance exceeding $50,000: although it can also be included in a cafeteria plan, this benefit continues to be taxable.[26] Also, retirement benefits cannot be included, except for a 401(k) plan. Many employers, however, opt not to include a 401(k) plan as part of their cafeteria plan because the regulations governing 401(k) plans are complex, especially when combined with Section 125 regulations.[26]

Legislative Activity. Since their inception, numerous bills have been introduced in the House and the Senate to improve the operation of cafeteria plans. In January 2003, Representative Jim DeMint (R-SC) and 43 cosponsors initiated legislation in the House (H.R.1177) to provide additional choice regarding unused health benefits in cafeteria plans and flexible spending accounts.[5]

Other Considerations. Although many employees enjoy the flexibility afforded by cafeteria plans, there are some potential pitfalls that both business owners and workers should consider. First, employees may not have the necessary knowledge or expertise to select the right mix of benefits to fit their particular situation. This could result in inadequate employee protection and major loss for the worker. For instance, younger workers may be motivated to choose the cash option, considering themselves to be healthy and invulnerable, instead of selecting high-option health coverage or disability insurance. Yet, should the employee experience a serious illness or suffer a disabling accident, that individual is exposed to serious physical and financial risk. Second, cafeteria plans usually offer a reduced level of benefits as the core coverage, and then a menu of optional benefits (or cash). Because these plans carry higher administrative costs than do traditional benefit plans, employers may compensate by lowering the dollar allocation for each benefit offered in the menu compared with the benefits offered under a more traditional plan. Thus, the employee may end up with inadequate coverage. Third, the employer may feel financial

pressures to “remodel” or adjust some of the benefits in the future to keep pace with increases in the cost of the core coverage.[26]

3.8 Flexible Spending Accounts

Description. Flexible spending accounts (FSAs) are a type of cafeteria plan first authorized by Congress in 1978 and regulated under Section 125 of the Internal Revenue Service Code. FSAs function exactly as MSAs do, except any funds not used by the end of the year must be returned and cannot be carried forward for future expenses. FSAs were born out of the changing needs of employees seeking to tailor their health care benefits to their individual circumstances, such as expenses for child care or an elderly or disabled dependent. Even taxpayers who do not itemize on their tax returns can receive a tax break with a health care or dependent care FSA by paying for these out-of-pocket expenses with pretax dollars.[27]

There are two kinds of FSAs: health care FSAs to reimburse general medical expenses, and dependent care FSAs to recoup costs associated with the care of children, the elderly, and adults with disabilities.[28] The types of expenses that can be reimbursed to employees in a health care FSA include deductibles or copayments associated with conventional health insurance plans. Also covered are physician-prescribed expenses for the diagnosis, treatment, cure, or prevention of a medical condition, and outlays for prescription drugs, orthodontia, a chiropractor, and hearing or vision aids. The types of costs that can be reimbursed in a dependent care FSA include fees for babysitting of dependent children age 13 or younger, and expenses associated with day care centers and before- and after-school care programs.[28] The account can also be used to pay elder care expenses if the employee is responsible for at least 50 percent of the support of an elderly parent. Such benefits can likewise apply to persons of any age living with the employee who are physically or mentally incapable of caring for

themselves and are listed as dependents on the employee's income tax statements.

Rules. Specific rules that FSAs must follow are listed below.

- An employee must voluntarily elect how much she or he will place into the FSA at the beginning of the year; however, all the money does not have to be contributed by the employee at that time. This amount is contributed through salary reduction.[28]

- The amount of the salary reduction cannot be changed during the plan year unless there is a change in the employee's family status—such as a birth or death of a dependent, marriage, divorce, or loss of employment by the spouse—or a major change in the health plan coverage or cost.[28]

- The full amount that the employee has chosen to contribute to a health care FSA must be made available by the employer at all times throughout the coverage period to reimburse expenses.[28]

- If there is a balance left in the FSA at the end of the plan year, the funds are forfeited by the employee and becomes the property of the employer. This is referred to as the "use it or lose it" rule. Employers, in turn, can do just about anything with this money, such as use it to offset administrative expenses, except return it to the employee who forfeited it. Employers can decide, however, to return unused monies to all employees if it is done on an equitable basis (i.e., each employee receives the same amount).[26,28]

- The maximum amount that an employee can contribute in a plan year for either type of FSA is $5,000. Some FSAs establish a minimum that must be satisfied (e.g., $25 or $50) before an expense will be reimbursed.[28]

- After the end of the plan year, the employer should allow 90-120 days for participants to submit claims for expenses incurred during the plan year.[28]

- An employee who participates in an FSA and is entitled to COBRA benefits can elect to continue the FSA upon leaving the employer; the business would have to continue to honor claims and accept payments. [28]

Other Considerations. FSAs can benefit both employers and employees. Employees can set aside a portion of their pretax salaries to pay for certain unreimbursed health and dependent care expenses or for health insurance premiums. An FSA can stand on its own or become part of a larger cafeteria plan. Employers benefit because FSAs are not subject to payroll tax, thereby reducing the employer's tax obligation.[27]

3.9 Health Reimbursement Accounts

Description. One of the newest vehicles for providing more employee choice and control over their health care benefits is the health reimbursement account (HRA). This option is also known as a personal contribution account, defined contribution account, consumer-directed health care account, or self-funded medical reimbursement account. Authorized by the U.S. Treasury Department and announced in June 2002, this type of account gives both employers and employees more flexibility in health plans.

HRAs resemble several products already on the market. They are similar to FSAs with one major difference—at the end of the year employees do not lose their money but instead can rollover any unused funds to the next year. There are no limits on the amount that can be carried forward. These accounts are also similar to MSAs except that HRAs are funded by the company, are available to employers of all sizes, and are flexible in design.[29, 30]

Formally, such products are known as health reimbursement arrangements, which have existed for years, although they were not offered as an option to employees until full cafeteria plans gained popularity in the late 1980s. Now, as employers seek new ways to cope with extraordinarily high health care costs, the concept has been given new life by the Internal Revenue Service and the U.S. Treasury Department, which issued new guidelines for HRAs last year.

The guidance, which consists of a notice and revenue ruling, "provides that medical benefits paid by HRAs that meet certain requirements are not taxable. The guidance also clarifies that HRAs generally are not subject to the complex design requirements for health flexible spending arrangements funded through salary reduction under a cafeteria plan."[31]

Rules. The rules for an HRA are as follows:[32]

- **Tax treatment.** Coverage under an HRA and all expenses that are reimbursed through it are excluded from the gross income of the covered person. However, as with FSAs, individuals cannot claim an income tax deduction for expenses that have been reimbursed through their HRAs.

- **Strictly an employer-paid benefit.** An HRA must be funded solely by the employer and may not be directly or indirectly paid for through an employee salary reduction; nor can it be provided through the employer's cafeteria plan.

- **Reimbursement for medical expenses.** Monies placed in an HRA can be used to reimburse employees only for medical expenses (as defined under Sec. 213 in the tax law), which must be substantiated properly by the employee. Allowable reimbursable expenses include costs paid for premiums for health or accident coverage. HRAs can also be used to pay long-term care premiums, but not direct long-term care expenses. At no time can employees

receive any cash, directly or indirectly, or any taxable or nontaxable benefits from their HRAs.

- **Carry-over of unused funds.** One of the most appealing features of HRAs is that any unused portion of this plan coverage can be carried forward to subsequent coverage years. Even better, there are no limits on how much or how far into the future an amount can be carried. However, there can be no cash disbursement of unused funds, directly or indirectly.

- **Retirees and former employees.** Both current and former employees (including retired persons) and their spouses and tax dependents may be covered under an HRA. Thus, persons with an HRA who no longer work for the employer can maintain access to unused reimbursements. Furthermore, a surviving spouse, as well as dependents of a deceased employee, may be covered.

- **Coordination with major medical plan.** An HRA may be offered in conjunction with the employer's principal group health plan. For instance, a business could offer a major medical plan that carries a high deductible along with health coverage under an HRA. In this manner, the HRA could be used to receive reimbursement for deductibles, copayments, and other expenses that the primary medical plan does not cover.

- **Subject to COBRA.** HRAs are group health plans and, therefore, are subject to COBRA continuation requirements. Thus, employees with unused reimbursements in an HRA who leave an employer can use this coverage to pay health premiums if they find themselves temporarily uninsured.

With issuance of new guidance by the U.S. Treasury Department last year, Secretary Paul O'Neill stated that "we clear the way for employers to adopt health

plans with patient-directed features so that employees have more choice and greater control over their health care coverage."[31]

Other Considerations. HRAs can be instituted rather easily by small businesses that may be unable to afford the expense of large health insurance premiums. For example, by deciding how much the business can afford to spend on health coverage and dividing this amount among all employees in the form of an HRA, the business can provide some level of health coverage to protect its workers. Employees can use the funds in their HRA to purchase health insurance on their own. Alternatively, an employer can reduce its health care costs by selecting group insurance plans with higher deductibles, offer HRAs in exchange, and use a percentage of the savings (since high deductible plans are cheaper than low-deductible plans) to fund the HRAs.

Many companies are bundling their health benefit offerings with an HRA. In fact, the most successful HRA plans are those that are a part of a larger health plan design.[29] For example, an HRA can coexist with a Section 125 Cafeteria Plan with certain restrictions. As noted earlier, these cafeteria plans operate as salary reduction plans in which employees have a predetermined amount deducted from their salaries and deposited in their health plan. Employees can then use the money to pay expenses that they incur over a period of time, but will lose all monies that are not exhausted by the end of that time. Under the IRS guidance, an employer could offer both an HRA and a Section 125 cafeteria plan; however, medical expenses must be reimbursed first from the 125 plan before the HRA can contribute.

3.10 Small-Group Purchasing Cooperatives

Description. In the early 1990s, many state governments and businesses responded to the lack of access to affordable health care by legislating various insurance reforms and creating employer health insurance purchasing alliances.

These alliances are known by many different names, and differences between the entities are often unclear.[33] The most common names are multiple employer welfare associations (MEWAs), consumer choice health purchasing groups (CHPGs), and health insurance purchasing cooperatives (HIPCs). [34] Purchasing cooperatives purport to help level the playing field for small employers by offering them some of the same advantages that larger businesses enjoy. These include choice of multiple insurers and benefits packages, administrative simplicity, and leverage in negotiating lower health insurance premiums.[33]

In 1999, more than 20 states had enacted legislation that created or authorized the creation of such purchasing cooperatives for private companies, state or local governments, or both, although specific laws varied considerably by state. Many states limited the participation to groups of 50-100 employees. Some of the functions exercised by the purchasing cooperatives include gathering and disseminating comparative information on plan quality and rates, negotiating with health plans, and providing consumer support.[34] Small-employer purchasing cooperatives are usually prohibited from rejecting groups or individual employees on the basis of adverse health status or risk.

CHPGs are organizations that bring employers and consumers together for the purpose of collectively purchasing health plans from insurers.[35] Governed by an employer-consumer board, a CHPG establishes criteria for selecting the health plans, along with sets of standardized benefits and data-reporting requirements. It may also determine the need for related administrative services (e.g., enrollment of participants and collection and payment of premiums) and provide employees with information to compare the price, characteristics, and performance of each plan. A CHPG can likewise help resolve problems between consumers and the health plans. CHPGs are currently offered in just six states.[35]

Other Considerations. To explore the advantages of small-employer purchasing cooperatives, the Government Accounting Office examined the experiences of

five such cooperatives, all of which provided coverage to businesses with 50 or fewer employees and offered at least two fully insured coverage options.[33] The study found that these small-group purchasing cooperatives offered several advantages, including administrative services and a number of benefit options. "By participating in a cooperative, small employers have a single point of entry to multiple insurers' plans with standardized benefit packages that can be compared easily instead of having to individually identify insurers and their agents, review widely varying benefit options, and determine price and terms of coverage."[33] Such findings are in sharp contrast to the single-plan option to which many small employers have grown accustomed.

The cooperatives, however, did not provide leverage in negotiating lower health insurance premiums. The study attributes this reality to limited market share, the inability of cooperatives to lower the administrative costs for insurers, and state laws and regulations that restrict the degree to which insurers can vary premiums charged to different groups purchasing the same health plan.[33] The study also found that small-group purchasing cooperatives have had mixed success in maintaining their viability (i.e., ensuring the participation of sufficient insurers and employers). Such difficulties have been due in part to the perception by many insurers that such entities are likely to attract high-risk individuals and groups. "Today, there are probably fewer than 20 small group health care purchasing pools that are close to the original … concept. Few, if any, of these pools currently sell their products based on favorable price or even expanded access. Instead pool sponsors focus on ease of administration for the employer, expansion of employee choice, and access to information about quality of care." [36]

3.11 Health Marts

Description. A health mart is a type of pooled purchasing arrangement that employers can join to buy health coverage.[34] Spearheaded by Representative Tom Bliley (R-VA), health marts are non-profit administrative entities or

cooperatives of employers, workers, insurers, and consumers that are formed to offer more choice in employer-based coverage and care to firms with two to 50 employees. In lieu of selecting a health insurance carrier for all of a firm's employees, the employer signs up with a health mart that, in turn, offers a wide range of health coverage options (e.g., HMOs, PPOs, MSAs and others). Employees then choose the options that are most attractive to them.[37]

Rep. Bliley modeled health mart legislation after the Federal Employee Health Benefits Plan (FEHBP), which offers congressional members and Federal employees multiple managed fee-for-service, point-of-service, and HMO plans. Health marts build upon the FEHBP model of consumerism by "fostering the creation of private, competitive, and patient-empowering voluntary choice cooperatives."[38] Health mart legislation "would pre-empt insurance mandates that have had the unintended effect of increasing the cost and decreasing the array of health insurance plans. Indeed, according to Blue Cross/Blue Shield, there were more than 1,000 state laws mandating that specific benefits and providers be covered by health insurers in 1998. This doesn't include laws regulating managed care plans or coverage for specific patient populations. The impact these mandates have had on the cost of coverage is significant, with General Accounting Office estimates ranging as high as 22 percent."[38]

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CONCLUSION

The challenge facing women business owners and other entrepreneurs in accessing affordable health coverage is one that has persisted for well over a decade. Health insurance premiums remain high, and choice in health plans is still limited. Many small business owners, however, are becoming more proactive in finding ways to overcome these obstacles. These owners realize the adverse health consequences of workers' living without coverage. At stake are not only the health and well-being of their employees, but also the ability of business to attract and retain a qualified work force.

On the basis of information presented in this report, the following suggestions are offered to guide entrepreneurs as they evaluate health plan options:

- **Be Realistic About Health Care Costs**. It is unlikely that new legislation and innovative insurance vehicles will immediately alter the health care landscape. Given that health care costs have been rising steadily since the 1990s, business owners should not expect to see huge differences between current premiums and those that would result from any one of several proposed solutions.

- **Plan Strategically for Health Coverage**. Many small firms do not offer coverage when launching the business, but tend to add it as they grow. It is important for business owners to realize that health insurance is a major expense that can significantly impact the company's bottom line and corporate talent pool year after year. By planning strategically at the outset for health coverage, entrepreneurs may become better positioned for business success.

- **Take Advantage of Existing Opportunities for More Affordable Coverage.** There may be resources within reach of business owners who are

not offering coverage that would improve employee access to affordable health care. For example, business owners can find out whether there are any AHPs operating in their state that could offer coverage to them. Also, health insurance is available to business owners through a number of business associations. Additionally, business owners can still set up MSAs through health insurers through the end of 2003.

- **Become More Knowledgeable About Health Benefits.** Given the variety of health care plans and products that exist today, it is important that business owners understand insurance terminology. Familiarity with the technical language will enable owners to evaluate different health plan options and products and to choose ones that work best for them. In this regard, workshops or other assistance from human resource professionals, financial planners, local insurance brokers, and business associations may prove beneficial.

APPENDIX A: TOPICAL RESOURCE LIST

ACCESS TO AFFORDABLE HEALTH COVERAGE BY WOMEN-OWNED BUSINESSES

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