State of Connecticut
GENERAL ASSEMBLY

SPEAKER'S WORKING GROUP ON SMALL BUSINESS HEALTH CARE
LEGISLATIVE OFFICE BLDG., ROOM 4100
STATE CAPITOL
HARTFORD, CONNECTICUT 06106

Speaker's Working Group on Small Business Health Care
Report and Recommendations
January 30, 2012

Working Group Membership

Rep. Robert Megna, 97th District, *Chair*
Rep. James Albis, 99th District
Sen. Joseph Crisco, 17th District
Sen. Terry Gerratana, 6th District
Rep. Susan Johnson, 49th District
Rep. David Kiner, 59th District
Rep. Betsy Ritter, 38th District
Rep. Robert Sanchez, 25th District
Rep. Ezequiel Santiago, 130th District

Charles Beyer, Beyer Precision, LLC
Michael V. Brown, New Standard Institute
Richard Carbray, Apex Pharmacy
Brenda Cerezo, Cerezo New Image Salon
Jennifer Clark, Realtor, First Choice Realty
Chris Donohue, Riefberg, Smart, Donohue and NeJame, PC
Kevin Galvin, Connecticut Commercial Maintenance
Jerry Hardison, West End Eye Care
Carolyn Malon, Family Dental Care of Farmington
Séan Moore, Greater Meriden Chamber of Commerce
John Pakutka, The Cresent Group
John Seiffer, Better CEO
Linda St. Peter, Realtor, Broker/Owner of IBIS Consortium
Angel Reyes, Check Cashing and More
Lesley Waldron, IPS Limited & IPS Physician Services
Cornell Wright, Parker Wright Group

Introduction

The obstacles are huge for entrepreneurs trying to start or run a business. One of the most daunting obstacles is health care—it is one of the highest expenses after salaries. As health care costs have grown, small businesses have had to drop and cut coverage, or sacrifice job growth. Some can't attract and retain talented employees because quality health insurance is unaffordable.

The majority of Connecticut's businesses are small businesses and historically, during good times and bad, Connecticut has relied on them to be job generators. Small businesses are at a major disadvantage when it comes to health care. According to the Kaiser Family Foundation, while almost all (97.4%) Connecticut businesses over 50 employees are able to offer employee health care, only half (53.1%) of businesses with fewer than 50 employees can offer coverage.

Further, rising health care costs threaten innovation and choke off investment. High health care costs prevent small businesses from bringing on new employees and also from providing coverage to the ones they have. For small businesses, health insurance affordability is just the tip of the iceberg. Health insurance must also be easily comparable, available, accessible, and meaningful.

This report represents the product of the Speaker's Working Group on Small Business Health Care. The working group met during the fall of 2011 and winter of 2012. It examined a number of topics related to the ability of small businesses (less than fifty employees) to access affordable health care, including insurance regulations on the small group and individual markets, the markets' current offerings, barriers that small business owners face when attempting to secure quality affordable coverage and alternative health insurance models.

Overview

In an effort to better understand the regulatory landscape, the working group invited the Department of Insurance to give a presentation on the rules governing the small group and individual markets, policy rating guidelines and changes to the insurance market pursuant to the federal Patient Protection and Affordable Care Act (PPACA). The group also heard from the Office of the State Comptroller on the Municipal Employers Health Insurance Program (MEHIP) and Connecticut Healthcare Partnership programs. MEHIP offers small employers, municipalities and certain nonprofits the opportunity to purchase insurance through the state and take advantage of administrative efficiencies and simplified underwriting that is advantageous to some groups. The Connecticut Healthcare Partnership will soon permit municipalities and certain nonprofits to join the state employee pool and share in the large pool's competitive pricing and long term stability. This plan can serve as a model for small businesses seeking relief from unpredictable annual rate increases, high administrative costs and low value for their premium dollar.

The working group also examined the health insurance exchange that Connecticut is developing under the PPACA. The group heard from Tia Cintron, Project Director of Insurance Exchange Planning at the Office of Policy and Management; Robert Tessier, Executive Director of the Coalition of Taft-Hartley Funds and Member of the Health Insurance Exchange Board; and Patrick Holland, Managing Director of Wakely Consulting Group and former CFO of the Massachusetts Health Connector (that state's exchange). The exchange will serve as a marketplace for individuals and small businesses seeking health insurance options. The exchange has the ability to add value to the marketplace, by offering health care purchasers new tools for comparing health plan options, and encouraging competition on price and quality. The small employer exchange (which is also known as the Small Business Health Options Program or SHOP Exchange) will allow small employers to purchase insurance for their employees. Under the PPACA, the SHOP exchange can also add value by collecting premiums, providing call center services and offering other help to small employers in administering health insurance.

The working group also examined the Consumer Operated and Oriented Plan (Co-Op), a nonprofit health insurance company for which the Connecticut State Medical Society is pursuing federal funding under the PPACA. The Co-Op would be a licensed non-profit health insurance company and offer products aimed at improving the quality, coordination and continuity of care in individual and small group markets. These products would compete with private plans on the exchange and could promote competition and value among the market as a whole.

Finally, the group heard from Melissa Cummings-Niedzwiecki, Special Projects Director for the Affordable Care Act at the Internal Revenue Service, who explained the tax credits now available to small businesses that offer medical insurance and pay at least 50% of employee premiums. Qualifying employers are eligible for tax credits for up to 35% of their premium costs through 2013 and up to 50% of their costs after 2013. Some nonprofits are also eligible.

Findings

Based on working group members' individual experiences and their survey of the insurance markets' current offerings for individuals and small businesses, the group found that small employers and self-employed individuals lack leverage, purchasing power and the ability to aggregate their risk in a larger pool. Many of the products available provide only a modest benefit for a high price. Small employers and their employees are subject to unpredictable health care costs from year to year.

These challenges may be due in part to a lack of competition in the current market. In 2011, a Kaiser Family Foundation study on state insurance market competitiveness found that Connecticut's individual insurance market is highly concentrated and small group market is moderately concentrated. In the individual market, one insurer controls 52% of the market share. In the small group market, one insurer controls 31% of business and has only a few competitors.

The challenges of the marketplace are also due to the way risk is shared. Currently, each carrier must pool risk across its books of business to calculate a community rate or premium. It can then modify this premium based on the demographic factors of a particular group (e.g., age, gender, family composition, geographic area, industry). This is called adjusted community rating. Under the PPACA, carriers will continue to pool risk within their individual and small employer books of business (regardless of whether the policies were purchased inside or outside of the exchange). However, starting in 2014, the PPACA will limit the types of adjustments that can be made to a community rate to only age, tobacco use (within a certain degree), family composition and geographic region. The federal law gives states the option of merging their individual and small group risk pools in the exchange. States have the discretion to add large groups in 2017. The fragmented nature of the current market puts individuals and small groups at a disadvantage when it comes to accessing quality, affordable options.

Recommendations

In general, the working group supports initiatives that aggregate risk by bringing more groups and lives together in the same risk pool. This benefits small employers and self-employed individuals by generating efficiencies and creating stability. Stronger efforts should be made to develop health insurance buying groups, combat fragmentation in the market and level the playing field between consumers and insurers. The group has examined several models that could be strengthened as a means of aggregating risk and reference several examples in their recommendations below.

1. Permit small businesses, including businesses of one, to purchase employee health insurance through the state employee plan.

   Rationale: This would permit small employers to take advantage of the state's large risk pool, along with its bargaining power, low administrative costs and cost containment strategies.

2. Stimulate greater competition within the individual and small group markets on and off the exchange by promoting non-profit health insurance options that add value, such as a publicly administered health insurance plan and the Co-Op, an option available under health reform.

   Rationale: The current insurance markets for small businesses are controlled by a small number of health insurance carriers. The market, as currently structured, has failed to drive value up while keeping costs down. The inclusion of a public, non-profit option both inside and outside of the exchange, would force insurers to trim profits, advertising budgets and expensive claims denial systems and create more value for the premium dollar.

3. Improve transparency in health care costs by promoting initiatives that help employers and health care consumers compare coverage and costs and promote strategies that better manage health.

   Rationale: Individuals and members of small groups often have high out of pocket costs. They need access to better information that is presented in a consumer-friendly format to help them estimate and compare health plans and costs. For example, Connecticut's Office of Health Reform and Innovation has convened a working group to develop a plan to implement a statewide multipayer data initiative, which would collect information from private and public insurance plans.

4. Implement "pure" community rating in the small group market so that a small business's premiums can no longer be adjusted based on the age, gender or similar demographics of the group.

Rationale: Vermont and New York currently require health insurers selling small group policies to charge community-rated premiums. Insurers charge all people covered by the same type of health insurance policy the same premium without regard to age, gender, health status, occupation or other factors. The insurer determines the premium based on the health and demographic profile of the geographic or total population covered under a particular policy. In essence, this change would aggregate risk across the whole book of business so that costs would be spread equally across the covered lives, averaging higher cost groups and lower cost groups. This means that premiums will no longer rise just because employees grow older. This system removes a disincentive on small employers to hire older, more skilled workers

5. Require insurance carriers to rate and offer a policy to association groups.

   Rationale: Most small employer plans (2-50 employees) are offered on a guaranteed issue basis. This means small employers cannot be turned down by a health plan based on the health status or demographics of its employees. However, there is no requirement that carriers quote and issue a policy to large groups. Even though Connecticut's 1993 legislation (PA 93-69) permits small employers to group together to secure health insurance coverage through an association, such groups have had difficulty securing coverage. (Sec. 38a-567 (22)(A)(B), exempts a group of small employers purchasing an association group plan from the small employer rating law and permits them to pool their risk together across the association if they insure at least 3,000 employees and meet certain requirements.)

6. Require carriers to report the actuarial value of plans to the purchaser of the plan starting in 2012.

   Rationale: A health plan's actuarial value indicates the percent of covered medical expenditures that a plan is likely to pay across a "typical" covered population. In 2014, in order to fulfill the federal individual coverage mandate, a policy must have at least 60% actuarial value. This means that across a typical population, the plan must pay 60% of the overall medical expenses, leaving the consumer to pay 40% out of pocket through a plan's cost-sharing requirements (deductibles, copays and coinsurance). Employers currently offering plans below 60% actuarial value will have to offer a more robust plan. Employers need this information as soon as possible so that they can seek out affordable options for themselves and their employees if their current coverage does not meet this floor.

7. Strongly consider merging the individual and small group markets inside and outside the exchange.

Rationale: The federal law gives states the option of combining their individual and small group risk pools in the exchange. Aggregating risk creates efficiencies, enhances bargaining power and better distributes the cost of claims, resulting in more rate stability and predictability. This change could also enable individuals leaving small group plans to maintain their coverage. Individuals and small groups would benefit by being part of a larger pool, which can mitigate the potential for annual premium spikes. The exchange would still provide services to help small employers run their insurance plans.

8. Consider offering a Basic Health Program for low income individuals in order to lower costs for small businesses in the exchange.

   Rationale: The Basic Health Program (BHP) is an option for states to cover non-Medicaid eligible adults below 200% FPL. The federal government will provide states with 95% of premium and cost sharing subsidies it would have provided to this population if they were to purchase insurance in the exchange. Implementing this option reduces the number of people in the individual market who are eligible for the exchange, but also may reduce premiums by improving the health of the overall pool, as adults under 200% FPL tend to have greater health needs.