

Oregon

2007

Analysis of state-designed small employer health plans

April 2007



Introduction

The Legislature created the Office of Private Health Partnerships (OPHP)¹ in 1987 as part of a series of reforms known as the Oregon Health Plan. These reforms intended to guarantee access to health care for all Oregonians. The original mission of OPHP was to encourage small previously uninsured employers to offer group health insurance. Today, OPHP works to increase access to private health insurance by educating employers, health insurance producers and others on insurance benefits and programs, subsidizing premiums through the Family Health Insurance Assistance Program (FHIAP), and certifying² health plans for small employers.

The office targets small businesses because they employ a significant share of Oregonians (32 percent of workers today) yet struggle to offer health insurance. Fewer than 60 percent of small businesses offer health insurance as a benefit. Those that do, typically contribute to the coverage of employees but not their employees' dependents. Part-time workers are rarely covered.

At the same time, nearly 80 percent of the uninsured nationwide are in working families.³ Thus, increasing the number of small businesses that offer health insurance is vital to reducing the number of uninsured Oregonians.

In 1990, not long after the agency became operational, nearly 16 percent of Oregonians were uninsured. This number dropped to about 10 percent by the mid 1990s only to peak at 17 percent a decade later. Today, the percent of uninsured Oregonians is the same as in 1990 although the share of adults compared to children increased.⁴

In an effort to reach uninsured businesses, the Oregon Legislature twice authorized OPHP to certify health benefit plans offering affordable options. This occurred in 1989 (HB 2594) and again in 2003 (HB 2537).

In March 2005, following at least four years of double-digit premium increases, the agency unveiled two "alternative" health plans. These state-designed plans are available to businesses with 2-50 employees that didn't offer insurance on or after July 1, 2003, or were formed after that date without insurance. Few plans sold, and they will sunset in January 2008 barring action by the 2007 Legislature.

This paper documents these two very different experiences in an effort to provide insight into the small employer market and what strategies may succeed in the future.

¹ Originally "The Insurance Pool Governing Board," the agency was renamed the Office of Private Health Partnerships, effective Jan. 1, 2006.

² OPHP authorizes health insurers to offer low-cost benefit designs that exclude certain mandated benefits required in regular market plans, the most common being mental health/chemical dependency.

³ Academy Health, *State of the States*, January 2007

⁴ Oregon Population Survey, 2006

Health Care Reform in the 1980s

In the late 1980s and early 1990s, the uninsured in Oregon accounted for about 16 percent of the state's population. Contributing factors included:

- Small employer and individual health plans required medical underwriting, excluding many Oregonians from coverage. People with health issues were either precluded from purchasing the plans or their medical conditions put premiums out of reach.
- Small businesses did not offer health benefits to their employees. These businesses either could not get the coverage or could not afford it.

These factors inspired Oregon to consider health care reform initiatives to address the issues. The state implemented three such initiatives, collectively known as the Oregon Health Plan (OHP), in the late 1980s “to achieve the goals of universal access to an adequate level of high quality health care at an affordable cost” (Oregon Revised Statutes 414.018).

In 1989, three components of the OHP were established⁵:

- The Oregon Medical Insurance Pool (OMIP) for persons excluded from private-sector coverage based on pre-existing health conditions.
- The framework for the Medicaid Demonstration to expand coverage to Oregonians below 100% FPL and base benefits on a list of prioritized health conditions and treatments.
- The employer mandate requiring all employers to provide insurance or pay into a pool that would be used to purchase coverage on behalf of the employer's workforce.

The employer mandate was established to address small employer resistance to offering employer-paid health insurance. This “*play or pay*” model:

- Required employers lacking benefits to cover “permanent” employees (working at least 17.5 hours per week) and their dependents or make a contribution to a new state fund to help pay for coverage of employees and their dependents.
 - *Play option:* The employer provides health insurance coverage to employees and dependents. There are no requirements regarding a minimum employer contribution or benefit level.
 - *Pay option:* The employer pays an amount equal to 75 percent of an employee's premiums and 50 percent of the dependents' premiums into a state fund providing coverage for the uninsured.

⁵ <http://www.oregon.gov/DAS/OHPPR/docs/HRSAAEarlierEfforts.pdf>

Health Care Reform in the 1980s

- Was amended in 1993 to require the state to gain federal exemption from ERISA by January 1996 in order for the mandate to take effect.⁶

The employer mandate was originally scheduled for a January 1994 effective date, but was delayed twice. In 1993, legislation required Oregon to gain an ERISA exemption, which ultimately caused the mandate to expire.

In 1991, Oregon undertook two additional initiatives:

- The Health Resources Commission was established to conduct medical technology assessments to assure that Oregonians were not incurring health expenses for redundant or ineffective services.
- Mandated all insurers offering coverage to small businesses to offer, as an option, a basic benefit package based on the prioritized list developed by the Oregon Health Services Commission.
- Health insurance reforms were implemented for the small group market that required a guaranteed issue plan and limited the effect of rating factors.

In 1995, Oregon adopted additional reforms for small group insurance:

- Rating was limited to age and geography
- All plans were guaranteed issue.
- Group health portability plans established

The 1997 Legislature modified these reforms:

- Further defined and enhanced market reforms regarding portability portions of group and individual insurance.

⁶ Among other things, ERISA prohibits states from requiring employers to offer an employee health benefit plan. Since the Oregon employer mandate was thought to potentially violate ERISA, the legislature created the exemption requirement along with a deadline to receive the exemption. When the exemption was not obtained by the deadline, the law that created the Oregon employer mandate was repealed by the sunset provision.

One Solution: State-Certified Health Plans

In 1987, the Oregon Legislature assembled a voluntary board to address its increasing concern over the rising rate of uninsured. Legislators charged the board to find solutions to the problem by defining a basic benefit package, partnering with insurance carriers to offer this package, and encouraging enrollment of uninsured small businesses in the plans. The Office of Private Health Partnerships (OPHP) was born.

Plan design

In an effort to guarantee access to healthcare for all Oregonians, as well as entice small businesses to offer insurance, the Oregon Legislature directed OPHP to develop low-cost basic health plans. Participating carriers offered basic benefit packages with deductibles as low as \$200 for healthy applicants. Applicants faced medical underwriting, although some suggest that underwriting standards were more “relaxed” than for regular market plans. The plans were “community rated,” meaning everyone pays the same premium regardless of age.

Pricing

The plans were offered at a set price of \$53.33. This set price of \$53.33 was loosely equivalent to a minimum employer contribution of \$40 and a maximum employee contribution of 25 percent.

Tax credits

Many firms that employed low-wage workers could not afford to offer an employee health plan and many of the uninsured in the 1980s worked for such firms. These same low-wage workers were often ineligible for public programs and individual insurance was too expensive. In 1987, in an effort to entice these firms to “play,” the Oregon Legislature authorized a declining tax credit to small employers who voluntarily provided insurance to their employees. The 1989 legislature modified and extended the credit.

- For 1989 and 1990, tax credits were \$25 per employee per month.
- Credits declined annually to \$18.75 in 1991, \$12.50 in 1992, and \$6.25 in 1993.

The tax credit was non-refundable. Although it could not really be tracked because it was included in the “other credits” section of the state tax return, the credit proved ineffective, primarily because many of the eligible small businesses did not have sufficient income to utilize the credit. In the end, legislators determined that marketing the plans was more effective than the tax credit.

One Solution: State-Certified Health Plans

Employer eligibility

Small businesses with one to 25 employees qualified for the plans.

Period of Uninsurance (POU)

Businesses interested in purchasing the state-certified plans could not have offered health benefits to their employees for two years.

Marketing

OPHP was established with no marketing budget or staff. As a result, outreach efforts were minimal in the beginning. The primary marketing strategy consisted of a letter that was mailed to approximately 90,000 businesses. This letter introduced the plans and the associated tax credit. The letter was drafted on Department of Revenue letterhead to get businesses' attention. And it did. The Governor's office and OPHP received a flood of calls from insured businesses that didn't qualify for the plans or tax credit and felt they were penalized for doing "the right thing." OPHP did not use this marketing method again.

The 1993 Legislature allocated \$300,000 for outreach, allowing OPHP to develop a more systematic marketing plan. This outreach included:

- Creation of marketing materials that were mailed to new businesses via the Secretary of State's office.
- Training of health insurance producers.
- Travel statewide to promote the plans.

Ultimately, these efforts led to high enrollment rates and proved far more effective than the promise of a tax credit.

Enrollment

The state-certified plans of the 1980s and 90s enjoyed a great deal of success:

- 21,066 employers and 60,827 people were served between 1989 and 2000.
- By the end of December 1996, plans had reached peak enrollment of 33,006.

One Solution: State-Certified Health Plans

Market Reforms

As discussed in “Health Care Reform in the 1980s,” a variety of health care reforms were implemented in the 1980s and 90s. Reforms were phased in over the decade, some having more of an impact on the state-certified plans than others.

Three stand out relative to the OPHP plans:

1. In 1991, health insurance reforms mandated a single guaranteed issue plan for small groups.
2. In the same year, limitations on rating were adopted.
3. In 1995, Oregon adopted reforms for small employer health insurance that limited rating factors to age and geography. All plans for small employers were guaranteed issue.

Plans Discontinued

The OPHP certified plans enjoyed great success during the decade they were offered. The rate of uninsured Oregonians dropped from 16 percent to just over ten percent. The economy was on the upswing and favorable market reforms made commercial market plans more attractive.

Enrollment in the plans tailed off, as age rating drove younger, healthier applicants into private insurance plans. This left the OPHP community-rated plans with an aging population. The plans were phased out by the end of 2000.

Small Employer Health Plans: Today's Approach

Market Conditions

Small businesses employ a significant share of Oregonians (32 percent of workers today)⁷ yet struggle to offer health insurance. Fewer than 60 percent of small businesses offer insurance as a benefit. For example, 48 percent of firms with three to nine workers offer health benefits. Small firms that do offer benefits typically:

- Contribute to the coverage for employees but not their employees' dependents.
- Offer benefits only to full-time workers. Part-timers are rarely covered.

Nearly 80 percent⁸ of the uninsured across the country are in working families, so increasing the number of small businesses with insurance is a critical agency mission and key to reducing the number of uninsured Oregonians.

Rising premium costs make it increasingly difficult for uninsured businesses to purchase a plan – let alone pay 100 percent of employee premiums. Yet, unless the business pays the entire premium for its employees, it often lacks enough employee interest to meet insurance carrier participation requirements.

Small employers that already offer insurance face ongoing pressure to shift costs to employees, reduce benefits, or worse, drop coverage altogether. This dilemma will only increase for both insured and uninsured businesses alike as cost shifting becomes more prevalent.

Premiums began to increase sharply in 2000 and continued to rise for the next four years, prompting legislators to seek new solutions. From 2000 to 2004, carriers served double-digit increases to the market.

Legislative Directive

HB 2537, passed by the 2003 Legislature, directed the Office of Private Health Partnerships to increase access to health insurance and health care by providing affordable health benefit plans for small employers. The office designed two plans – one for adults and one for children. The affordable nature of these plans intended to offset rising premium costs and motivate employers to purchase health insurance for their employees and dependents.

⁷ Oregon Employment Department. The department's 2005 data shows 109,938 businesses with 0 to 49 employees, out of a total of 114,421 businesses. The 620,290 employees in those business account for 32 percent of Oregon's 1.3 million employees.

⁸ Academy Health, *State of the States*, January 2007

Small Employer Health Plans: Today's Approach

Carrier Participation

In the fall of 2004, the agency released a formal Request For Proposal (RFP) to solicit private insurance carrier partners. Two carriers answered the call and ultimately were selected to offer both the adult and children's plans to Oregon small businesses.

- **Health Net Health Plan of Oregon, Inc.** is an Oregon-based HMO company with more than 130,000 members in the state.
- **Regence BlueCross BlueShield**, a member of The Regence Group, serves nearly one million members in Oregon and Clark County, Washington through its Preferred Provider network.

Alternative Group Plan (AGP) For Adults

Period of Uninsurance (POU)

To be eligible for the guaranteed issue plan for adults, businesses had to be uninsured on or after July 1, 2003, or formed after that date without health insurance. The POU date was established by the Legislature to prevent insured businesses from dropping coverage for a less comprehensive option. Two key consequences resulted from this stipulation:

- It limited the market. The AGP could not be an option for insured businesses that were looking to drop benefits due to cost. As time passes, fewer and fewer businesses are able to meet this requirement.
- Carriers were reluctant to commit marketing funds.

Employer Qualifications

To qualify for the state-certified plans, employers must also:

- Be a small business with two to 50 employees.
- Contribute at least \$50 per employee per month.⁹

Eligible Employees must work an average of at least 17.5 hours per week to qualify for the plans. The definition of "employee" includes sole proprietors, business partners, and limited partners, but excludes independent contractors or individuals who work on an intermittent or irregular basis.

To purchase the AGP, 100 percent of eligible employees must participate unless they are able to opt out under current Small Employer Health Insurance (SEHI) guidelines.

⁹ Although a minimum contribution was established for the plans, employers may contribute up to 100% of the cost of coverage.

Small Employer Health Plans: Today's Approach

Benefits

Covered Services: The AGP is a health benefit plan that covers essential services. The plan covers physician, hospital services and prescription medications, subject to coinsurance and deductibles. Covered benefits include:

- Physician services such as doctor visits, maternity and women's health services
- Diagnostic, lab and X-ray
- Miscellaneous services such as diabetes self-management, durable medical equipment, home health care, hospice care, rehabilitation in and outpatient, and skilled nursing care.

Services Not Covered: In addition to certain mandated benefits listed below, the plan does not cover dental or vision services, well baby/well child visits or immunizations.

Mandates/Other Limitations: The intent was to design a stripped-down, mandate-free benefit plan to create an affordable alternative to regular SEHI market plans. Ultimately the adult plan did integrate some of the mandated benefits.

Oregon had 25 **health insurance mandates** in 2003.¹⁰ The Board initially debated the mandates and **recommended exclusion** of seven:

1. Mental health/chemical dependency
2. Reimbursement for diabetes self-management programs
3. Coverage of particular drugs
4. Reimbursement for maxillofacial prosthetic services
5. Reimbursement for inborn errors of metabolism
6. Reimbursement for mammograms; schedule of covered mammograms
7. Reimbursement for pelvic and Pap exams

OPHP **restored** three benefits after conversations with legislative stakeholders and special interest groups:

- **Diabetes self-management program reimbursement.** Advocates and consumers worried that without self-management education, testing and treatment would be less effective. Additionally, carriers testified that the rate impact was nominal and eliminating the benefit could actually increase costs over time.

¹⁰ "Analysis of Group Health Insurance Mandates Required by the Oregon Insurance Code" created by the Insurance Pool Governing Board, March 12, 2004.

Small Employer Health Plans: Today's Approach

- **Mammograms and Pelvic/Pap exams:** There was an appearance of inequity between men's and women's health services and screenings, since mandates related to mammograms, pelvic exams, etc. were initially taken out, while prostate screenings remained.

Four mandated benefits remained **excluded** from the final plan design:

1. Mental health/chemical dependency
2. Coverage of particular drugs
3. Reimbursement of maxillofacial prosthetic services
4. Reimbursement of inborn errors of metabolism

Of these, only **mental health and chemical dependency** made a noticeable (5-7%) reduction in rates.

Four state benefit mandates were **not considered** for exclusion because they are also required by federal and/or state labor law:

1. Reimbursement for mastectomy-related services
2. Reimbursement for pregnancy and childbirth expenses
3. Emergency services
4. Enforcement of Newborns' and Mothers' Health Protection Act of 1996

Four population and 10 provider reimbursement mandates were **not considered** for exclusion. Provider reimbursement mandates require that care administered by certain health care providers be reimbursed if the care is a covered expense. The population mandates require coverage of certain populations. Provider mandates do not affect the cost of health insurance since they do not require that services be covered. Since the small employer health insurance market is guaranteed issue, population mandates do not impact the affordability of health benefit plans. There was no reason to exclude these mandates.

Limits

Attempting to further reduce premium costs by mitigating carrier risk, the adult plan employed other cost saving strategies in the form of **benefit limitations**.

- An annual benefit cap of \$50,000 per year, first two years.
- A lifetime maximum of \$500,000.
- Higher than normal deductibles and coinsurance levels.

Small Employer Health Plans: Today's Approach

Affordability/Pricing

Unlike the plans of the 1980s, the Legislature did not mandate specific premiums for the SEHPs. By limiting benefits and increasing member cost-sharing, OPHP sought rates that were 30 to 50 percent less than regular market plans. The findings:

- Plans typically reached the premium target when compared to the participating carriers' own SEHI plans, but not necessarily compared to other carrier prices.
- During the 2006 renewal, agency staff explored options for further reducing premiums. In discussions with the participating carriers, all parties agreed that the only way to do this short of creating new plans was to further reduce benefits and/or increase cost sharing.
 - Both the OPHP Board and legislative stakeholders were strongly opposed to further benefit/cost sharing changes as they strayed too far from the mission.
 - SEHP carriers developed two new plans as alternatives to the current Alternative and Children's Group Plans. One plan was designed to address typical adult insurance needs, while the other focused strictly on the benefits most utilized by children. Although intrigued when presented with these new plans, the governor's office decided against pursuing development of the plans.
 - Prices for the alternative plans failed to be sufficiently lower than regular market plans to encourage sales. Agency staff, on advice from the governor's office and legislative stakeholders, decided to allow the plans to sunset in January 2008.

Enrollment

Target enrollment for the first year ranged from 300 to 500 businesses. Actual results were disappointing at best.

- Although quotes started out strong with more than 400 during the first year, they tailed off to less than 50 during the last renewal period, primarily as a result of the reduced marketing.
- Of the more than 400 quotes requested only 10 groups covering 43 adult members enrolled in the Alternative Group Plan.

Despite lackluster results, the plans played some role in reducing the state's uninsured rate. The SEHPs are frequently used as a door opener, with each quote presenting an opportunity for a producer to consult with an uninsured business. Although only a few state-certified plans sold as a result of these interactions, many regular SEHI plans did sell.

Small Employer Health Plans: Today's Approach

Children's Group Plan (CGP)

The Children's Group Plan is a comprehensive plan that covers children up to age 23. The plan may be purchased with the Alternative Group Plan or as a stand-alone product to cover just the children of employees.

Governor-supported

"The rising cost of health care is a significant challenge for families, employers, and the state, which is why we must continue seeking innovative ways to help Oregon families afford basic health coverage. The plans unveiled today are two important steps forward in increasing access to health care for working Oregonians, particularly Oregon's children. Now if an employer can't afford to cover their employees and their families, there's an option to at least cover their employees' children."

Governor Ted Kulongoski – January 31, 2005

Benefits

Covered Services: The CGP is a comprehensive plan that provides many benefits, such as immunizations and well checks, with low out-of-pocket costs. The plan keeps all mandated benefits intact and covers physician, hospital services and prescription medications, subject to coinsurance and a low \$500 deductible. Other covered benefits include:

- Preventive services.
- Mental health and chemical dependency treatment.
- Some limited vision services.

Services Not Covered: Dental.

Participation Requirements

To purchase the children's plan, 75% of eligible families with children must enroll. All of the eligible children in an enrolling family must enroll, unless other group health insurance or the Oregon Health Plan covers the child.

Small Employer Health Plans: Today's Approach

Family Health Insurance Assistance Program (FHIAP) Eligibility

With its lower deductibles and cost sharing, along with its higher benefits, the children's plan qualifies for premium assistance through the state's subsidy program, FHIAP. FHIAP helps pay monthly insurance premiums for lower-income, uninsured Oregonians who meet income, asset and other qualifications.

Period of Uninsurance

Although businesses had to be uninsured on or after July 1, 2003 to be eligible for the adult plan, there is no business period of uninsurance requirement for the children's plan.¹¹ During renewal discussions with the carriers in 2006, they cited the period of uninsurance requisite as a key barrier to employers purchasing the plan. As a result of these discussions, certified plan contracts were modified to give carriers the ability to market the CGP to their own existing "employee-only" groups.

Affordability/Pricing

Carriers were charged with keeping premium costs for the children's plan low, while at the same time developing a plan with comprehensive benefits and lower cost sharing. Targeted premium reductions of 30 to 50 percent below regular market rates were not achieved for the children's plan. Contributors include:

- A comprehensive benefit package.
- Lower cost sharing, including prescription co-payments, annual deductibles and member coinsurance levels.
- A higher lifetime maximum benefit of \$1,000,000.
- A first day benefit for newborns.
 - Carriers cited this as a real cost contributor, since the risk was unknown. Because this is a children's only plan, carriers could not be sure that appropriate prenatal care had been given to the mother, which could result in a higher than normal rate of premature births.

Although the 30 to 50 percent premium reduction could not be met with this plan due to its comprehensive nature, carriers were able to achieve a 10 to 15 percent price reduction.

¹¹ The business POU differs from the FHIAP requirement that members be uninsured for six months in order to eligible for state subsidies.

Small Employer Health Plans: Today's Approach

Enrollment

Although initial hopes were that enrollment would reach 500 to 2,500 children during the first year, results were bleak. After the first year only three groups covering 10 child dependents enrolled in the CGP. In designing the children-only plan, some thought parents would want to cover their kids even if they couldn't insure themselves. In reality, it appears:

- Parents are more concerned about their own insurance status, since untreated illness could preclude them from working and taking care of their families.
- When forced to choose, most employers would insure their employees in order to reduce absenteeism and increase employee production.

Interestingly, the decision to allow participating carriers to market the children's plan as dependent coverage to their own existing "employee-only" groups had no impact on the results. As it turns out, each carrier only had a handful of these groups.

Funding

Although the Legislature directed OPHP to design and market the state-certified plans, the agency received no money for marketing. As a result, OPHP's Information, Education, & Outreach staff absorbed the marketing and additional publication needs into their existing budget using current staffing levels.

Although a fee of \$1 per member per month eventually was assessed to those in the plans, low enrollment did not generate many marketing dollars.

Participating carriers initially responded to marketing needs by creating and distributing their own publications and marketing materials. However, the extended period of uninsurance required for businesses to qualify for the plans ultimately resulted in their reluctance to expend much energy or funding toward the plans, especially the adult plan.

Marketing Plan

Governor Kulongoski kicked off the new plans during his press conference in January 2005.

The agency designed and distributed Small Employer Health Plan **publications** during the initial plan rollout. The marketing materials targeted two primary audiences:

- Producers charged with presenting the plan alternatives to their customers.
- Small businesses looking for health insurance alternatives.

Employers seeking information about the plans were assigned a producer (agent) in their area to work with. **Producers assisted employers** in obtaining insurance quotes for the state-certified product, as well as regular SEHI market quotes.

Small Employer Health Plans: Today's Approach

SEHP information was incorporated in the **New Producer Training** (NPT) materials. Special training sessions were arranged for producers already in the agency's producer referral program.

Results

Although the agency was successful in achieving a high number of quote requests during the initial rollout, it did not take long for producers and business owners alike to determine that the price differential between the state-certified and regular-market plans did not justify giving up the regular market benefits. Further, employers are not just worried about today's health benefit costs, but also tomorrow's expenses. In other words, the uncertainty of health care costs contributes greatly to many employers' reluctance to purchase this benefit.

Waning support from producers, combined with feedback from small employers, helped guide the decision to pull back marketing efforts for these plans.

Other States' Experience

Varying Approaches

States are exploring a variety of approaches to cover the uninsured. They include:

- New mechanisms to subsidize coverage for low-income families.
- Variations of employer and personal responsibility for insurance coverage.
- New strategies to ease the purchase of health insurance for small employers and individuals without access to employer-sponsored insurance.

“Many state efforts to expand coverage focus on compelling evidence that the increase in the uninsured is due in large part to the decline in employer-sponsored insurance... These state studies, as well as national reports, indicate that more than 80 percent of all nonelderly uninsured are either workers or living in families with working individuals – a finding that has led state leaders to focus most of their efforts to expand coverage to the working uninsured.”¹²

Examples of things to come:

- Maine's *DirigoChoice* and Massachusetts's *Connector* allow small employers to buy insurance through new purchasing arrangements, as well as subsidizing premiums for low-income workers.
- Massachusetts and Vermont require businesses to pay modest assessments toward state-offered coverage if they fail to provide insurance for their workers.
- Oklahoma's *Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)* allows employers to sponsor qualified group health plans with a minimum 25 percent contribution from the employer. Employees who qualify can have 85 percent of their share of premium paid by the state.

Success Rate

Enrollment success varies greatly by state. This is explained by the different goals of these programs, the diverse populations the programs intend to cover, the length of time in operation and the amount of state funding provided.

While states are reducing administrative barriers and enrolling more children in Medicaid or SCHIP, there is less focus on reducing administrative barriers in programs that might expand employer-sponsored insurance. Fewer resources are available to assist state policymakers in identifying how to overcome administrative barriers to enrollment.

In the case of initiatives that require employers to offer coverage, it remains unclear what factors inhibit higher enrollment. Operational barriers that include ramp-up time and budget certainly contribute. Also, business leaders are reluctant to commit to providing health insurance through a state program until the state can demonstrate program stability.

Conclusions

As OPHP responded to the 2003 legislative directive to design health plans affordable to small, uninsured businesses, it found that relatively few state mandates contributed significantly to the costs of health care. Four mandates eventually were excluded in a group plan that employers could purchase for their employees and/or spouses but not children. This Alternative Group Plan failed to achieve the hoped-for drop in premium price, even when combined with other benefit limits. It appears then that in Oregon mandates are not significant in driving health-care costs and are not the reason health insurance is unaffordable for so many small businesses in Oregon.

The state also designed a group health plan for children that allowed employers who can't afford to cover employees **and** their dependents to just cover the kids. Although a novel concept, employers clearly are most interested in their employees' health and productivity. Offering insurance to a worker's children but not the worker him or herself didn't make sense to a lot of business owners.

An array of health plans and premiums are already available in the commercial market. However, the adage "you get what you pay for" clearly applies. High-deductible plans are an option for those who can afford to pay any medical costs incurred before satisfying the deductible. Unfortunately, this is generally not the lower-income employee the state seeks to assist.

Thus, offering a viable health benefit package to lower-income workers will require some type of subsidy – whether it is a direct subsidy to employers or workers, a reinsurance program like New York's, tax credits or a combination of incentives.

Oregon has an existing premium subsidy program that helps lower-income, uninsured Oregonians pay the premium for job-based insurance¹³. However, it is available only to families with incomes up to 185 percent of the federal poverty level (\$2,648 monthly for a family of three). Even with a subsidy that pays part of the premium, families at these income levels often can't afford their share of private insurance costs. Further, families with incomes at double or even triple the federal poverty level still have difficulty affording health insurance, and there is currently no state subsidy program to help these families.

Our recent experience shows that the state can't design a health plan that combines the benefits that lower-income workers want with a price tag workers and/or their employers can afford.

While states continue to pursue a range of options to reduce the nation's uninsured population, no perfect solution has been found. More than likely, a combination of ideas is needed to make an impact.

¹³ Family Health Insurance Assistance Program (FHIAP)



Office of Private Health Partnerships

250 Church St. SE, Ste. 200
Salem, OR 97301-3921