LESSONS FROM A SMALL BUSINESS HEALTH INSURANCE DEMONSTRATION PROJECT

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FIELD REPORT

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EXECUTIVE SUMMARY

The lack of health insurance coverage among workers and their dependents is a major national problem. According to the 2000 census, 24 million employed Americans are not covered.[1] Numerous studies have documented that the uninsured frequently forgo needed care and, when they do obtain care, report less continuity and poorer quality, as well as serious financial stress in coping with the resulting bills.[2] Among workers in New York State, the absence of health insurance is more widespread (17.1% in 1999) than among workers nationally (15.6%). And, among employees of small businesses in New York State, the lack of coverage reaches an extremely high level: 25 percent of those employed by companies with fewer than 25 workers.[3]

To help New York City's small business employees obtain health coverage, the Mayor's Office of Health Services launched a pilot project in 1997 called the Small Business Health Insurance (SBHI) demonstration. For this effort, Group Health Incorporated (GHI), an insurer, and the New York City Health and Hospitals Corporation (HHC), the city's public hospital system, cooperated to provide low-cost health insurance to small businesses located in two areas: one in North Brooklyn, and the other in the South Bronx and nearby parts of northern Manhattan.

GHI agreed to provide comprehensive coverage, with only modest copayments and deductibles, and premiums that are approximately half of the usual market rates, ranging from $99.80 per month for an individual to $235.22 for full family coverage. Businesses located in the demonstration areas and having between two and 50 employees were eligible. SBHI provided coverage only for the use of the HHC inpatient and ambulatory facilities that were located in the demonstration areas, except in emergencies. These facilities agreed to offer steep discounts from their usual billing rates. "Community marketing" was used to supplement promotion of the program through direct mailings. HHC hired Nurse Care Coordinators to assist new SBHI enrollees with appointments and facilitate their use of clinic and pharmacy services. The first company enrolled in the program in December 1998.

As of December 1, 2000, only 53 small businesses had joined the program, and 49 were continuing their participation. Focused mailings and personal outreach by GHI and HHC representatives appear to have been moderately effective in generating interest, as reflected in requests for more information. But, clearly, SBHI had not succeeded in achieving its most basic objective: enrolling a significant number of employers. Small business owners surveyed by telephone and in focus groups provided information that

suggests that two factors were primarily responsible for this outcome: the lack of effective follow-up in the SBHI sales process and its geographically limited provider network, which didn't fully meet the needs of business owners and their families. Higher rates of enrollment in a number of other small business health insurance programs, which differed from SBHI in certain aspects, provide support for this interpretation.

Due to the program's slow growth, a decision was reached to terminate the demonstration. As of October 1, 2001, GHI is no longer accepting applications from companies wishing to enroll in SBHI, but GHI and HHC are still providing SBHI insurance coverage and medical services to the employees of those firms that are already enrolled.

While enrollment in SBHI was disappointing, the program was relatively successful in a number of other ways. The program did succeed in focusing on its primary target, small businesses that had not offered health insurance in the past, and employees who had not previously been covered by any third-party payer. Those who joined SBHI were quite pleased with the program, especially its low cost and prescription drug coverage, and the support and facilitation services provided by SBHI's Nurse Care Coordinators. Employees indicated that SBHI insurance coverage was a factor that attracted them to their current employer, and one that makes it more likely that they will remain with this employer. Also, a comparison of health service utilization patterns before and after obtaining SBHI coverage suggests that there was an encouraging shift from emergency room use to scheduled appointments for care, as well as a possible decrease in hospital admissions.

Because of the program's limited enrollment, little can be said about its impact on the participating insurer and provider network, except to note that the demonstration program served as a valuable learning experience for both organizations, and that it did not provide evidence of any negative fiscal impacts that might be anticipated by an insurer or provider network contemplating participation in such a program.

Evaluation of the SBHI demonstration project, and comparison of SBHI with similar programs in the New York City area, reveal a number of key lessons for others contemplating the design of similar programs to improve health insurance coverage among small business employees, especially programs involving public hospital systems:

There is a significant market for very-low-cost comprehensive health insurance in the urban small business community. In the SBHI demonstration, widespread interest was

suggested by the responses to a telephone survey conducted before the program's inception, and was confirmed by the large number of requests for more information that were generated by the program's modest marketing efforts.

The businesses that are attracted to a product like SBHI, and their employees, will primarily be those without prior health insurance. Eighty percent of the businesses that purchased SBHI had not provided health insurance previously, and 64 percent of the individuals who enrolled in SBHI had neither private nor public third-party coverage. Insurance companies considering participation in such a program may fear that it will entice employers to transfer out of their more lucrative, higher-cost plans. Similarly, hospitals asked to offer a significant discount under a program like SBHI may suspect that the participating individuals will come from insurance plans that would have reimbursed them at higher rates. Neither of these fears was supported by our findings.

Participation by public hospitals may detract somewhat from sales, but this impact was not a major one. Small business owners who had heard of SBHI but had not enrolled had negative perceptions of waiting times and customer service in public hospital outpatient departments, but positive impressions, on the whole, of the quality of inpatient care. They objected to a program with a geographically limited provider network, but not to a program with a public hospital–based network.

Coverage for previously uninsured employees can produce a shift from emergency room use to scheduled ambulatory care visits, and may decrease the rate of hospital admissions. It does not appear to result in high overall levels of utilization that would compromise the finances of an insurer offering modest premiums. In general, previously uninsured individuals can be expected to have relatively high levels of unmet health care needs, but in a young population—like small business employees and their families—these unmet needs are not extensive.

If there is a market for products like SBHI and they can have positive impacts on those who enroll, without creating undue risks for participating providers and insurers, how can the obstacles to their growth be overcome? Our findings indicate that in order to succeed:

1. **Persistent follow-up and a more "user-friendly" enrollment procedure are crucial.** Marketing may elicit initial interest in low-cost health insurance, but small business owners are unlikely to have the time or staff to make employee benefits a priority. Because a program such as SBHI is subsidized to keep

premiums low, the traditional use of sales brokers, who are motivated by high commissions, is unfeasible. Brokers need to be offered some sort of additional incentives, or some other mechanism needs to be designed to shepherd potential clients through the enrollment process.

2. **Benefit coverage must meet the personal needs of employers and their families.** Many small business owners base their insurance purchasing decisions largely on the needs of their own families. Low cost is a major attraction, but they are likely to reject plans—no matter how inexpensive they are—if they restrict coverage to any geographically narrow provider network and there is no option for out-of-network coverage. Small business owners may live in different neighborhoods than their employees, often farther away from their company locations, and their dependent children may live completely out of the area (e.g., at college). Greater flexibility of coverage can be achieved in a number of ways, such as offering an optional rider for out-of-network coverage, or allowing each employer and his or her employees to select from a range of benefit options through a purchasing cooperative or one of the "health insurance supermarkets" that are being developed as part of the emerging "defined benefit" approach to employment-based health insurance. States, local governments, and other program sponsors could promote the growth of purchasing cooperatives and supermarkets that include SBHI-like low-cost plans among their choices.

LESSONS FROM A SMALL BUSINESS HEALTH INSURANCE DEMONSTRATION PROJECT

BACKGROUND

The lack of health insurance among employed New Yorkers is a large and growing concern. In New York State in 1999, 73 percent of workers were offered insurance by their employers, but only 65 percent were eligible for enrollment, and only 55 percent accepted coverage—a proportion that had declined from 58 percent in 1995. This left 1.4 million working people in the state uninsured. Among employees of small firms, the picture was even bleaker, with only 41 percent of workers in businesses with fewer than 25 employees even being offered insurance coverage.[4]

The absence of employment-based health insurance affects not only workers in small businesses, but also their spouses and children. Nationally, 20 percent of the 11 million children who were uninsured in 1988 had parents who were employed by businesses with fewer than 100 workers. Of the 18.8 million children in such families, only 51 percent had employer-based coverage, compared with 75 percent of the children of employees working for larger firms.[5]

With health insurance premiums rising since 1996, more small business owners have been discontinuing their insurance plans, eliminating coverage for family members, or increasing their employees' out-of-pocket costs in the form of premium contributions and deductibles—which many low-wage workers cannot afford.[6] In 1998, 27 percent of the entire under-65 population in New York City was uninsured, a proportion that had risen from 20 percent in 1990,[7] and is likely to rise further, with the current downturn in the economy.

The Small Business Health Insurance (SBHI) demonstration was conceived by the city's Mayor's Office as one of several pilot projects to address the lack of health insurance among New Yorkers, particularly employees of small businesses. It is an innovative joint effort of a provider organization, the New York City Health and Hospitals Corporation (HHC), and an insurer, Group Health Incorporated (GHI), with support from the Mayor's Office of Health Services and the NYC Department of Health's Office of Health Care Access.

GHI provides very comprehensive coverage with only modest copayments and deductibles, as shown in Table 1. Eligibility for SBHI is limited to businesses with between two and 50 employees, regardless of prior insurance status. The premiums for

SBHI are approximately half of the usual market rates: $99.80 per month for employee-only coverage, $161.29 for an employee and one or more children, $224.02 for an employee and spouse, and $235.22 for full family coverage.

SBHI was designed as a demonstration project for businesses located in selected areas of New York City, as shown in Figure 1. In Brooklyn, the demonstration area includes the neighborhoods of Bushwick, Williamsburg, Greenpoint, and parts of Bedford-Stuyvesant and Fort Greene, with a population that is predominantly black and Hispanic, but also includes large numbers of recent immigrants from China and Poland. The demonstration area in the South Bronx covers the Highbridge, Morrisania, Fordham, Tremont, Westchester, Hunts Point, and Mott Haven communities, which have largely Hispanic populations. In Manhattan, the predominantly Hispanic East Harlem community, and parts of the ethnically mixed Upper West Side and Morningside Heights neighborhoods are included. With the exception of the Upper West Side, the demonstration area is a mix of extremely poor and working-class neighborhoods.[8]

These neighborhoods are served by two of HHC's six networks: the North Brooklyn Network (Woodhull Medical and Mental Health Center and its ambulatory care satellites) and the Generations Plus Network (Lincoln Medical and Mental Health Center in the South Bronx, Metropolitan Hospital Center in northern Manhattan, and their satellites). Except in emergencies, SBHI benefits provide coverage only for services provided by facilities in these two networks. This limitation, and the steep discount that HHC has applied to their usual billing rates, are the primary factors that allow GHI to offer its extremely low premiums for SBHI. HHC also provides outpatient prescription drugs to SBHI enrollees through its in-house pharmacies, with only a $5 copayment per prescription. In addition, HHC hired Nurse Care Coordinators, dedicated to SBHI, to welcome and orient new enrollees, assist them with appointments, and facilitate their use of clinic and pharmacy services on-site.

Another distinguishing feature of SBHI is its use of "community marketing" to supplement promotion of the program through direct mailings to small businesses. HHC hired Health Insurance Specialists (HIS), and GHI selected brokers familiar with the target communities. Together or separately, the HIS workers and brokers visited small businesses and made presentations at local business and community groups. Flyers and posters were produced, and advertising was placed in local and ethnic newspapers.

The first company enrolled in the program in December 1998, and its employees began to utilize services in January 1999. The program began in earnest in March 1999,

with GHI's direct mailing to 10,017 small businesses in the demonstration areas. Due to limited enrollment, the SBHI demonstration was terminated in October 2001, and GHI is no longer accepting applications from companies wishing to enroll. GHI and HHC are still providing SBHI insurance coverage and medical services for the employees of those firms that are already enrolled, and GHI is exploring alternatives to continue their coverage in another, more viable low-cost insurance program.

EVALUATION METHODOLOGY

PricewaterhouseCoopers LLP (PwC) was asked to evaluate the impact of the SBHI demonstration, and funding for this purpose was provided by The Commonwealth Fund, HHC, and the New York City Department of Health's Office of Health Care Access.

The evaluation methodology developed by PwC was refined in conjunction with a Data Workgroup, composed of representatives from HHC's Generations Plus and North Brooklyn Networks, the central office of HHC, GHI, the Office of Health Care Access, and the Mayor's Office of Health Services.

Because of the limited enrollment in SBHI, several quantitative analyses originally planned could not be carried out (e.g., definitive analyses of the fiscal impact of the program on GHI and HHC), and a more qualitative analysis was performed, focusing on the lessons to be learned from SBHI's modest growth, and the perceptions of employers, employees, and HHC and GHI executives concerning the program's impact. The following sources of information were used for this report:

- a total of 1,385 requests for more information received by GHI in response to direct mailings, advertisements, outreach efforts, news stories, and other sources;
- the enrollment forms completed by 40 of the companies entering the program;
- 54 questionnaires completed by employees newly enrolled in SBHI;
- a focus group of nine small business owners who enrolled in SBHI;
- a focus group of eight small business owners who had requested more information about SBHI, but did not enroll;
- a telephone survey of 300 non-enrolling businesses;

- utilization data provided by the two participating HHC networks;
- GHI's lead tracking files and enrollment rosters;
- 13 interviews with representatives of HHC, GHI, the Mayor's Office of Health Services, the New York City Department of Health's Bureau of Health Care Access, the New York Health Purchasing Alliance, and the New York Business Group on Health; and
- narrative reports and data provided by several other small business health insurance demonstration projects and subsidy programs.

To place the rate of SBHI's enrollment growth in context, and to evaluate the impact of various factors on the program's appeal to potential purchasers, three other efforts to provide affordable health insurance to small businesses were examined in detail:

- The New York State Regional Pilot Project (RPP) was a statewide initiative that included a demonstration in Brooklyn operated by the Health Insurance Plan of Greater New York (HIP). The program began in 1989, enrollment was frozen in 1993, and continuing enrollees were transferred into the NYSHIPP program (see below) in 1997. RPP provided subsidies of 50 percent of the HIP premium for firms that had not been providing health insurance and had 20 or fewer employees. Employers paid the other half of the premium, and there was no employee contribution. RPP resembled SBHI in its comprehensive range of benefits. It also was similar to SBHI in its limitation of services to a specific provider network: HIP health centers. HIP's network, however, was much more extensive, covering all five boroughs of New York City and much of the suburbs. Marketing in RPP was primarily through direct mailings and telephone calls to small businesses. Instead of using insurance brokers, HIP partnered with the Brooklyn Economic Development Corporation to perform door-to-door solicitation of small businesses. As in SBHI, all employees of an enrolled firm were required to enroll in RPP if they did not already have coverage (e.g., under a spouse's plan).[9]
- The New York State Health Insurance Partnership Program (NYSHIPP) is also statewide. In 1996, all companies remaining in RPP were transferred into this new program. The enrollment of new companies was limited by each year's state funding cap, with preference given to low-wage firms. NYSHIPP provides subsidies of up to 45 percent of premiums to businesses with fewer than 50

employees (including sole proprietorships) that had not been providing health insurance. Employers are responsible for the remaining 55 percent, but can choose to require their employees to contribute up to 10 percent. Not all uninsured employees of a firm are required to participate, and employees hired after the start of each funding year are not eligible for coverage until the next annual enrollment cycle. By 1999, when new enrollment in the program was ended, 34 insurance plans were offered through NYSHIPP, including HMO, POS, and indemnity plans, but—unlike the HealthPass multiplan program (described below)—NYSHIPP requires all covered employees in a given company to choose the same health plan. Plans were marketed through direct mailings, distribution of material through state legislators, telemarketing, coverage in local media, and a toll-free "NYSHIPP Hotline." Brokers were not involved in sales, but NYSHIPP contracted with MDI Associates as an "Outreach Contractor" for the program. By 2003, continuing members will be transitioned into the new Healthy New York program, which aims at reducing premiums by providing HMOs and other insurers with stop-loss protection, as NYSHIPP is phased out.[10]

- HealthPass has been operated since late 1999 by the New York Health Purchasing Alliance, a subsidiary of the New York Business Group on Health. Like SBHI, it is supported by the New York City Mayor's Office. HealthPass offers insurance plans from four carriers: Physicians Health Services, Horizon Healthcare, HIP (as in RPP), and GHI (as in SBHI). Each insurer offers closed-panel (HMO or EPO) plans with two levels of copays, and open panel (PPO or POS) plans with three levels of copays, for a total of 20 benefit options. Various prescription drug options increase the number of choices further. As in SBHI, all sales are made through insurance brokers. Marketing involves direct mailing, print and broadcast media, and an interactive website, through which prospective clients can obtain detailed information and estimated premium quotes. Companies located in all areas of New York City and having between two and 50 employees are eligible, whether or not they had been providing health insurance in the past. At least 75 percent of the uninsured employees in a firm are required to participate. HealthPass, alone among the programs discussed in this report, allows each employee to choose a different plan, and facilitates the process by providing each employer with a single enrollment form, a single monthly invoice, and a central customer service number. Unlike the other programs, there is no subsidization of premiums, but HealthPass provides guaranteed issue at premium prices that resemble those paid by large firms. The level of employee contributions, if any, is up to the discretion of each employer.[11]

LESSONS FROM SBHI'S LIMITED ENROLLMENT

Early in the planning for what would become SBHI, a market research firm explored the extent of interest in this type of low-cost health insurance among small businesses in the program's target areas. Thirty percent of owners responded that they were "very likely" to purchase a plan with the features and premium price of SBHI.[12] Based on this research, it had been anticipated that 3,000 previously uninsured employees of small businesses would enroll in SBHI over a two-year period. By December 1, 2000, two years after its inception and 21 months after large-scale marketing efforts began, only 53 small businesses, with 311 employees and 166 spouses and dependent children had enrolled in SBHI (a total of 477 covered lives).

Several other efforts to provide low-cost health insurance to similar populations in the New York City area experienced more rapid growth. These included the three programs described in the preceding section of this report. As shown in Table 2, which summarizes their main features, the numbers of New York City businesses, employees, and covered lives enrolled in each of the three programs were at least twice as large—and often 10 times as large—as they were in SBHI at similar points in their development.[13] Because enrollment in HIP-RPP was limited by state subsidy caps and demand was high, substantial waiting lists developed. The same has been true of NYSHIPP. After HealthPass had been in existence for 11 months, it had enrolled 18 times as many employees as SBHI had during a similar period, and covered 24 times as many lives.[14]

In theory, the rate at which cumulative enrollment in an insurance product grows is influenced by three main factors:

1. The adequacy of marketing—its nature, scope, and intensity. This is reflected most immediately in the volume of "leads" (requests for more information) that are generated.

2. Actual sales, which largely reflect two factors: (a) the effectiveness with which the sales force pursues leads, and (b) the attributes of the insurance product that attract or discourage potential purchasers.

3. Customer retention: once employers and employees have enrolled, their satisfaction with the program influences retention and the rate of disenrollment.

The results of our evaluation—particularly the survey of companies that heard about SBHI but did not enroll and the focus groups of business owners who did and did

not choose to enter the program—suggest that inadequate marketing played a role in limiting the growth of SBHI, but that the second group of factors (those determining whether a lead becomes an actual sale) had the largest impact. Those employers and employees who did enroll in SBHI were generally very pleased with it, so dissatisfaction and disenrollment were not significant problems. In fact, the high level of member satisfaction makes the program's failure to thrive all the more unfortunate.

Marketing

Previous demonstration projects have shown that selling health insurance to small businesses is extremely difficult.[15] The small employer typically has a narrow profit margin. Though many may wish to offer health insurance benefits, even low, subsidized rates may be seen as prohibitively expensive.[16] Similarly, the employee in a small business typically has a low salary and little disposable income to spend on his or her share of a health insurance premium.[17] Many small businesses are in industries in which health insurance is not traditionally provided, and many owners and employees in urban areas are recent immigrants who may be unfamiliar with health insurance as an employee benefit. In the face of these barriers, significant, repeated, and sustained marketing is essential.[18]

In the first year of the SBHI demonstration project, the total spent on marketing by GHI and HHC combined was less than $250,000 (plus the salaries of HHC staff involved in community outreach efforts and some portion of the commissions GHI paid to brokers who participated in community outreach). The first year sales and marketing budget for HealthPass was approximately seven times as large.[19]

The initial marketing effort for SBHI occurred in March 1999, when GHI identified 10,017 small businesses in the SBHI target areas, and sent them each one direct mailing (in both English and Spanish). Unfortunately, businesses in several of the target area zip codes in Brooklyn and most of the target area zip codes in Manhattan were inadvertently omitted from the mailing list. During and after the mailing, HHC Health Insurance Specialists and brokers selected by GHI visited small businesses and community groups, but no advertisements were placed in local newspapers until six months later, no second mailing was distributed until 15 months later, and the bulk of the flyers and posters that had been printed for the program were not distributed during the first year. At the inception of the Brooklyn RPP program, by contrast, 22,000 businesses received one (and usually two) direct mailings, and 17,000 received follow-up telephone calls.[20]

At the end of September 1999, six months after the first GHI mailing, eight owners of small businesses who had received the mailing but had not enrolled in SBHI

attended a focus group. When they were asked why they had not enrolled, several stated that they had "not been ready" at the time they were first contacted. Perhaps it was "a bad month" for their firms. They had not necessarily decided against enrolling, and might still do so if a reminder reached them "at the right time."

Despite the lack of thoroughness and intensity in the initial marketing of SBHI, the response it elicited was comparable to response rates in similar programs. In the first full year of the RPP program, 6.3 percent of the 22,000 small businesses in Brooklyn that had been contacted by HIP responded by requesting more information,[21] generating 1,386 "leads." In the first year of the Albany portion of the RPP program, 7.6 percent of the firms contacted by Community Health Plan requested additional information.[22] These response rates are not much higher than the 6.0 percent response rate from target area businesses generated over just 10 months by the first SBHI mailing.

The second and third SBHI mailings, distributed in June and July 2000, were sent to a larger number of businesses (23,000 vs. the original 10,000). They not only acted as reminders, but also covered the 21 target zip codes mistakenly omitted in the first mailing. The materials mailed out in June and July emphasized two points that had been identified as major attractions by the focus group of small business owners who enrolled in SBHI: coverage for prescription drugs, and the assistance provided by Nurse Care Coordinators.

The flow of response cards and telephone calls requesting more information about SBHI confirms the effectiveness of SBHI's expanded but somewhat belated marketing efforts. Six weeks after the initial mailing to small businesses, GHI had received 524 requests. During the next eight and a half months, after increased GHI and HHC outreach and the placement of advertisements in local newspapers, an additional 325 requests were generated. After another eight and a half months, during which outreach continued and two more rounds of direct mailings were sent out, another 536 requests were received, for a total of 1,385.

The repeat mailings also appear to have contributed to actual sales of SBHI policies, especially in the large portions of the Manhattan target area that had been omitted from the initial mailing. In the 15 months between the first mailing and the second mailing, 25 businesses enrolled in SBHI, including only two in Manhattan. Within just six months of the second mailing, an additional 26 companies enrolled, including seven in Manhattan.

Certain marketing components appear to have been effective in generating interest in SBHI. Table 3 is a tabulation of requests to GHI for more information concerning SBHI, sorted by the respondents' answers to the question, "How did you first hear about SBHI?" Figure 2 displays the percent distribution of these responses from firms located within the SBHI target areas and firms located elsewhere. Of the 1,385 requests that were received through October 4, 2000:

- The largest proportion (35 percent of all responses and 39 percent of responses from businesses located in the program's target areas) were in response to direct mailings.

- The second largest response (38 percent of target area responses) was to visits by HHC outreach staff and GHI brokers.

- Smaller but significant numbers of inquiries were prompted by newspaper advertisements and TV news coverage of the program, but these were largely from companies outside of the demonstration areas, which were not eligible for participation in SBHI. It is difficult or impossible to focus publicity or advertisements in the mass media appropriately for a demonstration program that only covers a small geographic area. City- or statewide programs, such as HealthPass and NYSHIPP, are able to use such promotional media more effectively.

- A smaller number of inquiries were attributed to contacts at HHC facilities and community meetings, and even fewer were in response to other aspects of community marketing (flyers, newsletters, and posters), or to the business owners' colleagues, friends, or employees. The brief reference to SBHI on GHI's website generated only one inquiry.

Of 1,007 requests for more information from companies located in the SBHI target areas, the largest number of businesses (469) were located in North Brooklyn, followed by the South Bronx (274), and northern Manhattan (264). Heavily represented among the respondents were businesses in the food and restaurant, consumer services, consumer goods, and health and medical industries.

Sales: Effectiveness of Sales Force Follow-Up

More intensive initial marketing of SBHI might well have yielded more early "leads" to give the demonstration a vigorous start, but even more serious difficulties arose in

attempting to convert leads into actual sales. The 53 businesses enrolled in SBHI represented only 5.3 percent of the 1,007 target area businesses that had expressed interest. By comparison, HIP's RPP program had enrolled slightly over 10 percent of the companies that requested more information during its first year of existence.[23] These poor sales results appear to have been related to lack of sales follow-up and the failure of the insurance product itself to appeal sufficiently to small business owners.

Quantitative information about the sales follow-up process emerged from the telephone survey of business owners who had not enrolled in SBHI, which was conducted by Schulman, Ronca, & Bucuvalas, Inc. between December 20, 1999 and February 4, 2000. The survey targeted employers from among the 10,017 firms that had received the first mailings about SBHI in March 1999. Respondents included 101 business owners who had contacted GHI for more information, and 199 who had not. Much of the respondents' reluctance to enroll in SBHI had little to do with the program itself, but rather related to factors like high employee turnover and their reliance on part-time workers. However, their responses suggest that more persistent follow-up would have been worthwhile:

- Only half of the 101 respondents who had requested more information remembered ever hearing of SBHI, and only 36 percent recalled asking for more information.

- Of those who remembered requesting more information, 46 percent rated their contact good or excellent, while 54 percent rated it fair or poor, and 59 percent thought it would have been helpful if someone had followed up again, to see if they wanted additional information.

- Of those who said they were still in the market for health insurance, 85 percent indicated that the survey researcher should forward their names to GHI for additional follow-up. (These 35 names were forwarded in late February 2000. Over the next few months, all were contacted, but none enrolled.)

Shortly after the survey, in March 2000, a focus group was held for small business owners who were enrolled in SBHI. Nine people attended, representing SBHI target areas in all three boroughs. The attendees provided more detailed information about the sales process. They were enthusiastic about the program itself, but six of the nine complained that the process of obtaining additional information and completing the enrollment procedure required great effort and persistence. Several stated that they had to make

numerous calls to GHI before reaching anyone who was familiar with SBHI. Others complained about brokers who did not return their calls or failed to appear for appointments they made. The attendees said that they had finally managed to join the program only because they had pursued enrollment as a high priority, and several had eventually reached one specific broker who was helpful. They suggested that other business owners probably tried to enroll but abandoned the effort due to similar frustrations.

It was pointed out in interviews with GHI and HHC senior management that the brokers assigned to SBHI were chosen by GHI because of their close ties to the target communities. However, their financial incentives for selling this very inexpensive product, which selectively attracts the smallest of businesses, were very weak. The brokers receive, as a commission, the same 6 percent of the first year's premium, whether they sell a plan with a $99.80-per-month premium to a company with five employees, or a $250-per-month plan to a company with 20 employees. Given the difference in potential remuneration, they may have concentrated their efforts on selling more expensive plans to larger companies.

Sales: Attributes of the Insurance Product

As mentioned previously, the attractiveness of an insurance product marketed to small businesses appears to depend on whether or not the product meets the highest priority *personal* needs of the business owners themselves. An analysis of 40 SBHI company enrollment forms supported this impression. We found that most employers who joined the plan paid a relatively low proportion of the premium for employee-only coverage, and a higher proportion of the premium for family coverage. (This is the reverse of the usual pattern in larger companies, where employers routinely contribute either an equal or smaller share of the premium for family coverage: nationally, in 1996, employers paid 82 percent of individual premiums and 64 percent of family premiums.[24]). In SBHI, employers indicated that they were contributing, on average, 64.8 percent of the individual premium and 71.6 percent of the family premium. Eleven of the 40 employers chose to pay a higher proportion of the SBHI premium for family coverage than for individual coverage, with seven employers paying 100 percent of the family premium but zero to 50 percent of the individual premium. Only seven employers chose to pay a higher proportion for individual coverage, and the remaining 22 paid equal proportions for individual and family coverage.

The September 1999 focus group session for small business owners who had responded to the initial marketing of SBHI by calling GHI or sending postcards requesting

more information, but who had not enrolled, provided an explanation for this unusual observation. The focus group was attended by eight owners of very diverse small businesses, including a publishing company, an air-conditioning repair service, a driving school, a day care center, a graphic design firm, a nonprofit housing agency, and two special events/party-planning firms.

There was a striking difference between those considering SBHI coverage for themselves and their families (relatively hesitant), as opposed to those considering it as a benefit for their employees (quite positive). For their own families, their highest priority was inexpensive catastrophic coverage, with wide choice of physicians and out-of-area coverage. For their employees, they felt that any very-low-cost coverage that included routine medical care was reasonable. The members of the focus group said they would react positively to an affordable SBHI-like product that also had an optional rider for out-of-network and out-of-area coverage. (This would provide them with choices similar to those available in a multiple-option plan like HealthPass.)

Information gathered in the telephone survey of 300 small businesses that had not enrolled in SBHI provided quantitative support for these impressions. After hearing a description of the plan and being asked to name its best and worst features, 46 percent thought that the program's exclusive use of HHC hospitals and doctors was a positive feature, but 15 percent thought that being restricted to *any* relatively small group of providers was a negative feature, and another 15 percent thought that the restriction to HHC per se was a negative feature. When asked "How interested would you be in the plan for your company if you had the option of purchasing additional benefits for yourself and your family?" 70 percent indicated that they would be interested, and 46 percent would be very interested. Commonly cited additional benefits of interest included a larger choice of doctors (18%), a larger choice of hospitals (10%), and out-of-area coverage or an expanded coverage area (7%).

Finally, the March 2000 focus group of business owners who did enroll in SBHI provided additional details on this topic. These very small businesses averaged around four employees each. These were typically the owner, the owner's spouse or adult child, and two nonrelatives. Owners stated that the SBHI product, with its very-low-cost and comprehensive coverage, was an excellent idea for the two unrelated employees, but did not meet the needs of their own families. They often lived farther away from the business and from the participating HHC hospitals, and several had out-of-area dependents (e.g., children at college). They regretted SBHI's lack of out-of-area and out-of-network coverage, but had enrolled because of strong commitments to their longtime employees,

or the need to offer health insurance in an industry with a high level of competition for skilled employees. Some had purchased supplemental coverage, outside of SBHI, for their own families.

One solution to the disparity between small business owners' perceptions of the needs and financial constraints of their employees and themselves is exemplified by HealthPass. At the end of 11 months of operation, enrollment of 1,733 subscribers in the array of plans offered by HealthPass was distributed as shown in Table 4.[25]

HealthPass has not collected information separately on the enrollment of employers and their employees. Based on information gathered in the evaluation of SBHI, however, it is a fairly safe assumption that the two lower-cost, closed-panel plans (which most closely resemble SBHI and together account for 56.4 percent of total enrollment) have predominantly been attracting low-wage employees, and perhaps young employees with little expectation of illness. The highest cost, open-panel plan (which includes coverage for out-of-network/out-of-area providers) has been the second most popular choice, accounting for 19.7 percent of total enrollment. It has probably been chosen largely by employers, higher-wage employees, and those with existing chronic illnesses in their families. The greater attraction demonstrated by more rapid enrollment in HealthPass appears to be due, in part, to the fact that enrolling individuals do have these options.

Sales: Other Factors

The focus group and telephone survey of business owners who did not choose to enroll in the demonstration program provided additional information about the potential market for low-cost health insurance:

- Fifty-five percent of the 300 businesses surveyed were not providing health insurance for their employees, including 8 percent that once offered health insurance but had discontinued it, mainly due to cost. The employers who were offering health insurance were paying—on average—$229 per month for an individual premium (2.3 times the SBHI premium). In theory, therefore, a substantial market exists for a very-low-cost plan.

- The surveyed businesses tend to be fairly stable, with 73 percent in business for more than five years, and 54 percent in business for more than 10 years. The median size of the companies responding was seven employees: three full-time and three part-time, plus the owner. Employee turnover is lower than might be expected: two of three full-time employees have been with the company for more

than five years. These characteristics should make many of these businesses relatively good prospects for health insurance.

- Forty-two percent of the business owners (and 27 percent of their employees) were born outside of the United States, suggesting that employment-based health insurance may be a relatively new concept for them. A marketing program that included effective and, perhaps, multilingual education about the nature and benefits of health insurance might be an effective approach to sales in such a community.

- Perceptions of HHC were predominantly positive concerning inpatient care, but mixed concerning ambulatory care. HHC's participation in the SBHI demonstration is the prime factor allowing for the program's very low premiums, so it is important to note that strong or widespread aversion to the public hospital system was not a major reason why more employers were not attracted to the program.

- The focus group's positive attitudes about HHC were based on the inpatient experiences of friends and relatives of four group members (good medical and nursing care). Only one group member had a vague but strong negative perception of HHC, and one other member had reservations about "how good the medical care is in public hospitals" in general. These two and one other had experienced or heard about long waiting times and "poor staff attitudes" in HHC outpatient departments.

- The telephone survey revealed an important difference between the perceptions of respondents who had never received care at HHC facilities, and those who had. When non-users were asked to rate the care they might expect to receive at HHC hospitals, 31 percent responded excellent or good and 30 percent fair or poor. However, when those who had received care at HHC were asked for an overall rating, 69 percent responded excellent or good, and 27 percent fair or poor.
    - The aspects most frequently rated excellent or good were the location of HHC facilities (84%), the quality of the doctors (69%), the quality of other staff (63%), and facilities and equipment (61%).
    - The unsolicited positive comment that respondents most frequently made concerned the perceived competency of the doctors.

- The aspect most frequently rated fair or poor was administrative services (30%).
- The unsolicited negative comment most frequently made had to do with "long waiting times."

Customer Retention

Employer and employee dissatisfaction leading to disenrollment from the plan has not made a significant contribution to SBHI's limited cumulative enrollment. In fact, enrolled employers and their employees have been very pleased with the program. As of December 1, 2000, only five of the 53 companies that had enrolled in SBHI had exited the program, and one reenrolled a month after disenrolling. Four permanent disenrollments from SBHI over a two-year period (7.5%) does not appear to be an unreasonable rate when compared with the experience of HealthPass during its first 11 months: 312 firms enrolled and 16 (5.1%) left the program.[26]

Two of the four companies leaving the SBHI program permanently were terminated for failure to pay their premiums, one changed insurers for an unknown reason, and one had to disenroll because none of its employees chose to join the plan. None of the four cited dissatisfaction with services or covered benefits as a reason.

The nine business owners who attended the March 2000 focus group for enrolled companies were enthusiastic about the program. One stated that he had come to the session because he had heard that the SBHI demonstration might be terminated, and he wanted to "help save it." Several other attendees voiced agreement with this. All nine owners agreed that they would recommend the program to their friends and business associates. They were particularly pleased with the program's low cost, its comprehensive coverage (especially the provision of outpatient prescription drugs), and the direct access to specialists facilitated by the program's lack of primary care "gatekeeper" requirements.

Those business owners who had personally used HHC services under the program (or whose family members had used them) were very enthusiastic about the assistance provided by the Nurse Care Coordinators. They referred to the Care Coordinators at Lincoln and Woodhull Hospitals by name, had clearly established relationships with them, and related stories about how the two women helped them and their relatives with appointment scheduling, obtaining pharmacy services, and understanding physicians' instructions. They complained vigorously about the recent termination of the Care Coordinator role at Lincoln Hospital, and pointed out that there are many "hassles" and

delays in HHC outpatient departments when Care Coordinators are not available to assist patients.

Comments written on some of the 54 intake forms completed by newly enrolled SBHI members also praised the assistance obtained from the Nurse Care Coordinators, and commented positively on the continuity of care they received from HHC's primary care physicians. There were a few complaints, however, about long waits (especially for pharmacy services) and rude ambulatory care staff.

Summary Comparison of Four Programs

Among the four programs geared to providing health insurance to small businesses and their employees that we have examined, there appear to be three areas in which SBHI equals or excels the attractiveness of other programs, and four ways in which SBHI is at a disadvantage.

Relatively slow growth in SBHI cannot be attributed to the three areas in which SBHI is at least equal to programs that grew more rapidly:

- SBHI is not less attractive due to high cost to employers. None of the other programs had lower premiums. Because of state subsidies, the employer's share of the premiums in HIP-RPP and the lowest-cost plans participating in NYSHIPP were roughly equal to the SBHI premium. The lowest premiums in HealthPass are twice as expensive as the SBHI premium.

- SBHI does not offer less comprehensive coverage. SBHI's scope of coverage, with its inclusion of outpatient prescription drugs, is equal to that provided by the most comprehensive HealthPass plans, and broader than the coverage provided in the other programs and other HealthPass options.

- Limitations on enrollment in SBHI were somewhat stricter than in HealthPass, but not more restrictive than in the other two programs. None of the four programs accepted employee groups larger than 50. HIP-RPP, like SBHI, excluded enrollment by sole proprietorships, and required virtually all employees to enroll for a company to be eligible. In addition, RPP and NYSHIPP—unlike SBHI—excluded companies that had offered health insurance in the recent past, and NYSHIPP excludes employees hired by a participating employer after the close of each year's enrollment period.

All three of the more successful programs, however, share four important features that distinguish them from SBHI and appear to have contributed to their more rapid enrollment growth:

- Eligibility for HealthPass is citywide, and the other two programs were statewide initiatives. This allowed HealthPass and the New York City components of the other programs (e.g., the HIP-RPP program in Brooklyn) to benefit from the visibility and "name recognition" that can be generated by broader promotion through the mass media.

- Marketing efforts at the beginning of the HealthPass program were more extensive and thorough than they were for SBHI. According to written accounts and budgets, this was also true in the early months of the NYSHIPP and HIP-RPP programs.

- There is evidence of more aggressive sales follow-up in the three other programs as well. Brokers have greater financial incentives to pursue sales of the more expensive HealthPass products. In both HIP-RPP and NYSHIPP, brokers were replaced by contracted partner organizations.

- In various ways, each of the three relatively successful programs offered small business employers access to a greater choice of providers than does SBHI, and more flexibility to meet the needs of their own families. Only the HIP-RPP program resembled SBHI in restricting services to a single provider network, but that network was geographically broader than SBHI's, covering all of New York City and many suburbs. NYSHIPP offered each enrolling company a wide choice among 34 health plans. HealthPass, which has been the most successful of all in terms of early enrollment growth, provides the greatest flexibility, offering each employer and employee a personal choice among 20 benefit options, plus several levels of prescription drug coverage.

SBHI'S IMPACT ON EMPLOYERS AND EMPLOYEES

Because of the small enrollment during the first two years of SBHI, the demonstration cannot provide definitive information on the impact of this type of health insurance on small business employers and employees. There is suggestive data, however, concerning its ability to attract the previously uninsured, to affect employee recruitment and retention, and to bring about changes in the use of health care services.

Providing Health Care Coverage to the Previously Uninsured

Intake questionnaires, in both English and Spanish, which were mailed to new enrollees by the SBHI Nurse Care Coordinators provided information concerning health insurance and health care utilization by individual SBHI members in the period before SBHI enrollment. If no questionnaire was returned, the Care Coordinators administered them when enrollees came to the hospitals for their baseline visits. If no baseline visits were scheduled, the Care Coordinators attempted to administer the questionnaires by telephone. Through the end of January 2001, 54 employees completed intake questionnaires, providing information about themselves, 13 spouses, and 28 children enrolled in SBHI, for a total of 95 covered lives.

Fifty-two of the 81 people for whom responses were entered (64%) reported having no third-party health care coverage before enrolling in SBHI, and only 29 people (36%) had some form of coverage: 12 (four employees, one spouse, and seven children) had private insurance, eight (three employees, one spouse, and four children) had Medicaid coverage, three children were covered by Child Health Plus, and six (two employees, one spouse, and three children) had coverage of an unknown type.

As for the businesses themselves, completed enrollment forms from 40 companies show that 32 (80%) had not provided health insurance to their employees before joining SBHI.

With 80 percent of enrolled companies and 64 percent of individual members lacking prior health insurance, SBHI was clearly more focused on ameliorating the problems of the uninsured than programs such as HealthPass. Only 52 percent of companies enrolling in HealthPass did not previously provide health insurance, and only 24 percent of members did not have third-party coverage before joining.[27]

Improving Employee Recruitment and Retention

Our data indicate that small business enrollment in the SBHI project did play a role in attracting and retaining employees. Of 54 employees completing SBHI intake questionnaires, 25 (46%) stated that they were "more likely to stay with this company because of SBHI coverage," 12 (22%) said they were not more likely to remain, 16 (30%) did not know or left the answer blank, and one said, "Irrelevant—I'm the owner!"

Eleven of the 54 employees stated that they began working with their current employers after the employers enrolled in SBHI, and six of the 11 (55%) answered yes to the question, "Was the fact that this company offers health insurance one of the reasons that you took this job?"

Improving Patterns of Health Care Utilization

The data presented in Table 5 and Figure 3 suggest that SBHI exerted a positive impact on enrollees' health care by encouraging a shift from emergency room use to scheduled ambulatory visits and possibly causing a decrease in hospital admissions.

These results can only be considered suggestive, however, because of the small numbers involved and differing sources for information about utilization during two time periods. For services received prior to enrollment in SBHI, we relied on self-reported information from the intake questionnaires, while information on services received after enrollment until the end of December 2000 is based on tabulations compiled by the Generations Plus and North Brooklyn Network SBHI Coordinators.

For purposes of comparison, utilization rates in Figure 3 are expressed in terms of visits per person per month and admissions per person per 12 months. The intake questionnaire asks employees for the number of visits and admissions that family members had "in the past year," and we assumed that the responses reflect roughly 12 months of utilization. For utilization since enrolling in SBHI, effective dates and termination dates for 496 covered individuals who enrolled on or before December 15, 2000, were used to calculate the total number of member months through December 31, 2000 (3,391).

The most striking and encouraging finding is the increase in the rate of scheduled ambulatory physician visits from 0.08 to 0.10 per person per month, and the concomitant decrease in the rate of emergency room visits from 0.05 to 0.01. There also appears to have been a 50 percent decrease in the hospital admission rate, although the number of admissions may be too small to be reliable.

Only 55 percent of adult SBHI enrollees had complete checkups in the three years before joining the program and only 43 percent reported having "a regular doctor." After joining SBHI, enrollees received 79 additional "complete checkups" at baseline visits, and every beneficiary who made at least one appointment was assigned a primary care provider.

SBHI'S IMPACT ON PARTICIPATING PROVIDERS AND INSURERS

Financial Impact

Because of the small enrollment in SBHI, there is not nearly enough utilization and reimbursement data to perform a meaningful quantitative assessment of the program's financial impact on the sponsoring insurer and participating provider network. The data that do exist do, however, suggest that several negative impacts that might be anticipated

by an insurer or hospital participating in such a program do not appear to have materialized.

Table 5, which is based on the tabulations completed by HHC Network Coordinators, shows that SBHI enrollees made 324 scheduled ambulatory visits to HHC (i.e., exclusive of emergency room visits), for a rate of 1.15 visits per person per year. This is quite low. (HMOs and POS plans submitting HEDIS report cards for 1999 reported 3.03 and 2.94 visits per member per year for commercial and Medicaid members, respectively.) The SBHI hospital admission rate of 0.04 per member per year was also lower than the 1999 HEDIS commercial and Medicaid rates of 0.05 and 0.10 per member per year.[28] SBHI enrollees are younger, on average, than the general commercial HMO/POS population, but not younger than Medicaid enrollees. These low rates occurred despite the fact that the SBHI population is newly enrolled, and 79 of the 324 encounters (24.4%) were baseline visits. These data would suggest that insurers contemplating participation in such a program need not fear a high early utilization rate (and a disadvantageous medical loss ratio) due to previously unmet needs. Hospitals, on the other hand, should not look forward to a high volume of services generating extensive revenue.

None of the 40 employers who enrolled in the SBHI program and submitted enrollment forms for our analysis had transferred from other GHI insurance plans with higher premiums. It is also clear that SBHI is not merely paying HHC steeply discounted rates for the continuing care of established HHC patients who once had more generous third-party payers. Most enrollees are new to the HHC system: of 95 covered individuals described on the intake questionnaires, only eight were reported to have used HHC facilities in the prior year, and only three of the eight had third-party coverage immediately before enrolling in SBHI.

Other Effects

In interviews, representatives of central HHC and the two participating networks discussed a number of impacts of the SBHI program not directly related to utilization or reimbursement. For one thing, the partnership that has developed between HHC and GHI is viewed as a major accomplishment, with considerable value for the corporation beyond the SBHI demonstration.

SBHI is also seen as a valuable learning experience. Senior staff were familiar with the literature on previous attempts to provide low-cost health insurance to small business employees, but firsthand involvement in SBHI is adding a much deeper understanding of

the difficulties involved. HHC is learning valuable lessons about marketing and is looking at communities and potential customers in new ways. They reported that they were learning "to think like an insurer" and "how to behave when patients have choices." Participating in SBHI has forced HHC staff to come to grips with the often negative public perception of their facilities and services in a way that has been very uncomfortable, but which is understood to be necessary in an increasingly competitive environment. These lessons are particularly important as members of HHC's traditional Medicaid population begin to make new choices under New York State's mandatory Medicaid managed care provisions.

Interviews conducted with GHI senior management revealed nonfinancial impacts on GHI that were quite similar to the effects of SBHI discussed in interviews with HHC representatives. The GHI executives agreed that the partnership with HHC and participation in new forms of community outreach had been valuable. Just as HHC staff valued "learning to think like an insurer," GHI staff noted that the SBHI experience is "teaching us to think about things from the hospital's point of view."

CONCLUSION

There appears to be a significant market for low-cost health insurance products like the one evaluated in New York City's Small Business Health Insurance demonstration. And the idea of achieving a below-market premium price by discounting the services of public hospitals with unused capacity is an intriguing one, especially if the program's enrollees represent new users of the hospitals' services or continuing patients who were able to pay even less in the past. It would also seem that such a program can have positive impacts on the utilization patterns and satisfaction of those who enroll, while at the same time avoiding any undue financial risks for the participating insurance company.

Despite all these appealing features, SBHI failed to attract more than a handful of business owners. How can future efforts to address the need for health insurance among employees of small businesses build on the positive aspects of SBHI, but achieve more vigorous program growth?

The answer may lie in more careful market analysis early in the design of such programs. For several decades, public health planners have been borrowing problem-solving techniques from the advertising industry and applying them in the "social marketing" of preventive programs. These techniques have become common in family-planning and infectious disease control efforts in the developing world.[29] Similar thinking needs to be applied more rigorously to the design and marketing of insurance products for

the previously uninsured here in the United States. Specifically, program planners must use focus groups and other market research methods to understand the thinking of the individuals who will be making the purchasing decisions—the small business owners who offer the insurance, as well as small business employees who decide whether to enroll. Price is obviously a crucial factor for both types of customers, but additional considerations can make the difference between a successful program and one that fails.

One consideration is the need for an extremely user-friendly enrollment process. The insurance company involved in a small business demonstration project must be committed to its success at the highest levels of management and must communicate this commitment to the frontline staff who interact with potential customers by telephone, mail, and in person during the information-gathering and enrollment processes. The brokers who play a major role in assisting business owners to choose and enroll in a health plan are customarily compensated for their efforts with a percentage of the premiums paid to the insurance company. With a program aimed at enrolling the uninsured and the smallest of businesses, which relies on subsidies or other mechanisms to keep premiums very low, brokers must be offered additional compensation or other incentives to promote that program.

A second challenge lies in the area of network and benefit design. The SBHI insurance product appeared to satisfy employers' requirements for the coverage of their employees, but not for the coverage of their own families, due to its geographically limited provider network. This suggests that an insurance plan that minimizes premium costs by limiting coverage to the care received from a specific network of providers—whether public or private—is much more likely to be successful if the participating network is a geographically broad one, or if the plan is offered as one of several choices. In order to be attractive, this choice among plans must be offered to individuals, rather than at the group level.

Such flexibility can be achieved in a number of ways, such as offering each enrolling employee the opportunity to purchase a rider for out-of-network coverage, or the ability to select from a range of benefit options through a purchasing cooperative like the HealthPass program described in this report. Either one of these mechanisms could be adapted for use in programs in which states or localities provide subsidies to a range of health plans enrolling small business employees, such as the indirect subsidies (stop-loss coverage) provided in the new Healthy New York program.[30]

The purchasing cooperative model is currently gaining in popularity. In one "defined contribution" approach, employers purchase their coverage through a "health insurance supermarket" that offers a range of benefit options, while employers limit their contribution to each employee's premium to some preset amount. Government could promote the growth of such models, in which employees would have a choice between a very-low-cost plan with a limited network and other more expensive plans with broader networks, out-of-network coverage (preferred provider or point of service options), or totally open choice among providers (an indemnity option). The low-cost plan could resemble SBHI, with access limited to a public hospital system offering discounted rates.

There is every likelihood that an inexpensive health insurance plan like SBHI can play a role in expanding health insurance for small business employees, but only if it actively recruits small business owners and assists them in enrolling in a program that is flexible enough to meet the needs of both their employees and their own families.

Table 1. Small Business Health Insurance Summary of Covered Services

Service	Benefit	Out-of-Pocket
Medical/Surgical Inpatient Admission*	365 days of care, includes: semi-private room and board, physician services, operating and recovery room, intensive and special care units, X-ray, lab tests, anesthesia, prescribed drugs, physical and occupational therapy (limited to 1st 30 days per admission), radiation therapy, chemotherapy, and maternity admissions	In-network $250 deductible per admission** Out-of-network $500 deductible per admission**
Ambulatory Surgery*	[In-network only] outpatient facilities and physician services	$100 copayment per procedure
Emergency Room Treatment*	Emergency room facility services	In-network $50 copayment (waived if admitted) Out-of-network $150 copayment (waived if admitted)
Preventive Care	[In-network only] annual adult physical, prenatal and well baby care, immunizations, pap smear and mammography screenings	None
Office Visits	[In-network only] physician visits unlimited except: Allergy and Speech Therapy 16 visits Physical Therapy 10 visits	$15 copayment per visit
Chiropractic Care	[In-network only]	$15 copayment per visit
Lab, Pathology and Radiology	[In-network only]	None
Mental Health Services*	[In-network only] 30 inpatient days per year	$250 deductible per admission**
	20 outpatient visits per year	$25 copayment per visit
Substance Abuse Services*	[In-network only] 30 inpatient rehabilitation days per year, 7 detoxification days per year	$250 deductible per admission**
	60 outpatient visits per year	$25 copayment per visit
Home Health Care*	[In-network only] 100 visits/person/year	20% of Allowed Charges
Home Infusion Therapy*	[In-network only]	None
Durable Medical Equipment	[In-network only] *Precertification for items over $2,000	$100 deductible $4,000 maximum/person/year
Hospice*	[In-network only] 210 days/person/lifetime	None
Skilled Nursing Facility*	[In-network only] 210 days/person/lifetime	None
Pharmacy	Prescription drugs covered by HHC at HHC facilities. (This is not a GHI covered benefit.)	$5 copayment

* Precertification is required.

** $500 maximum annual deductible.

Source: GHI.

Table 2. Comparison of SBHI and Other Small Business Health Insurance Subsidy Programs in New York State: Major Features and Early Enrollment

PROGRAM	Cost to Employer	Scope of Coverage	Limitations on Enrollment	Area Included in Program	Marketing	Sales Follow-Up	Choice of Providers	NYC ENROLLMENT AFTER 11 MONTHS OF OPERATION		
								Enrolled Companies	Employee Contracts	Covered Lives
SBHI	Very low	Comprehensive	Strict	Small: N. Brooklyn, S. Bronx & N. Manhattan	Limited	Limited	Restricted to geographically narrow network	22	95	126
HealthPass	Moderate to high	Moderately broad to comprehensive	Less strict	Large: New York City	Extensive	Active	Choice among 20 benefit options with varying networks	296	1,733	3,022
NYSHIPP	Very low to moderate	Moderately broad	Strict	Very large: New York State	Fairly extensive	Active	Choice among 34 plans with varying networks	221	618	Not Reported
RIP	Very low	Moderately broad	Strict	Very large: New York State	Fairly extensive	Active	Restricted to geographically wide network	138	220	610

These data reflect current enrollment in each program at the end of its 11th month in operation: i.e., after deducting businesses, employees, and covered lives that had disenrolled. Due to differences in reporting, the 11th month is the only month for which data is available for all four programs.

- For SBHI, Month #1 was March 1999 (when the first mailing was distributed).
- For HealthPass, Month #1 was December 1999.
- For NYSHIPP, Month #1 was November 1997. Only businesses and employee contracts in New York City are counted here. (The program is statewide.) Businesses "grandfathered" into the program from RPP are not counted.
- For the portion of the RPP (which was also statewide) involving New York City (HIP in Brooklyn), Month # 1 was May 1989.

Sources:

- SBHI; GHI Enrollment Roster
- HealthPass; Personal communication. M. Brown, New York Health Purchasing Alliance
- NYSHIPP; Personal communication. R. Bielefeldt, New York State Department of Health
- RPP; Status Report on the Regional Pilot Projects, NY State Department of Health

Table 3. Initial Source of Information for Companies Requesting More Details About SBHI

Source of Information	Companies Citing Each "First Source of Information" About SBHI	
	Target Areas	Non-Target Areas or Location Unknown
Direct Mailing	395	95
Visit by "SBHI Representative" (GHI and/or HHC)	385	39
HHC Staff or Facility	71	17
Newspaper Article or Advertisement	40	67
TV News Story	14	84
Community Meeting	18	4
Newsletter, Poster, or Flyer	3	0
Colleague or Friend	7	12
Employee	1	2
Fax	6	3
GHI Website	0	1
None Specified	67	54
TOTAL, ALL SOURCES	1,007	378

Source: GHI 10/4/2000 Lead Tracking File.

Table 4. Distribution of Health Plan Enrollment in HealthPass

Benefit Option	Copayment	Premium for Individual Coverage	Percent of Subscribers Enrolled
Plan 1: Closed-panel (HMO & EPO) plans	$15 per visit	$209–$258	44.5%
Plan 2: Closed-panel (HMO & EPO) plans	$20 per visit $500 per admission	$198–$233	11.9%
Option 1: Open-panel (PPO & POS) plans	$10 per visit	$285–$323	19.7%
Option 2: Open-panel (PPO & POS) plans	$15 per visit	$274–$307	13.0%
Option 3: Open-panel (PPO & POS) plans	$20 per visit $250 per admission	$226–$236	10.9%

Source: Enrollment as of November 15, 2000. Personal communication with Michelle Brown, New York Health Purchasing Alliance.

Table 5. The Impact of Health Insurance Coverage on the Utilization of Health Services by Small Business Employees and Their Dependents

	Utilization	
Utilization Measure	In the Year Before Joining SBHI N = 95	Since Joining SBHI N = 496
Number of Scheduled Physician Visits in Ambulatory Settings	89	324
Number of Emergency Room Visits	59	38
Number of Hospital Admissions	8	10

Sources:

- For the year before joining SBHI: 54 completed enrollee intake questionnaires covering 95 individuals: 28 adult women, 39 adult men, and 28 children.
- For period after joining SBHI: Numerators based on tabulations by Network SBHI Coordinators. Denominators based on GHI Weekly Enrollment roster (496 SBHI members with effective dates on or before 12/15/2000, with a total of 3,391 member months of enrollment through 12/31/2000).

Figure 1. SBHI Demonstration Areas and Participating HHC Hospitals

New York City

Figure 2. Initial Source of Information for Companies Requesting More Details About SBHI

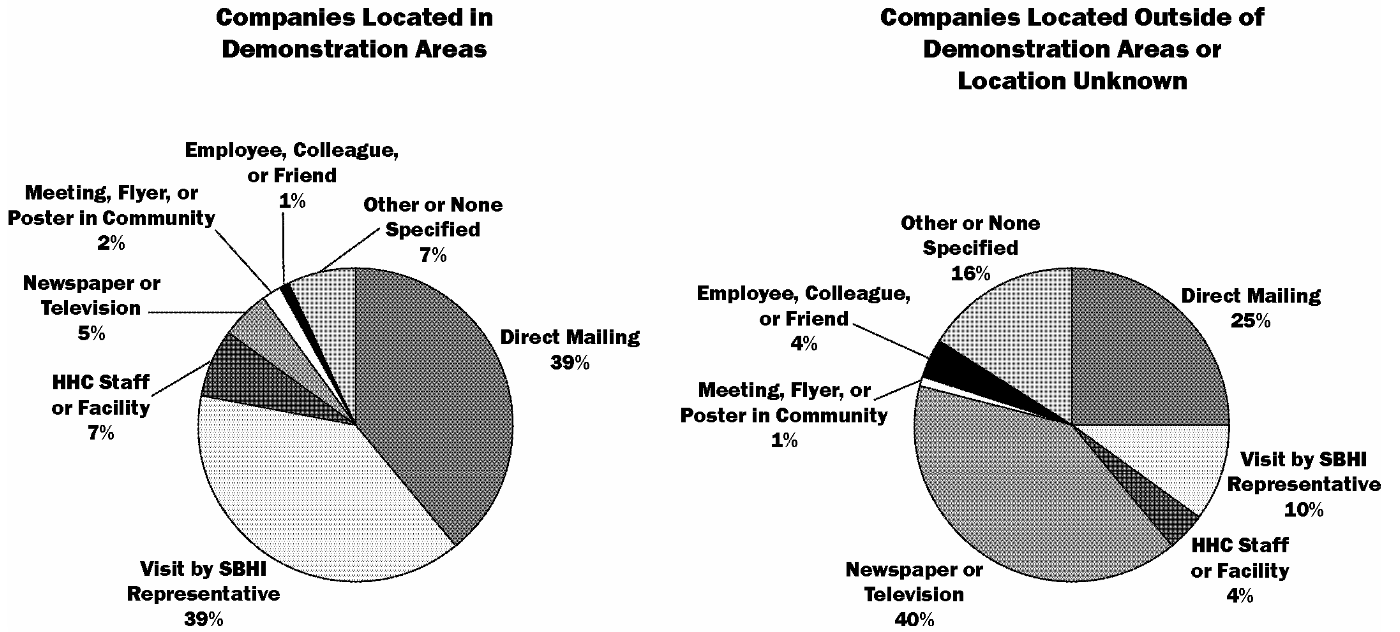
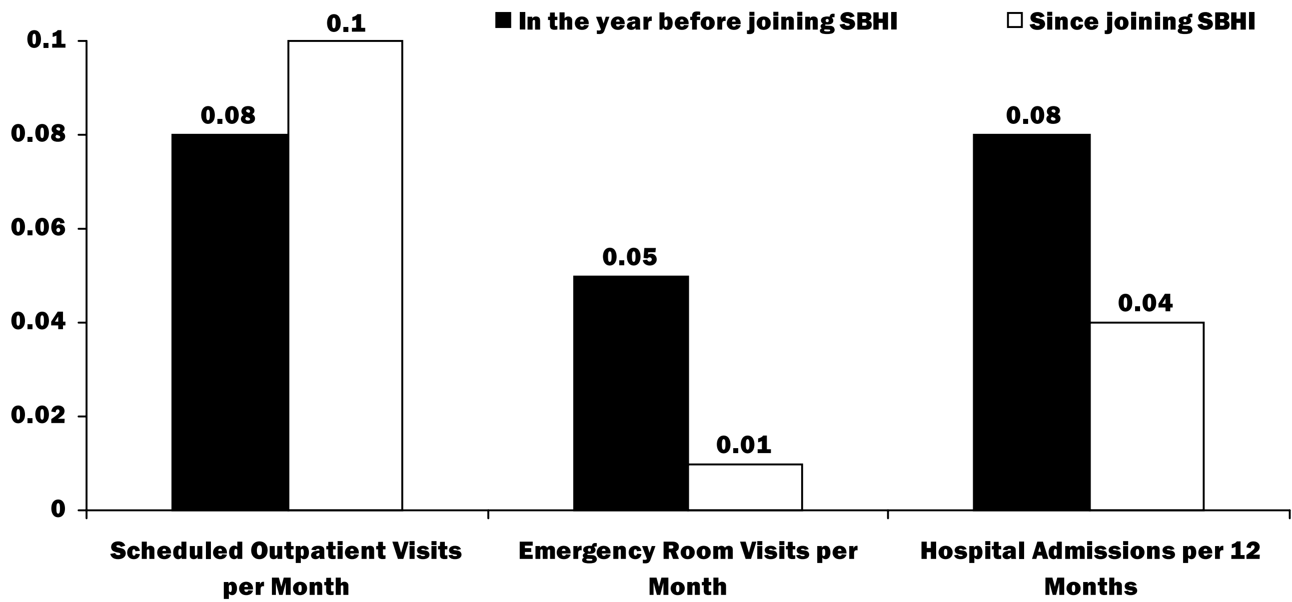


Figure 3. The Impact of Health Insurance Coverage on the Utilization of Health Services by Small Business Employees and Their Dependents



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#485 *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication #424 (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#349 *Health Care in New York City: Understanding and Shaping Change* (September 1999). David R. Sandman. This issue brief highlights Fund programs that have been implemented to protect health care access for New York City residents—especially its low-income citizens—in the face of rising uninsurance, the move to mandatory Medicaid managed care enrollment, and the increasing strain on the city's safety net providers and academic health centers.

NOTES

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[9] New York State Department of Health, *Status Report on the Regional Pilot Projects for the Uninsured* (Albany, N.Y.: New York State Department of Health, June 1990); The Bronx Health Plan, *The Regional Pilot Project Program Nine Years Later: What Have We Learned About Serving the Uninsured in New York?* (New York: The Bronx Health Plan [on behalf of HIP of Greater New York, Empire Blue Cross Blue Shield, Community Health Plan, and The Bronx Health Plan], August 5, 1998); K. Thorpe, A. Hendricks, D. Garnick, et al., *An Evaluation of New York State Regional Pilot Projects for the Uninsured: Final Report* (Albany, N.Y.: New York State Bureau of Community Health Insurance and Finance Systems, January 1992).

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[14] Michelle Brown, New York Health Purchasing Alliance, personal communication (December 19, 2000).

[15] K. Thorpe, A. Hendricks, D. Garnick 1992.

[16] W. Jacobson 2000.

[17] K. Thorpe and C. Florence 2000; W. Jacobson 2000.

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