BUSINESS INITIATIVES TO EXPAND HEALTH COVERAGE FOR WORKERS IN SMALL FIRMS

VOLUME I: OVERVIEW AND LESSONS LEARNED

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EXECUTIVE SUMMARY

More than 80 percent of uninsured Americans live in households where at least one resident is employed. About 47 percent of the working uninsured are employees of small businesses (those with fewer than 100 workers).[1] Health insurance offer rates at smaller businesses have increased over the last few years—67 percent of small firms offered insurance in 2000, up from 54 percent in 1998. However, that increase pales in comparison with the rate for businesses with 200 or more workers, 99 percent of which offered coverage in 2000.[2] These data suggest that improving coverage levels for small businesses might be one way to tackle the problem of the uninsured. While this is easier said than done, a number of public and private organizations in the United States are taking steps to help small businesses offer health insurance by identifying and minimizing the obstacles these businesses face in the insurance market.[3]

This report assesses the potential of private-sector efforts to improve small firms' access to insurance coverage. We discuss ways in which large employers are helping to expand coverage options for small businesses; the challenges of this strategy; the effectiveness of such initiatives so far; and what it would take for this strategy to become an important and viable element of a larger effort to reform the U.S. health care system.

Summary of Findings

In essence, a market-based solution teams small business with private entities that have what small firms lack—experience and knowledge of the market, clout, and the staff required to make things happen. Our research shows that large employers are involved in helping small firms get coverage only to a limited extent—individual employers, on their own initiative, are not reaching out to help smaller businesses. However, over the past five to ten years, several business coalitions have voluntarily used their influence and familiarity with the market to help small employers get better access to affordable coverage. Some of these initiatives have made a difference; others have died or failed to make it beyond the design stage.

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[1] Paul Fronstin, "The Working Uninsured: Who They Are, How They Have Changed, and the Consequences of Being Uninsured" (Washington, D.C.: Employee Benefit Research Institute, Issue Brief No. 224, August 2000).

[2] Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET), *Employer Health Benefits 2000 Annual Survey* (Chicago: American Hospital Association, 2001), 33.

[3] A recent Commonwealth Fund report by the Economic and Social Research Institute documents the efforts of states in this area. See Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (New York: The Commonwealth Fund, February 2001).

How It Happens

Business coalitions usually use one of two mechanisms to help small firms get health insurance. We call the simpler model "network access." In it, coalitions give small firms access to the coalition's provider networks and associated discounts. Typically, insurers and third-party administrators handle the marketing, sales, and servicing of the small-business accounts. The business coalition itself usually has little to do with the network once it has been launched. The network access model is the basis for current health insurance products that originated with The Alliance in Madison, Wisconsin; the Health Care Network of Wisconsin in Milwaukee; and the Buyers Health Care Action Group in Minneapolis. It was also the approach of the Memphis Business Group on Health, which participated in a six-year collaborative effort to expand coverage options for small firms. Volume I of this report includes brief descriptions of these programs.

Volume II contains detailed examples of the second and more complicated model, the "cooperative," in which coalitions develop and manage new organizations that enable small companies to become part of a larger health insurance buying pool. There are case studies of the small-group insurance products of four organizations: The New York Business Group on Health, New York City; the Pacific Business Group on Health, San Francisco; The Alliance, Denver, Colorado; and The Alliance, Madison, Wisconsin.

The Southwest Michigan Healthcare Coalition in Kalamazoo implemented a variation on this model that did not get past the start-up stage; Volume I includes a short profile of this initiative.

Why Large Employer Groups Get Involved

Most health insurance access programs for small businesses have been operating since the early to mid-1990s. Our research suggests that seven factors motivated employers to take action:

1. To secure the future of an employer-based system: Some employers recognize that small firms' poor access to affordable health care coverage poses a threat to the viability of the employer-based health insurance system.

2. To satisfy a sense of corporate responsibility: The contributions of many people who support these programs are consistent with the goal of some business leaders to be "good corporate citizens."

3. To raise all boats: Many business coalitions regard it as their mission to make health insurance coverage a better value for all employers in the community, not just coalition members.

4. To increase bargaining power: The decision of some coalitions to reach out to small firms is part of a larger strategy to increase the number of lives the coalition represents for contracting and negotiating purposes.

5. To keep government out of the way: Particularly in the early 1990s, some coalitions regarded small-business programs as a way to prevent the federal government from intervening in the health care market.

6. To help themselves by helping others: Some large employers want to help maintain the competitiveness of smaller businesses because those firms are their partners and customers.

7. To generate incremental income: Finally, and for a few employer groups, small-business programs can be a source of income. This is not a common scenario.

Why Large Employer Groups Cannot Do This on Their Own

ESRI's research suggests that employer groups are unlikely to be the primary force behind solving small businesses' insurance access problems. The first—and probably most important—reason is that employer groups are not really interested in playing this role, nor should they be expected to solve these problems on their own. The second reason is that even when employer groups are interested, their commitment may not be sufficient to get an initiative past the design stage. Finally, projects that do make it off the ground face a number of administrative and financial hurdles that keep them from achieving their goals:

1. Typically, these programs cannot offer small businesses better rates than they can get on their own.

2. Large employer groups often lack sufficient clout with insurers to effect changes in the program once it has been launched.

3. Small-group programs are expensive to launch and manage. It can take years for them to become self-sufficient.

4. Large employers' expertise in health care purchasing does not always translate into knowledge of the small-group market.

5. State regulations usually give these programs limited leeway to design health plans that can meet the needs of small employers and offer advantages over insurers already in the market.

Lessons Learned

- Small-group programs sponsored by large employer coalitions do not have much of an effect on lowering the number of uninsured. With the exception of New York's HealthPass program, only 10 to 20 percent of the companies that enrolled in these programs since the mid-1990s are offering insurance for the first time.

- Since these programs have not been able to offer lower rates than the outside market, they have not been able to overcome the biggest barrier facing small businesses—affordability.

- Although size is a problem, programs set up by business coalitions to assist small firms are faced with a classic "Catch-22": they need to represent a large number of lives in order to negotiate good rates and spread the risk, but they cannot attract the number of lives they need because the costs are too high.

- What these programs have done well is to enable small firms to offer choices to their employees. While this has value to some businesses, it does not appear to be a compelling reason to buy coverage.

Policy Implications

The primary policy implication of our research is that private-sector sponsored health insurance initiatives are not the panacea that some proponents would like them to be. If a higher level of coverage in the small-business sector is the goal, the public sector will have to step in to make private insurance more accessible and affordable. To the extent that employer groups' programs fill a niche in the market, the public sector could facilitate a market-based strategy in three ways:

1. Stimulate the business community's interest in lending its expertise to smaller firms: While many employers are aware of the obstacles that small businesses face in the insurance market, most do not understand that this problem may threaten the employer-based system, nor do they know how they could contribute to a

solution. Also, those who may be interested do not necessarily know where to get advice and technical assistance.

2. Provide seed money and other resources to support a small-group program until it can be self-sufficient: In addition to funding, useful resources include technical advice, administrative support, office space, and/or staffing.

3. Give small-group programs the regulatory leeway to attract small firms:
While community rating has benefits for individual small employers, most employer-sponsored programs would like to be able to use their size to negotiate more competitive rates that are consistent with their ability to spread risk. If this is not acceptable to the government, it could implement policies (e.g., tax credits) that would increase the total number of people who have insurance coverage. At least some of the newly insured would be likely to gravitate to a coalition-sponsored health plan.

BUSINESS INITIATIVES TO EXPAND HEALTH COVERAGE FOR WORKERS IN SMALL FIRMS

VOLUME I: OVERVIEW AND LESSONS LEARNED

INTRODUCTION

Health policy experts have proposed a variety of strategies to assist the 38 to 39 million Americans who have no health insurance. Addressing this long-term problem will require some mix of public and private strategies, and feasible solutions should build on the strengths of the employer-based system. These strengths include ease of enrollment (about nine of 10 workers eligible for employer-based coverage sign up)[4] and the preference of many workers for obtaining coverage through their employer. A 1999 Commonwealth Fund survey found that 56 percent of those with job-based health insurance preferred that employers continue to be the main source of coverage for workers; 15 percent preferred that government become the main source of coverage; and 20 percent preferred to buy coverage on their own.[5] The U.S. Census Bureau reports that 158 million people currently obtain coverage through the employer-based system. Given the strength and pervasiveness of the employment-based system for health care coverage, the job-oriented approach to expanding it could potentially reach many of the 82 percent of uninsured people from households with at least one part-time or full-time worker.[6]

About 47 percent of the working uninsured are employees of small businesses (defined as less than 100 workers).[7] Consequently, these firms have received much scrutiny from researchers, policymakers, and business groups trying to identify and minimize obstacles to offering health insurance. Thanks to the strong economy and tight labor market of the late 1990s, insurance offer rates have increased—while only 54 percent of businesses with three to 199 workers (small firms) offered coverage in 1998, 67 percent

[4] Dahlia K. Remler, Jason E. Rachlin, and Sherry A. Glied, "What Can the Take-Up of Other Programs Teach Us About How to Improve Take-Up of Health Insurance Programs?" (Cambridge, Mass.: National Bureau of Economic Research, Working Paper No. W8185, March 2001).

[5] The Commonwealth Fund Task Force on the Future of Health Insurance, *Listening To Workers: The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (New York: The Commonwealth Fund, January 2000).

[6] Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 1999 Data Update" (Menlo Park, California: Henry J. Kaiser Family Foundation, December 2000), 5. Prepared by Catherine Hoffman, Kaiser Commission on Medicaid and the Uninsured, and Mary Pohl, Urban Institute.

[7] Paul Fronstin, "The Working Uninsured: Who They Are, How They Have Changed, and the Consequences of Being Uninsured" (Washington, D.C.: Employee Benefit Research Institute, Issue Brief No. 224, August 2000).

did so in 2000 (Figure 1). Even at the smallest firms (those with three to nine workers), the offer rate rose from 49 to 60 percent in the same period. This level of coverage still pales in comparison with that of employers with 200 or more employees (large firms), 99 percent of which offered coverage in 2000. And only 35 percent of small firms with low-wage workers (defined as those in which at least 35 percent of employees earn less than $20,000 per year) offer coverage.[8]

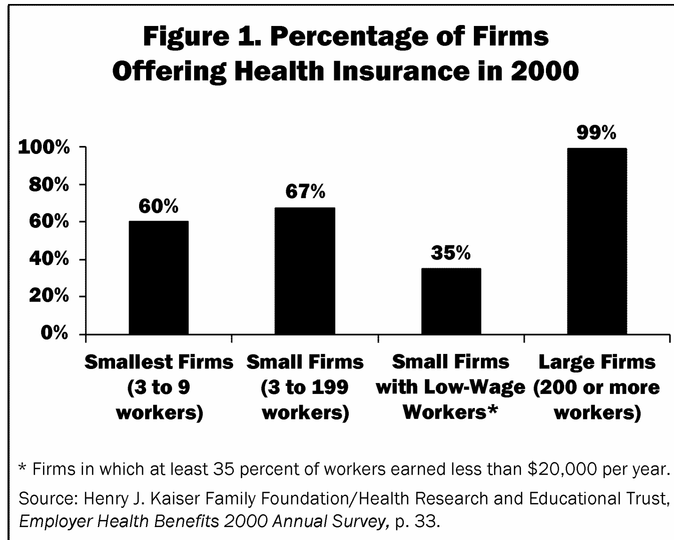

Figure 1. Percentage of Firms Offering Health Insurance in 2000

* Firms in which at least 35 percent of workers earned less than $20,000 per year.
Source: Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits 2000 Annual Survey,* p. 33.

What keeps small businesses from offering health insurance coverage? In most cases, the problem comes down to money. First, health coverage is more costly for small groups than it is for larger firms. Since insurers in the small-group market have fewer covered lives over which to spread the risk of serious or catastrophic illness, it is necessary to medically underwrite the groups. In addition, many small businesses use insurance brokers to help them select health plans, which adds to administrative costs. Thus, the loading charges, which include all administrative costs, are much higher in the small-group market. For example, one study showed that loading charges for businesses with fewer than 10 workers were five times as high (40%) as they were for businesses with 1,000 or more workers (8%).[9]

Frequently, health benefits are a small company's biggest expense after salaries. One reason is monopolistic pricing—in many areas, there is little or no competition in the small-group market. Indeed, in recent years, some insurers have steered away from marketing to small groups, fearing they will encounter adverse risk selection and churning (where groups select a new insurer each year). Another complicating factor is that states, to varying degrees, require that health coverage include a set of mandated benefits that may add up to an expensive package. While well intentioned, state mandates can reduce the likelihood of small firms offering coverage, yet "bare-bones" policies do not seem to

[8] Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET), *Employer Health Benefits 2000 Annual Survey* (Chicago: American Hospital Association, 2001), 33.

[9] Beth Fuchs and Mark Merlis, Private Health Insurance Options for Reform. United States Government Printing Office, Committee Print 101-35, 1990.

significantly affect offer rates.[10] In sum, it comes back to small employers' price sensitivity to the cost of coverage. (Most large employers are self-insured and thus are exempt from state mandates under the federal ERISA law.)

In addition to being high, health care costs for small businesses are increasing at a higher rate than for the market overall. In 2000, for instance, small firms' health care costs rose by an average of 10.3 percent, versus a 7.5 percent rise for firms with 200 or more employees.[11] Finally, insurance costs are unpredictable, and this can be a serious impediment for small businesses with constrained budgets. One major illness of one employee or dependent in a given year can cause the next year's rates to shoot through the roof.

Another factor that appears to stop small employers from offering coverage is employers' inability or reluctance to offer workers a choice of health plans. This problem is more prevalent among small businesses than among larger firms. In some cases, only one insurer is available or affordable; in others, the administrative work involved in offering more than one health plan is simply too complicated for an employer with no human resources staff. Consequently, only 9 percent of all workers employed by firms with fewer than 200 workers that provide coverage are offered a choice of plans. In contrast, 53 percent of firms with 1,000 to 5,000 workers offer more than one plan, and 84 percent of companies with 5,000 or more workers offer a choice.[12] In another twist on the choice issue, some businesses may be reluctant to offer coverage from an HMO, even if it is the only plan they can afford, because HMOs limit enrollees' choice of providers and point-of-service models charge workers more for out-of-network care.

Small businesses are not happy with this situation. Surveys conducted by the National Federation of Independent Business show that the ability to find affordable health care benefits has been the number-one concern of small firms for the past ten years or so.[13] But small businesses are poorly positioned to address this situation on their own. They have neither the expertise nor the clout to make the market work for them rather than against them. Moreover, small firms do not have experienced staff to devote to the administration and management of health benefits. Nearly all small companies that offer coverage depend on outside organizations—typically brokers and agents—to handle the administrative process for them.

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[10] Gail A. Jensen and Michael A. Morrisey, "Small Group Reform and Insurance Provision by Small Firms, 1989–1995," *Inquiry* 36 (Summer 1999).

[11] KFF/HRET, *Employer Health Benefits 2000 Annual Survey,* 17.

[12] KFF/HRET, *Employer Health Benefits 2000 Annual Survey,* 56.

[13] William J. Dennis, Jr., "Small Business Problems and Priorities" (Washington, D.C.: National Federation of Independent Business (NFIB) Education Foundation, 2000).

A market-based solution to this problem is to team small businesses with entities that have what small firms lack—experience and knowledge of the market, clout, and the staff required to make things happen. Over the past five to ten years, several coalitions of large U.S. employers have volunteered to use their influence in and familiarity with the market to help small employers get better access to affordable coverage options. Some of these initiatives have made a difference, but others have died or failed to make it beyond the design stage.

This study discusses what large employers are doing to expand coverage options for small business; the challenges of this strategy; the effectiveness of these initiatives to date; and what it would take for this strategy to become an important and viable element of a larger effort to reform the current health care system.

Goal of This Study

This study aims to assess the viability of relying on large employers to assist small businesses to offer affordable, high-quality, health care coverage. Our research tried to answer the following questions:

1. To what extent are large employers or coalitions of large employers interested and involved in helping expand access to health insurance coverage beyond their own population of employees and their dependents?

2. What are they doing to help small businesses get affordable, attractive coverage?

3. In what ways have they succeeded so far? How have they failed?

4. Is this strategy feasible? What is required to make it work?

5. Is it reasonable to expect large employers to take the lead in solving the problems small business faces in the health insurance market? What would it take to get more large employers involved in initiatives to help small businesses?

Methodology

In step one of this study, the Economic and Social Research Institute (ESRI) researchers sought out sites where coalitions of large health care purchasers are or have been involved in developing or implementing a vehicle for expanding health coverage options available to small employers. We also looked for examples of similar or related activities by individual employers. To help identify these sites, ESRI mailed a survey to 24 executive

directors of business coalitions and representatives of large employers. The survey was designed to capture basic information about health care buying practices and to identify any level of activity related to helping small firms gain access to health coverage. Our mailing list was based on ESRI staff's knowledge of large-purchaser activities and on information from experts in this area. We received 17 responses—eight from coalitions and nine from individual employers.

Using the survey responses, as well as new leads from knowledgeable sources, we conducted follow-up interviews with 10 coalitions that appeared to be working with smaller companies at some level. We sought information about their small-group initiatives (if any) and probed to learn more about how large employers regard the challenges that face small businesses and the uninsured.

The results of these interviews were intended to identify five sites for more extensive study. We had hoped to be able to present a variety of strategies that large employers are implementing to assist smaller firms in the insurance market. However, our research effort uncovered fewer examples of coalition-sponsored insurance programs than we had anticipated, and we found no examples of single employers acting on their own to help smaller firms. As a result, we honed in fairly quickly on the following four continuing programs—all sponsored by business coalitions—whose activities are extensive enough to merit a full case study:

- The New York Business Group on Health, New York, New York
- The Alliance, Denver, Colorado
- The Alliance, Madison, Wisconsin
- The Pacific Business Group on Health, San Francisco, California

ESRI staff conducted extensive interviews at each of these four sites with coalition staff, board members, representatives of health plans associated with the program, and other relevant parties. All of the programs profiled use the cooperative model, which enables employers to pool their lives and choose from a menu of insurance products. (See ESRI's recent report, *Barriers to Small-Group Purchasing Cooperatives,* for a more detailed analysis of this specific strategy.) Volume II contains detailed profiles of these programs.

We also identified three coalitions that have pursued a “network access” model, in which large employers make their provider networks (and associated discounts) available to small firms. While we provide brief descriptions of such initiatives in this volume, we did not produce any case studies because the model is fairly straightforward and generally requires little strategic involvement from the coalitions once they have negotiated access to the network. Since one or more insurers market the network and sell the coverage, small businesses may not even be aware that a coalition plays a role in making network access available.

Our research also uncovered three employer groups whose efforts to help small businesses with coverage either failed to get off the ground or were short-lived. Since all of these initiatives offer insight into the challenges of an employer-oriented strategy, the findings in this study are based on what we learned from all of our interviews, not just the ones that served as the basis for the profiles in the accompanying volume. Table 1 offers a brief description of all of the initiatives that are discussed in this study.

Table 1. A Summary of All Programs Cited in This Study

Coalition Name	Program Name	Location	Operating Since…	Covered Lives	Contact	Comments
Coalitions that offer access to coverage through the Cooperative Model						
New York Business Group on Health and New York City	HealthPass	New York, New York	December 1999	4,800 (as of June 2001)	Laurel Pickering, Executive Director 212-252-7440 Laurel@nybgh.org	Offers 20 HMO and POS plans from four health plans
Pacific Business Group on Health	PacAdvantage	San Francisco, California	July 1993; (PBGH took over in 1999)	140,000 (as of May 2001)	Chuck Kiskaden, Director of Marketing, PacAdvantage 949-766-1905 chuck.kiskaden@ pacadvantage.org	Offers HMO, POS, and PPO plans from 13 health plans
The Alliance	Cooperative for Health Insurance Purchasing (CHIP)	Denver, Colorado	1994	30,000 (as of May 2001)	Tom Rockers, CEO 303-333-6767 trockers@ alliance-ppo.com	Offers 16 HMOs through three plans; 5 PPOs through one insurer
The Alliance	The Alliance-Chamber Health Insurance Plan (A-CHIP)	Madison, Wisconsin	1994	3,000 (as of March 2001)	Cathy Mahaffey, Manager, Member Services and New Business 608-210-6638 cmahaffey@ alliancehealthcoop.com	Offers HMO and POS plans through one managed care plan

Coalition Name	Program Name	Location	Operating Since…	Covered Lives	Contact	Comments
Coalitions that use the Network Access model						
Health Care Network of Wisconsin	(same)	Milwaukee, Wisconsin	1991	148,000	Jim Wrocklage, CEO 262-641-2568 Hcnofwis@aol.com	Offers access to provider network through local insurance company
The Alliance	Small Employer Initiative (SEI)	Madison, Wisconsin	1994	2,270 (as of March 2001)	Chris Queram 608-210-6638	Leases provider network to two insurers serving small-group market
Buyers Health Care Action Group	Patient Choice Healthcare	Minneapolis, Minnesota	To be launched January 2002	N/A	Carolyn Perry, Executive Director 952-896-5185	Offers access to provider-based care systems developed for large employers
Coalitions that attempted small-group programs						
Memphis Business Group on Health	Business Group Health Insurance Alliance	Memphis, Tennessee	1994–2000	2,300 at its peak	Cristie Travis, CEO 901-767-9585 ctravis493@aol.com	Offered access to provider network; failed due to spiraling costs
Southwest Michigan Healthcare Coalition	Purchasing Alliance	Kalamazoo, Michigan	1999–2000	3,400, but none from small firms	Marilyn Bell, President and CEO 616-342-5525 m.bell@net-link.net	Tried to create a purchasing group with a mix of employer sizes
Midwest Business Group on Health	N/A	Chicago, Illinois	N/A	N/A	Jim Mortimer, President 773-380-9090 Mortimer@mbgh.org	In mid-1990s, never got beyond planning stage; currently evaluating new effort to expand HMO contract to smaller firms

Summary of Findings

ESRI applauds the efforts of large employer groups that have dedicated significant staff time and financial resources to help smaller firms get better insurance products. However, these efforts are few and far between, and have had limited success in achieving their goals. Given some government-supported enhancements, this strategy may hold some promise for communities where large employers are truly motivated to make it work. On the other hand, it is hard to envision a scenario in which this approach becomes commonplace, primarily because large employers generally do not seem to believe that they have much to gain by it.

What Large Employers Are Doing

When they are involved at all, business coalitions help small firms get coverage in one of two ways. In most cases, the large employer group creates (or in the case of the Pacific Business Group on Health, takes control of) a purchasing cooperative for small employers. For example:

- **The Alliance, Denver, Colorado**
  The Alliance was created in 1988 as a way for large employers to leverage their combined purchasing power in the local marketplace. In 1993–94, concerns about state and national legislative proposals to expand the government's role in the insurance market drove the group to implement a private-sector solution to the problems facing smaller employers. The Alliance formed the Cooperative for Health Insurance Purchasing (CHIP) to offer a choice of insurance products to small employers. Since that time, the CHIP has grown to serve over 1,800 employers. Through the CHIP, employers have access to three HMOs offering four products each, as well as PPO products available through an insurance carrier.

- **The Alliance, Madison, Wisconsin**
  Created in 1990, the Employer Health Care Alliance is a vehicle for midsize and large self-insured employers to engage in direct contracting with providers. Like the Denver Alliance, the group took steps in 1993–94 to develop fully insured products for the small business community: the Alliance-Chamber Health Insurance Plan (A-CHIP) and the Small Employer Initiative, which is discussed below. The A-CHIP represents a collaboration between the Alliance and local Chambers of Commerce, which offer the product to their small-group members (i.e., those with less than 100 employees). The product offers employers a choice of three HMO plans sponsored by one local health plan. While the A-CHIP has been very well received by the business community, the program has recently had to be scaled down in response to serious financial losses sustained by the health plan.

- **The New York Business Group on Health**
  The New York Business Group on Health (NYBGH) is a mixed-model coalition with a membership that includes large employers as well as various health care organizations. In late 1999, the group collaborated closely with the City of New York to launch the HealthPass program, a public–private initiative to improve the health care coverage choices available to small businesses and their employees. The Healthpass product includes four health plans, all of which offer five standardized benefit options. While state regulations prohibit the participating plans from offering more favorable prices through this program, a steady stream of employers has been attracted by the ability to offer employees a choice of insurers that together cover much of the tristate area of New York, New Jersey, and Connecticut.

- **The Pacific Business Group on Health**
  Based in California, the Pacific Business Group on Health (PBGH) is a purchasing coalition that represents large private and public employers across the west coast. In 1999, PBGH took over the Health Insurance Plan of California (HIPC), a small-employer purchasing pool that had been established by the state in 1993. The HIPC, now called Pacific Advantage (or PacAdvantage), represents over 140,000 lives across the state. PacAdvantage offers small employers a choice of HMO, POS, and PPO products through 13 health plans.

Volume II of this report provides a more comprehensive picture of these four initiatives.

In other cases, large employer groups are sharing their provider networks—and thus, the discounts they are able to negotiate—with small employers. For example:

- **The Alliance, Madison, Wisconsin**
  In addition to operating a buying cooperative called A-CHIP (see above and Volume II), The Alliance, a coalition of 175 employers, sponsors the Small Employer Initiative (SEI). SEI is a vehicle that enables The Alliance to give small employers access to discounts from its well-regarded network of local providers. The group does this by leasing its provider network to two insurers that underwrite small groups. Operating since 1993, SEI gives the small companies (and the two insurers) lower prices than they could get on their own. It is also a winning proposition for The Alliance, which gets more lives to use in its negotiations with the providers in the network and income from the leasing arrangement with the insurers. For more information about SEI, see the profile of A-CHIP in Volume II.

- **Health Care Network of Wisconsin, Milwaukee, Wisconsin**
  The Health Care Network of Wisconsin (HCN) is a purchasing group of nearly 400 employers that created its own preferred-provider network, with which it negotiated discounted rates. About ten years ago, HCN arranged with local insurance companies that underwrite small groups (between 25 and 100 lives) to offer access to its network to smaller, insured employers. HCN regarded this project as a community service because its members were concerned that providers might shift costs to the smaller employers as a consequence of HCN's negotiations. The group also saw this initiative as a way to augment the PPO's membership; over time, employees of the insured businesses that use the network and their dependents have come to represent 40 percent of the PPO's total of 372,000 covered lives.

- **Buyers Health Care Action Group, Minneapolis, Minnesota**
  The Buyers Health Care Action Group (BHCAG) is an innovative coalition of 27 large employers that has launched the newest initiative. In the late 1990s, BHCAG turned the local managed care market on its head by arranging for its self-funded members to buy health care services directly from care systems (networks built around unique groups of primary-care providers, rather than the handful of managed care organizations that had dominated the market). In 2000, BHCAG contracted with a new for-profit entity called Patient Choice Healthcare to manage Consumer Choice and raise the capital to bring it to the insured market. Current plans call for a January 2002 launch for fully insured employers in Minnesota; other potential markets for Consumer Choice include Denver (through the Alliance's small-business cooperative, profiled in Volume II) and Portland, Oregon. Although Consumer Choice is available only to employers with 50 or more workers, it may be offered to smaller employers in time.

  Perhaps the most intriguing aspect of this initiative is that BHCAG has operated as an incubator that transfers technology to a new company—i.e., a company separate from the business coalition that has a license to sell the product. This approach allows employers who do not want to be in the insurance business to avoid doing so, while creating revenue that can be funneled back to BHCAG to fund initiatives that benefit its members.

What Large Employers Have Achieved

Though clearly well intentioned, the large employer groups profiled in this study have not had much of an impact on reducing the ranks of working uninsured in their markets. Generally speaking, they have failed in efforts to offer small employers more affordable

coverage than they could get on their own. What they have done well is to create and manage insurance products that give small employers and their employees choices they would not otherwise have had. Thus, the programs described in this report clearly fill a need in the marketplace for employers who can afford coverage and want to offer choices. They also make it easy to offer options that small employers would find difficult to manage on their own. The HealthPass program in New York, for instance, simplifies the amount of administrative work required of employers.

On the other hand, there is little evidence that large employer groups' insurance products are attractive enough to induce small firms not previously offering health coverage to begin doing so. Small businesses are unlikely to become interested in offering coverage just because a specific plan is available.

The mixed results of these initiatives raise numerous questions about the feasibility of this approach. Perhaps more important, there is little evidence to suggest that large employer groups will imitate these efforts in significant numbers. A consistent caveat we heard in our research was that these projects are not easy, even for employer groups that consider themselves experienced and highly knowledgeable buyers of health care services. One respondent noted that every aspect of the design and implementation of the insurance program—including finding a cooperative third-party administrator, hiring staff, attracting health plans to participate, working with regulators, marketing to small employers, and developing relationships with brokers—was more challenging and more costly than anticipated. If there really is a role for large-employer organizations in expanding small businesses' access to insurance, the groups will need financial support, technical assistance, and possibly regulatory flexibility in order to become a workable and effective part of a reformed system.

MOTIVATING FACTORS: WHY LARGE EMPLOYERS GET INVOLVED

A few themes arose repeatedly in our interviews, but it was not clear whether or not our respondents' views reflect the beliefs of a majority of employers. Moreover, even if other employers do share our respondents' concern, it does not necessarily mean they would be willing to act on it. This dilemma was best expressed by a coalition director who noted that even though large employers may feel they bear some responsibility for the working uninsured and they should play some role in coming up with a solution, they simply do not have much time to spend on this problem.

Depending on the community, however, a number of different concerns may motivate large employers who do play a part in conceiving and/or implementing a program to improve coverage options for small firms. Employers and coalition directors cited the following as motivating factors in their decision to take action:

1. To secure the future of an employer-based system

Some employers explicitly link their interest in helping small firms (and through them, the working uninsured) to their interest in a continuing role for employers as the primary source of health care coverage. They are aware that some of their practices, particularly their success at negotiating lower costs for themselves, have played a part in forcing small employers out of the marketplace. They also recognize that the high number of uninsured Americans is likely to be the biggest threat to the future of the employer-based model, since many health policy experts regard some form of universal coverage that would replace the employer-based system as the only way to resolve this issue.

Employers who want to preserve the employer-based health care system feel the solution to the problem lies in taking advantage of market forces to enable small employers to bargain for and buy health coverage on an equal footing with large companies. However, they are not naïve about the current small-group market; they recognize that one cannot expect small firms to get what they need in a dysfunctional system. Consequently, there is some support for incentives that would make health insurance more affordable for small businesses as well as for changes in underwriting rules that would allow small firms to pool their lives in order to get more affordable group rates.

2. To satisfy a sense of corporate responsibility

Some representatives of large employers regard their participation in initiatives to help small businesses get better access to health care coverage as a form of corporate social responsibility. Several board members of HealthPass, the small-business insurance product

sponsored by the New York Business Group on Health (see Volume II), noted in interviews that their contributions to the project were consistent with their companies' desire to be good corporate citizens. These respondents also admitted to a personal interest in helping others by sharing their expertise and knowledge of the health care market. The element of benevolence also came up in the context of business coalitions, which often want to demonstrate that they serve a purpose beyond meeting the business needs of their members. Of course, large employers are not blind to the practical benefit, in that they pay at least some of the cost of caring for the uninsured through their taxes. (Some respondents suggested that they also pay when providers shift the costs of uncompensated care to employers who offer coverage, but others argued that the employers' strong negotiating tactics have limited providers' ability to do this.)

While there is nothing wrong with altruism as a motive, it is hard to sustain and even harder to replicate. Our research suggests that individuals, rather than corporate policy, are often the driving force behind the focus on helping small businesses and their workers. When that individual moves on, the corporation he or she represented may or may not continue to support an initiative to help small businesses. One respondent noted that the next person in his position might have a different interest, which would effectively put an end to his company's direct involvement in the project. This is not likely to be a problem with programs that are well established, like those in Denver and Madison, because the commitment to helping small businesses seems to become part of the coalition's culture. However, it could undermine newer programs that are more dependent on support from individual companies.

3. To raise all boats

Many business coalitions are concerned that their gains with providers and insurers have come at the expense of other businesses that have less negotiating clout. While their primary objective may be to meet the needs of their members, most coalitions' mission statements include an intent to drive changes in the entire local market so that everybody can pay less for high-quality health care services. Some express this in terms of their ambition to improve the health of the community.

The Denver Alliance, for example, was formed in the late 1980s as a way for smaller self-funded employers to benefit from the clout larger employers have with local providers. Its product, the Cooperative for Health Insurance Purchasing (CHIP; see Volume II) was an effort to expand that concept to reach the smallest of employers. The Madison Alliance also refers to its insurance product for small firms as part of an effort to maintain a community-wide perspective on health care reform.

4. To increase bargaining power

Several coalitions noted that they wanted to help small firms so the coalitions could represent more lives and bring more business to the providers and health plans with which they contract. Coalitions in both Madison and Milwaukee have found that making their provider networks available to small businesses has strengthened the coalitions' hand in negotiations. In Milwaukee, in fact, employees of small businesses and their families make up 40 percent of the lives in the purchasing group's PPO. Even a buying group as large as the Pacific Business Group on Health, which represents about 3 million lives, is eager to embrace small business in order to have more leverage with the very big health plans in its market area.

A related benefit for some coalitions is that their efforts can lead to greater visibility in the community, which can help to attract new members and may heighten pressure on providers and health plans to be cooperative.

5. To keep government out of the way

In a few cases, the threat of government intervention has served as an impetus for employers to step into the fray. In Colorado, for instance, the CHIP was conceived as an alternative to a government-led initiative to broaden coverage for workers and their dependents. At the same time national health care reform proposals were being considered in the early 1990s, Colorado's state legislature was proposing its own solutions, which the business community did not welcome. The California HIPC—since taken over by the Pacific Business Group on Health (see Volume II)—was also a byproduct of the comprehensive reforms proposed during President Clinton's first term. In this case, however, the purchasing group was intended to be part of a broader strategy to institute universal coverage, not a way to avoid the need for it.

6. To help themselves by helping others

Assistance to small firms can also be a good business move. Small businesses are important as business partners or customers of some large employers. The small firms' ability to recruit and retain skilled workers by offering competitive benefits can have a direct effect on their sales and profits, which in turn affects the sales and profits of the large firms with which they interact.

Other large employers recognize that they have a stake in maintaining a varied employment market. A diverse and healthy small-business sector can help large companies recruit new workers who may be concerned about the ability of their family members to find employment in the same locality. By offering good benefits, small firms also make the

local economy more competitive vis-à-vis other markets and help to attract job seekers. For example, unemployment has been very low, and entrepreneurial ventures and start-ups are common in the Madison, Wisconsin, area. The Madison Alliance believes that it is playing a role in supporting the growth of these new companies by making health insurance more accessible.

As a related benefit, the spouses and dependents of a large company's workers may have access to small businesses' health care coverage, giving them an additional source of insurance. The availability of more options can translate into lower costs for the large employer when dependents select coverage under another plan. If the quality and cost of that other plan is attractive enough, the large company's own employees may even join their spouse's plan. Employers may also find that employee retention and productivity improve when workers know that their families' health care needs are being addressed.

7. To generate incremental income

Finally, small-business insurance products are a source of additional income for a few employer groups. The Pacific Business Group on Health makes money by administering PacAdvantage. It uses the revenue to help fund its quality-improvement initiatives. SEI also generates a small amount of income for The Alliance in Madison.

However, creating insurance products for small businesses is not a winning financial proposition for most business coalitions. The Madison Alliance makes no money on its A-CHIP program, which it has been managing and marketing *pro bono*. It is too soon to tell whether or not New York's HealthPass will be profitable, or at least self-supporting, but the program is under a great deal of pressure to break even by the time the City of New York withdraws its financial support. While the New York Business Group on Health did not launch this project to make money, neither is it in a position to support it financially.

The question of income is a tricky one for the organizations that administer small-group insurance products. If they are making money, they may be criticized for not decreasing their fees in order to offer lower rates to small businesses. On the other hand, the extra funding allows these groups to provide small businesses with the kind of information and services that are typically limited to large groups, e.g., quality reports and quality-improvement initiatives.

LIMITING FACTORS:
WHY LARGE EMPLOYERS CANNOT DO THIS ON THEIR OWN

Despite the factors that drive large employers to become involved in efforts to expand small businesses' access to health insurance coverage, ESRI's research suggests that they are unlikely to be the primary force in solving the problem of the uninsured. The first—and probably most important—reason is that large businesses are not really interested in playing this role, nor should they be expected to take the lead. The second problem is that even when large employers are interested, their commitment alone may not be enough to get an initiative past the design stage. Finally, projects that do make it off the ground face a number of hurdles that keep them from achieving their goals.

Barriers to Large-Employer Initiatives

Many business coalitions have embraced broad, well-intended missions to improve access to quality health care in their communities. However, while some large employers are aware of their contribution to the problem, coalitions are formed to serve their own needs, not to improve coverage for the uninsured. Also, coalitions see a difference between sharing the benefits of their programs with others (e.g., through projects to report on health care costs or improve quality) and actually developing programs that have only indirect benefits for themselves. The kinds of programs described in this study are not a natural fit for large-employer coalitions; even those involved in one often perceive them as outside of the group's core business, and a distraction for both the staff and the board. Moreover, many business coalitions are not interested in working with small businesses, which often deal with a different set of business and regulatory issues.

All four of the cases discussed in this study illustrate the high level of involvement required over a long period of time. It is possible that the development of a small-group insurance product simply requires a greater level of commitment than employers are prepared to make. Our research raises the question of whether large employers might not be more interested if these projects were not so hands-on—i.e., if they and the coalition staff could serve as consultants or advisers rather than day-to-day managers. This would allow them to help establish a program and move on to the next project. (This seems to be the logic behind the recent initiative of the Buyers Health Care Action Group.)

The case studies also indicate that the development and implementation of a small-group insurance product is time-consuming. Many of our respondents noted the large amounts of time and effort their staff put into educating and training brokers and small business owners about the program—what it was, how it worked, how to present it in the

best light, etc. To some extent, the need for education arises from the decision to offer a complicated product with multiple choices for employers and employees; a simpler offering would not be as hard to explain, but it also might not have as much appeal.

The following summaries of three coalition initiatives illustrate the issues that keep projects from getting off the ground, or cause them to fail:

1. The Southwest Michigan Health Plan Purchasing Alliance

The purchasing alliance was a project of the Southwest Michigan Healthcare Coalition, a group of about 30 employers in Kalamazoo that contracts with a national PPO's network of local providers. While most members are self-funded, some access the same network through an insurance company.

In the late 1990s, the coalition wanted to create a new form of health coverage to meet the needs of small employers. However, it was concerned about limiting the composition of a buying group to small employers—the members recognized that such a group needs stability if it is to attract health plans and providers, but that it is difficult for small businesses to make that kind of long-term commitment. Small-business health plans also require relatively more administrative time and resources. The coalition's solution was to create an insurance buying group composed of a mix of employers. The plan would have leveraged the covered lives and name recognition of large employers (those with more than 100 employees) to attract the health plans and gain their cooperation; over time, they would have added medium (50 to 99 employees) and small employers (less than 50 employees), and eventually, individuals. In this way, the business community would have taken care of its own, without any need for government intervention. The health plans were to have benefited by providing coverage for large employers, thus balancing the resources required for the smaller ones.

The alliance was set up as a managed-competition model with four standardized benefit designs (two were in-network only and two had out-of-network options), plus riders that employers could choose. Health plans had to bid on benefit designs and riders, and had to agree to work with small employers. Prices for employers depended on which of the designs they chose; employees then had a choice of two health plans.

After only one-and-a-half years of active purchasing, the coalition had to deactivate the alliance because it was not growing fast enough. Although many employers had said they would participate, they ultimately found reasons to stay with their current carriers. At some level, the alliance's success in obtaining better rates for large employers was

responsible for its demise. Some large firms used the rates available through the alliance to push for better prices; others allowed their consultants and third-party administrators to set up a similar benefit design. Some were simply more comfortable staying where they were. Turnover of staff originally involved in designing and launching the product also played a role. In the end, the large employers were focused on the short term—they were not committed to everything involved in a community-wide solution and did not factor into their decisions what it would take for the product to succeed over the long term.

2. The Memphis Business Group on Health

In the early 1990s, the large, self-insured members of the Memphis Business Group on Health (MBGH) secured favorable health insurance discounts by contracting directly with one of two competing physician-hospital organizations in the area. Concerned about the potential for cost-shifting to smaller employers, MBGH decided to collaborate with a third-party administrator (TPA), an underwriter, and the contracting health system to create a PPO for fully insured small employers that would leverage the coalition's existing relationships and the discounts it had negotiated.

The Business Group Health Insurance Alliance was created for employers of two to 100 workers (a few groups exceeded that size). MBGH waived its membership fee (a minimum of $1,250) for the small employers so as to make the coverage even more affordable, and the TPA reduced its marketing commission by half. The PPO plan had an attractive benefit design that included wellness, annual physicals, and mammograms. Employers could choose from three options with different coinsurance levels.

The size of small employers' premiums was based on a combination of individual experience and community ratings. Although this rating formula shielded some firms with higher risk profiles, all companies faced rising premiums as costs escalated. Within the first few years, companies with good risk profiles began to leave the pool for less-expensive coverage that was becoming available as a result of state insurance reforms, leaving behind the groups with bad risk profiles. Premiums for the plan then increased by 25 to 30 percent, so that all groups that could leave did so, leading to the all-too-common "death spiral." After six years, the pool's underwriter left the health care business, providing the final blow to the coalition's small-group initiative.

At its peak, MBGH's plan provided coverage for more than 100 groups representing 2,300 lives. Some of these employers had never offered insurance before; many had joined to take advantage of lower rates than they could get on their own. But

this plan suffered from a combination of adverse selection, weak oversight, a relatively generous benefit design, and to some extent, local small-group reform (normally a plus).

3. The Midwest Business Group on Health

Based in Chicago, the Midwest Business Group on Health (MBGH) is a large coalition of public and private employers of all sizes in an eleven-state region. Working with local business groups, MBGH made several attempts to launch buying groups for small businesses, only one of which got off the ground. In the mid-1990s, it participated in feasibility studies in the Quad Cities (which sit on the border of Illinois and Iowa) and Milwaukee, neither of which proved promising. The coalition came a bit closer when the Chicago Business Group on Health (CBGH, the local arm of MBGH) tried to launch an insurance product with the Illinois Chamber of Commerce. However, an 18-month design process came to a halt when the partners realized that neither the small employers nor the health plans were still on board. Employers apparently lost interest as they saw rates stabilizing in the mid-1990s. Local health plans became less eager to cooperate in a purchasing alliance as the Clinton reform proposal turned into a distant memory.

The one program that did get past the planning stages was the Northwest Indiana Health Alliance (NIHA), which MBGH created in 1994 in cooperation with its Northwest Indiana chapter and the local economic development council, the Northwest Indiana Forum. NIHA, which became a program of the forum, offered access to a variety of health plans through a cooperative structure. At its peak, participation exceeded 300 small employers, representing 6,000 employees and 14,000 lives. However, in the late 1990s, fewer health plans were willing to work with the purchasing group and those that stayed raised their rates. As a result, NIHA lost members and had to close in 2000.

CBGH is now talking about extending its Health Purchasing Initiative, which contracts with HMOs on behalf of large employers, to small and medium-size businesses. The current plan is to meet with brokers to see how the program may have to be modified to meet the needs of the smaller groups. While the coalition is moving slowly and carefully, it anticipates interest from the small employers. First, recent price increases have taken their toll, which makes the prospect of pooling lives more attractive. Second, recent press coverage of the Health Purchasing Initiative has resulted in some inquiries from small employers; this could indicate a latent demand for help and a desire to be part of a more organized program.

What Keeps Initiatives from Flourishing?

Of course, some large employer groups are able to avoid or overcome the kinds of problems discussed above. They succeed in getting past the design stage to launch innovative programs that borrow from some of the best strategies of large purchasers in the health care market. On the whole, small employers select, and stay, with the plan, health plans cooperate, and enrollees are pleased to have choices they never had before. Despite these successes, many small-group insurance products established by large employers do not appear to be achieving the larger goal of reducing the ranks of the uninsured. Enrollment, as a percentage of the potential small-business market, is low, and few of the employers who chose to participate had not offered insurance before. Why aren't these programs doing better?

Problem #1: No Bargain

Despite the good intentions and concerted efforts of large employers, the premiums available through small-group plans are not generally better than what is available in the open market. This finding emerges both from our case studies for this project and our earlier research on purchasing cooperatives.[14] At best, rates are competitive; but in some cases, they are higher. Since price is such a significant barrier to coverage for small employers, the inability to offer a lower price is a major factor in the low market penetration of these products.

The biggest contributor to this problem appears to be that health plans are not willing to offer lower costs to a purchasing alliance than they offer to the market at large. In some cases, regulations prohibit the plans from offering one set of customers a better deal than others, but in others, the pricing scheme reflects a strategic decision not to offer better rates to employers through a coalition. This was certainly so in Colorado in 1997, when the health plans participating in the CHIP, a small-group alliance, aggressively competed against the CHIP by offering lower rates to employers that bought directly. Even now, the CHIP's prices for most employers are slightly higher than a company would pay in the outside market for the same plan. Plans justify this with the claim that the CHIP's higher price reflects the higher value of a product with choices to employers and employees. They also suggest that a higher price makes up for the business the plans are giving up by participating in the CHIP, where they get fewer enrollees per group than they would in a direct contract situation.

[14] Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, *Barriers to Small Group Purchasing Cooperatives* (Washington, D.C.: Economic and Social Research Institute, March 2000).

Administrative cost is the second factor that influences the price of coverage through alliances. Health policy experts suggest that administrative cost may be higher than it needs to be because the alliance and its health plans are performing redundant functions. In theory, health plans were expected to reduce their administrative cost as alliances took on certain functions. The reality, however, is that the enrollment in alliances is typically too small to make much of difference in a health plan's administrative functions.

Problem #2: No Big Stick

One of the principal purposes of involving large employers in the development of an insurance product for small businesses is to take advantage of large companies' clout in the marketplace. The idea is that even if they are not actually negotiating together, the large employers can use the lives they represent to gain cooperation from health plans and/or providers.

But at some of the sites we studied, the large employers did not have a direct interest in what was happening and had little, if any, clout to wield. In Madison, for example, the self-insured members of the alliance have not been affected by major changes in the A-CHIP program for small groups; perhaps more importantly, they had no relationship with the health plan serving the small groups, so they were not in a position to influence its decisions. The small-group initiative of the Memphis Business Group on Health suffered from a similar problem in that the larger employers had no relationship with the underwriter.

Problem #3: Money, Money, and More Money

Money is a major stumbling block for employer-sponsored projects. The case studies in this report illustrate the importance of seed money, whether from large employers, the state, the city, or private foundations. In Denver, for example, initial funding for the CHIP came from large businesses, which donated the $750,000 surplus that had accumulated from the alliance's self-insured PPO, and from the John A. Hartford Foundation, which contributed $1 million. But the need for funding continues long after the start-up stage. Until the new plan is self-supporting, which can take several years, money is required for marketing, broker training, and the education of small employers. Money is also necessary to compete for a competent staff to do all this. Even coalitions experienced in buying for large groups are unlikely to have such expertise in-house.

Some large employer coalitions are willing to shoulder the financial burden of managing a small-group program; Madison's Alliance, for example, has been handling

marketing and some administrative tasks for the A-CHIP program *pro bono*. However, most coalitions cannot afford to do this, and large employers are chronically reluctant to ante up substantial funding for such purposes. Without continuing support, however, programs have little hope of bringing in enough lives to sustain themselves.

The public–private joint effort, which has been the strategy in New York City, is one remedy. While the New York Business Group on Health is the public face of the HealthPass project, the city has been an irreplaceable source of funding and other resources, including full-time managerial and administrative staff.

Another option is to live within a limited budget by managing costs more carefully. The New York Alliance, which administers the HealthPass program, realized fairly quickly that it could not afford to compete against the resources of other health plans that market to small groups. After a brief stint with expensive advertising, it recently implemented a direct-marketing strategy that allows it to use resources more efficiently. The group also has chosen to cultivate relationships with a limited number of brokers who are committed to its product.

Problem #4: Misplaced Confidence

The large employer groups that embark on projects to help small businesses with insurance coverage generally believe that their market savvy will contribute to the venture's success. This is true in many ways—even when they do not provide funding, large employers can and do play an important role by sharing their expertise. For example, the Pacific Business Group on Health's efforts to make its small-group plan mirror other offerings in the market reflect the coalition's experience as a major buyer. Other groups have helped small businesses manage their costs more effectively by teaching them how to use a defined-contribution strategy. This lets small employers who had not been offering coverage because they could not predict their costs budget appropriately and avoid surprises (and enables their employees to buy up if they want to).

However, expertise in issues important to large employers does not necessarily translate into knowledge of the small-group market. Some programs have struggled because the large employers did not appreciate brokers' importance to small businesses. Others did not understand what it takes to manage risk. In some small-group programs, for example, there are no policies to help the health plans minimize risk and spread it across more lives. The Denver CHIP requires that at least 75 percent of a firm's employees participate in the program, and the employer must cover at least 50 percent of the cost of the lowest-priced plan. New York's HealthPass requires at least 75 percent of employees

to have insurance of some kind, with a minimum number enrolled in a HealthPass plan. The Madison Alliance, on the other hand, has no minimum participation rate, which probably contributed to its health plan's financial losses. This issue also arises when employer groups impose well intentioned but risky requirements on health plans, like having to accept "groups of one" (i.e., self-employed individuals). It appears that health plans do not welcome efforts to extend the benefits of pooling to the individual marketplace, and this raises the larger policy question of what it would take to offer affordable coverage to this segment.

Moreover, for a variety of reasons, small employers may not share the growing interest of many large employers in quality improvement. In an effort to bring attention to the relative value of competing plans (rather than just their price), some large employer groups have introduced information on quality, or hope to do so in the near future. The Denver CHIP has been distributing information on quality and access to care since the program's inception. The Pacific Business Group on Health has plans to share its extensive information on quality with the members of PacAdvantage, and the New York group talks about doing this eventually, although it has no plans in place yet. It is unclear whether or not small employers or their employees are interested in this kind of data, presumably because they are still struggling with more basic concerns like affordability. At the same time, employer groups that try to tackle everything at once may be overly ambitious. Quality-reporting projects, while important, can distract from the larger issue of developing a reliable, affordable source of coverage.

Problem #5: No Leeway

Some programs for small businesses fail to attract employers because state regulations prohibit them from offering an insurance plan that meets small firms' needs. In New York, for example, strict community-rating rules nullify the usual benefits of pooling lives. No matter how big HealthPass gets, participating plans cannot offer rates lower than those they offer in the market at large. This makes it hard for HealthPass to compete for a bigger piece of the existing pie. At the same time, the state requires a fairly generous benefit package, which puts the cost of even basic coverage out of the reach of many small employers. A similar problem has limited the reach of the Madison Alliance's A-CHIP; it believes it could attract many new groups that have not been offering coverage if the state would allow some kind of modified community rating so that younger enrollees could pay a lower price.

This points to a need for some regulatory flexibility—perhaps on a case-by-case basis—to allow employers and health plans to experiment with more attractive plans. This

is a risky proposition that would compel regulators and employer groups to identify the downside. On a local level, for instance, changes in the community-rating scheme could be a zero-sum game overall if insurers then raise rates for older workers, which could lead small companies with older workers to drop their coverage. Large employers in Colorado explicitly wanted community rating for small employers in order to prevent insurers from rate banding, which helps employers with a young, healthy population to get affordable coverage, but hurts those employers with higher-risk workers.

LESSONS LEARNED

The lessons of this study are sobering. While small-group programs developed by groups of large employers do meet a need in the market, they are not the panacea that some proponents might like them to be.

Initial Assessment: Limited Impact, Limited Potential

First, these programs have little effect on lowering the number of uninsured. Informal surveys and educated guesses indicate that, in general, about 10 to 20 percent of the companies that sign up for these plans are offering insurance for the first time. In Colorado, that would translate into perhaps 2,500 to 3,000 newly insured lives; in California, it could account for as many as 25,000 to 30,000—still a small percentage of the total. The rate of new coverage in New York is significantly higher (52% of companies say they had not offered coverage before, and 28% of employees say they did not have coverage before), but the total number of people the program affects is still very small. Moreover, it would be inappropriate to give all the credit to the purchasing groups, since other circumstances (e.g., small-group reforms and the strong economy in the late 1990s) also seem to have contributed to increases in the number of covered lives.

Second, these organizations have not been successful at offering lower rates than the outside market. While their hands may be tied by state regulations or health plan policies, the bottom line is that they have not been able to overcome high costs—the biggest barrier small businesses face. In the end, purchasing alliances are simply not a big enough presence in their markets to get the prices they want. These groups must deal with a "Catch-22": they need to represent a large number of lives in order to negotiate good rates (and spread the risk), but they cannot attract the number of lives they need because the costs are too high.

Assuming that little can be done in the near future to change the environment in which these groups operate, it is important to identify and experiment with some strategies to avoid this dilemma. One possibility is to begin with a large number of lives, perhaps from another source. This could be done if small employers were folded into an existing network (as is being discussed in Chicago) or by creating a mixed group of large and small employers. The coalition in Southwest Michigan tried and abandoned the latter approach, but there may be ways to avoid the problems that kept that initiative from succeeding. States might also consider allowing small firms to enter the pools established for state employees.

The public sector could contribute by providing a subsidy of some kind to make health care coverage more affordable for small businesses. Some health policy experts have also suggested that the answer lies in government mandates for small firms to participate in purchasing pools,[15] which would result in a large number of covered lives. However, such mandates are not likely to be feasible in the absence of some kind of financial subsidy or incentive.

What these programs have done well is to enable small firms to offer choices to their employees. Some segment of the small-business community clearly values the ability to offer choice, and it is certainly attractive in a tight labor market when small firms are competing for workers against large companies with much better benefits. But choice alone does not seem to be enough to attract small businesses that would not otherwise offer coverage. It could be a compelling reason to enroll with a purchasing alliance for businesses already interested in offering coverage. But choice as a selling point does not seem to be convincing if the interest (or money) is not already there.

Our findings raise the possibility that choice is a more attractive draw for small employers on the large end of the scale (e.g., those with 50 or more employees). This might help to predict which markets would be amenable to this strategy. In the Denver CHIP, for instance, the average group size is about 15; over 90 percent of companies have less than 50 lives. But those small firms account for only half of the 27,000 enrollees; the 8 percent of companies with more than 50 lives represent 52 percent of total CHIP enrollment.

It also is important to note that the decision to offer choice, despite all its merits, appears to undermine health plans' commitment to a single product because no plan is likely to gain that many lives. Unless enrollment is substantial, the choice model may be at odds with the need to have plans that are willing to stick with one offering and make it available at a competitive price.

Finally, while buying cooperatives set up by large companies to help small businesses certainly play a valuable role in their communities, their reach is limited. Even if these programs could be made more attractive to small firms, it is hard to imagine that this approach could be replicated at a level that would ever make a substantial contribution to reducing the number of uninsured in the small business community.

[15] Richard E. Curtis, Edward Neuschler, and Rafe Forland, *Private Purchasing Pools to Harness Individual Tax Credits for Consumers* (New York: The Commonwealth Fund, December 2000).

Caveat: Are We Expecting Too Much?

It is important to point out that we may be judging these programs too harshly. It is possible that the programs are climbing a steep learning curve—as they continue to learn from one another's experiences, the large-employer groups may be able to develop more effective programs. It is also possible that our expectations are too high. The market for small-group coverage may not be as big as it seems—there may be a segment of small businesses—perhaps even a large segment—that would not buy coverage at any price. In that case, existing purchasing alliances may be doing a reasonable job of penetrating the actual market for health care coverage, versus the potential (but perhaps unrealistic) market of all small businesses.

Also, one could argue that the availability of a small-group cooperative is only one factor in improving coverage rates. Health policy experts have argued that California's HIPC (now PacAdvantage) has to share credit for the improved coverage rate with other factors, including the healthy economy, small-group reform laws, and competition in the small-group market. But that argument works in the other direction as well: if the coverage rate is not rising, there may be other issues that keep businesses from using an alliance.

What Can Be Done to Spur More Activity?

If we concede that these programs have some promise and succeed in filling a niche in the market by expanding coverage options, what conditions would facilitate the development of more—and more effective—programs for small businesses around the country? First, local large employers must have some interest in lending their expertise to the community of small businesses. Where that interest is lacking, there may be a role for outside organizations in educating employers about the insurance market and helping them see how higher levels of coverage in the community could serve their own interests. Once that interest has been established, the need for start-up funding comes into play. While employers are often willing to contribute time, expertise, and other resources, they are rarely a reliable source for the financing these projects need to get up and running. Finally, the program's success will also depend on the nature of the regulatory climate. A business-sponsored product for small groups is likely to need regulatory support in order to compete effectively against established insurers. We discuss these factors in more detail below:

Interested Business Groups

Our interviews with large employers and coalition leaders revealed that nearly all had some awareness of the difficulties small firms face in finding affordable coverage, and many supported the idea of market-oriented solutions. While most do not see a role for

themselves as individual employers in implementing a solution, our research suggests that a number of employers are willing to help support small businesses through their coalitions, whether for selfless or self-serving reasons.

However, it was not clear from our limited survey how much employers really understand about the obstacles that small businesses confront when seeking health care coverage, how this contributes to the number of uninsured, and how this situation undermines the employer-based system in our country. It is conceivable that more large companies would be interested in contributing their time, expertise, and perhaps money, if they knew more about small businesses' access problems, and simple ways in which they could become part of a solution. Foundations, government agencies, and business groups may want to sponsor further research to investigate this hypothesis, to share information about the pros and cons of market-based solutions, and to explore ways to get publicity for health care coverage issues.

Assuming some level of interest, the next step is to identify the organizations that may be willing to pursue a small-group insurance program and help them understand what would be involved. Foundations could convene meetings for groups that are likely to be interested in this kind of initiative and link them with experienced program sponsors and sources of technical assistance. Likely candidates include:

- Groups whose members have something to gain from greater coverage (e.g., providers and health plans): Employers are only one segment of mixed-model health care coalitions like the New York Business Group on Health, whose membership includes representatives of various organizations in the health care industry.

- Coalitions whose members have a stake in the economic health of the community. In our interviews, one large employer noted that a commitment to community-based solutions tends to come from "old economy" businesses like public utilities that are strongly rooted in the area.

- Groups whose members have an interest in the health of small businesses—e.g., financial institutions.

- Groups whose members would see the project as an opportunity to enhance their public image.

Financial Support

Market interest is necessary but not sufficient to get a small business project off the ground. These programs need seed money and a source of continuing support until they can sustain themselves. The latter could take the form of technical advice, administrative support, office space, or other resources that would have value to a start-up organization.

Both the New York and California examples in this study point to the positive role that state and local governments can play by making the initial investment and providing support. While corporations and private foundations can also contribute, a public–private partnership is a rational way to produce the public good of a higher coverage rate.

The New York case also illustrates how the public sector can serve as an impetus for a market-oriented program. By offering funding and substantial resources to launch a small business program, the City of New York actively sparked the interest of the local business group in a project it would not have otherwise attempted.

Conducive Regulatory Climate

While the specifics may vary by state, it would appear that some kind of regulatory leeway could be a critical boost for small-group purchasing alliances. Our research points to two different but related regulatory paths that policymakers may want to consider.

The first option would support programs' efforts to increase their share of the market for small-group coverage by competing effectively against local insurers' direct offerings to individual firms. In many cases, employer programs that pool small businesses cannot offer better rates because they are not treated like a large group (which is the purpose of pooling); instead they are subject to the same community rating as small groups. New York's community rating regulations stop the Alliance from offering rates different from the ones small firms can get on their own. Colorado law prevents the CHIP from using its size to gain an advantage in the market because it can only negotiate the administrative cost component of the premium dollar. If these alliances cannot get rates consistent with the number of pooled lives they represent, their ability to offer the small business community what it wants is limited. Coalition products might be more attractive to small businesses if regulatory policies allowed such groups to negotiate like other large groups and to benefit from some form of experience rating (or perhaps a combination of experience and community rating).

The second option is to take steps to increase the size of the overall market, with the assumption that at least some of the newly insured would gravitate to a coalition-sponsored product. Several states have implemented small-group reforms that have had this effect. However, the impact of this policy change is hard to predict in the absence of policies that would help small-group programs to offer better rates. Small-group reforms in Memphis, for example, drew businesses away from the coalition's product.

Advice for Future Endeavors

Our research with large employer groups and their small-employer programs leads us to offer the following recommendations for business coalitions hoping to learn from their experiences, both positive and negative:

1. Look for ways to work with health plans without giving away the store. While large employers' desire to make coverage accessible for the smallest of employers is well intentioned, they need to be realistic about the level of risk they are imposing on health plans. In order to win over the plans, it may be necessary to take a more incremental approach to bringing in higher-risk employers.

2. Market aggressively to small firms. Coalitions should not assume that small businesses will find out about the product or understand its features and benefits on their own. Seeking out educational opportunities to build awareness of and interest in the program is critical.

3. Cultivate the brokers and keep them involved in the project. The strategy of cutting out the middleman has failed every time it has been tried. In order to be successful with the small business community, it is essential to accept the role of brokers and make them part of the marketing team. The Denver CHIP, for example, has made a major investment to win over the brokers: it pays them full market rates, provides dedicated salespeople to service them, and provides a tool for instantaneous price quotes. Both the Pacific Business Group on Health and the New York Health Purchasing Alliance are taking similar steps for their small-group products.

4. Do not underestimate what a big task it is to design and implement a health care coverage program for small businesses. These projects are not easy, and they demand a long-term commitment of time and money. While an employer group can take on the work on its own, the New York example discussed in this report points to the value of a collaborative approach.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org.** Other items are available from the authors and/or publishers.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children's Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation's 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs,* vol. 20, no. 4. This new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs,* vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author explains that the Medicare+Choice options available to beneficiaries have diminished: existing plans have withdrawn from M+C, few new plans have entered the program, greater choice has not developed in areas that lacked it, and the inequities in benefits and offerings between higher- and lower-paid areas of the country have widened rather than narrowed.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion

of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the likely impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

#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.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication **#415,** presents a detailed side-by-side look at the 10 option papers in the series Strategies to Expand Health Insurance for Working Americans.

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health*

Affairs, vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs,* vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs,* vol. 19, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine.* Available online at www.medscape.com/ Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 *Current Population Survey* and *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.