

Saint Louis University Health Policy Legislative Analysis Team<sup>1</sup>  
**MISSOURI STATE HEALTH POLICY BRIEF # 1**  
*For the Missouri Foundation for Health (MFH)*

**State Policies to Expand Health Insurance Coverage  
For Workers in Small Businesses: A Comparison of Proposals**

Sidney Watson, Timothy D. McBride, Thomas Greaney, and Heather Bednarek  
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**INTRODUCTION**

Over 700 thousand persons were without health insurance in Missouri in 2005<sup>2</sup> and over 80 percent of the uninsured are either workers themselves or a dependent of a worker.<sup>3</sup> Since almost half of uninsured workers work for small employers<sup>4</sup>, proposals to expand health insurance coverage often focus on options to increase affordability of health insurance for small firms, hopefully expanding health insurance coverage for these workers and their families.

This Policy Brief compares and contrasts three different approaches to expanding insurance coverage for workers in small firms: (1) expanding the income tax deduction for health insurance for small businesses [Senate Bill 622], (2) permitting the inclusion of small employers in the Missouri Consolidated Health Care plan [SB593], and (3) removing statutory restrictions prohibiting employer purchasing alliances [SB663].<sup>5</sup>

These policy proposals respond in part to a long-standing goal of policymakers to expand health insurance coverage in the state and reduce the number of uninsured.<sup>6</sup> This was again emphasized in the recently completed Missouri Medicaid Reform Commission (MRC) Report that also concluded that *“Missourians without health insurance constitutes a grave public policy concern for the state,”* that the *“state must help working poor access private health insurance and help those receiving public medical assistance to transition to private health insurance”* and that this could be achieved in part by *“expanding employer-based coverage by providing affordable coverage to small businesses and the employees.”*<sup>7</sup> Thus the proposals discussed here may be vehicles for achieving the policy goals articulated in the MRC Report.

**UNINSURED WORKERS IN SMALL FIRMS IN MISSOURI**

Over half (61%) of the Missouri workers who lack health insurance coverage work in firms that have fewer than 100 employees, representing about 282,000 workers (see Table 1).<sup>8</sup> These uninsured workers are the focus of the legislation discussed here. In addition it is possible that workers with private insurance coverage or Medicaid may also be affected by the proposed legislation.

<b>Table 1. Missouri Workers, by Insurance Coverage Status in 2004</b>						
Insurance coverage Status	Less than 100 workers				100 or more workers	TOTAL
	Less 100 workers	Less than 10 workers	10-24 workers	25-99 workers		
Number of workers and percent of workers						
Uninsured Workers	281,749	161,754	54,951	65,044	179,928	461,677
	61%	35%	12%	14%	39%	100%
Workers with individual policies	100,338	64,320	24,648	11,370	51,508	151,846
	66%	42%	16%	8%	34%	100%
Workers with Employer sponsored coverage	719,571	302,274	156,986	260,311	1,343,597	2,063,168
	35%	15%	8%	13%	65%	100%
Workers covered by Medicaid	73,555	41,104	6,976	25,475	68,157	141,712
	52%	29%	5%	18%	48%	100%

Source: Analysis of March 2005 Current Population Survey, Missouri sample.

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## ANALYSIS

***Will the proposed approaches meet the goal of providing affordable coverage to small businesses and their employees, leading to an expansion of employer-based coverage and reducing the number of uninsured?*** This question is addressed here by comparing and contrasting the three Missouri Legislative proposals listed above. A more detailed description of each of these proposals, followed by the projected impacts of each proposal, is taken up in turn.

(1) Expanding the income tax deduction for small businesses [SB622].

Description. This bill gives individuals who own farms and small businesses a state income tax deduction for the costs of providing health insurance coverage for their employees. A sole proprietor can claim a deduction of 100% percent of “qualified employee health insurance expenses” while an individual owning a partnership or small corporation can claim a deduction prorated according to their ownership share. A small business is defined as a for profit entity with fewer than 50 employees and a farmer is someone who derives at least two-thirds of their income from cultivating crops, livestock, poultry, milk or dairy, fruit or other horticultural products. The chief sponsor of this legislation is Sen. Timothy Green, and this legislation is similar to SB 459, introduced in 2005.

Missouri state income tax liability is computed based upon the taxpayer’s federal adjusted gross income (AGI). In determining federal AGI, business owners are already allowed to deduct the costs of providing health insurance for their employees. This bill would allow an additional deduction for state income tax purposes.

The Missouri individual income tax rate is a flat 6 percent so this bill would give a small employer or farmer who spends \$10,000 on employee health insurance \$600 in state tax savings (6% of \$10,000). However, any amount saved on state taxes reduces the deduction available for state and local taxes for federal tax purposes. This means that \$600 in state tax savings is ultimately worth something less than \$600 to the taxpayer. (The exact amount of the reduced deduction depends on the individual’s federal income tax rate.)

Projected Impact of Provisions. Expanding tax incentives for insurance seems a promising avenue for expanding health insurance coverage, since these tax subsidies build on the existing system of employer-sponsored health insurance with tax subsidies. Moreover, tax incentives could lead to increases in coverage without requiring expansions of existing state or federal insurance programs.

In practice, however, state tax incentives have not led to significant increases in the number of people with health insurance, largely because the size of the state tax incentives, relative to the price of coverage, is minimal.<sup>9</sup> This is illustrated by the analysis of SB 622. A tax saving worth something less than 6% of the cost of health insurance premiums-- saving \$600 after spending of \$10,000--is unlikely to be a significant enough financial inducement for small employers and farmers to obtain health insurance for their employees.<sup>10</sup>

Moreover, SB 622’s tax subsidy is not targeted at employers who do not offer health insurance. Thus, it is likely that most of the subsidy payments would go to employers already covering their employees, thus not resulting in any decrease in the number of uninsured. On the other hand, to the extent that even this relatively small subsidy keeps a small employer from dropping coverage, this may keep the percentage of uninsured workers from rising any more in the future, at least at the margin.

(2) Including small employers in the Missouri Consolidated Health Care plan [SB593].

Description. This proposed legislation would allow small employers to join the Missouri Consolidated Health Care Plan (MCHCP). For purposes of this legislation, a small employer is defined as one that employs at least one but no more than 50 persons, and includes sole

proprietorship and partnerships. The bill requires that the MCHCP set up a separate benefit trust fund for premiums and payments from small employers. The chief sponsor of this legislation is Sen. Joan Bray, and this legislation is identical to SB 277 (proposed in 2005) and HB 1412 (proposed in 1998).

Projected Impact of Provisions. The goal of SB593 is to give small employers access to the purchasing power of the large MCHCP, relieving small employers of the administrative burdens (both time and money) associated with shopping for small group health insurance. By increasing the affordability of coverage for small businesses, this could lead to an expansion of employer-based coverage rates.

Many states allow various types of small employers to join state employee health plans.<sup>11</sup> However, there are no studies evaluating whether these efforts have succeeded in expanding access to affordable health insurance.<sup>12</sup>

In Missouri, experience using the MCHCP to expand coverage for smaller public employers is mixed. Statutorily defined "Public Entities" -- specifically, state colleges and universities and local government entities -- are already eligible to participate in the MCHCP. As of 2006, about 1,900 Public Entity members were enrolled compared to roughly 103,000 state employees, retirees or their dependents enrolled in the MCHCP.<sup>13</sup> However, between 2003 and 2005 MCHCP participation among Public Entity employees dropped by over two-thirds suggesting that many Public Entity employers were able to negotiate lower premiums on their own. While changes in the pooling for Public Entities resulted in a 16 percent enrollment increase among Public Entity members in 2006, MCHCP had become an increasingly less attractive option for Public Entity employers because of an escalating "adverse selection" problem.

The Public Entity members do not benefit as much from the purchasing power of the MCHCP state employee pool as might be imagined because they function as a separate pool: MCHCP offers different health plans to state employees and Public Entities. The cost for State employees is set by the MCHCP Board of Trustees based upon insurer bids and budgeted state contributions. MCHCP negotiates separate contracts for Public Entities which set their own employee contribution levels, although entities must contribute at least half the cost of the single rate. Health insurer bids are based upon the claims experience and risk rating of the employees who participate in the two different pools. As premiums increased for Public Entity employers, those that could negotiate lower prices on their own left the MCHCP, and the cost of coverage for those that remained rose, encouraging even more Public Entity employers to leave the pool.

To help address this adverse selection issue, MCHCP made several changes to the Public Entity program in 2005. Already participating Public Entities are still rated together but the pool is divided into several tiers. This allows Public Entities with good health insurance claims experience to take advantage of lower premium rate increases. At the same time, this tiering has tempered the premium increases for those with higher health care claims. New Public Entities entering the pool are now individually underwritten which makes MCHCP coverage more attractive for lower risk entities. Upon renewal these new Public Entities are added to the larger pool and help hold down the costs for all participants. Finally, all Public Entities have to commit to MCHCP for two years.

It is worth noting that the MCHCP will need to take similar steps to prevent adverse selection among that small employers covered by SB593. The bill specifies that the MCHCP must set up a separate benefit trust fund for small employer premiums and payments. This provision ensures transparency that small employer contributions are covering their health insurance costs (and not being subsidized by state employees). And while this provision does not appear to require MCHCP to offer different health plans to small employers than those offered to state employees, it is likely that MCHCP will consider setting up a separate bidding and premium structure for small employers and thus offer different plans. The state employee and small employee risk pools are quite different and health insurers are unlikely to be willing to enter one bid covering such different risks.

However, there are other reasons to expect that small employers may have a more positive experience with MCHCP than that of Public Entity employers. The small employers covered by this bill—those with 1-50 employee and especially those with 1-10 employees--may have more to gain from the economies of size and reduction of administrative overhead offered by access to MCHCP. Moreover, small employers likely face more considerable obstacles when negotiating on their own behalf than the Public Entities that have dropped out of MCHCP. On the other hand, the Fiscal Note for SB277, proposed in 2005, assumes that the administrative costs (except for one time start up costs) faced by the MCHCP would be passed on to the small employers, resulting in very little costs to the state from this legislation, but also resulting in little to no reduction in administrative costs to small employers interested in obtaining insurance through the MCHCP.

(3) Encouraging the formation of employer purchasing alliances from forming [SB663].

Description. This legislation modifies provisions of Missouri law (specifically Section 376.421, RSMo) to permit a group health insurance policy to be delivered to an employer purchasing alliance. Current law explicitly prohibits an association organized for the purposes of obtaining insurance from issuing a group health insurance policy. The proposed law defines employer purchasing alliances broadly to include nonprofit corporations run by a board of directors which is organized for the purposes of purchasing, coordinating, and administering health benefit plans on behalf of groups of employers and their employees. The chief sponsor of this legislation is Sen. Jason Crowell.

Projected Impact of Provisions. In theory, employer purchasing Alliances should lead to increased coverage by reducing premiums and increasing choice. Health insurance premiums would be reduced because the Alliance would have greater purchasing clout in the market, lower administrative costs through economies of scale, and reduce costs that result from variation in costs across individuals. Finally, Alliances can offer greater choice in health insurance plans by offering all firms the array of health insurance plan choices negotiated with the insurer.

However, where Employer Health Alliances have been tried in other states, Alliances have not generally led to significant increases in employer or individual coverage rates.<sup>14</sup> Health Alliances have often floundered — many have gone out of business or gone bankrupt — apparently because they were not successful in attracting a large enough number of small employers to gain bargaining leverage and reduce adverse selection problems.<sup>15</sup> Employers do not appear to be attracted to Alliances because they have not been able to lower the average costs of providing insurance to small employers. Specifically, Alliances have not significantly led to the promised reductions in lower administrative costs, economies of scale, or reduced claim variation.<sup>16</sup> The inability of Alliances to achieve significant market penetration has contributed to their lack of success — most Alliances account for less than five percent of each state's small-group enrollment, a share that is too small to make it possible to reduced administrative costs and premiums.<sup>17</sup> Even where premium reductions are achieved, the magnitude has not been sufficient to induce take-up by employees or employers.

In practice, the advantage of Alliances appears to be primarily increased choice of plans and information. Firms purchasing their coverage through a cooperative are more likely than other small firms to offer a choice of health plans to their employees and are more likely to have better access to information about those plans, such as the benefits offered and the quality of care provided.<sup>18</sup>

Certain obligations would attach to employers participating in Alliances under SB663. Employers participating in an alliance and purchasing fully insured products would be subject to certain reporting requirements under federal law, the Employee Retirement and Income Security Act (ERISA). These would make employers subject to certain fiduciary obligations under ERISA, including avoiding certain prohibited transactions including self-dealing or receiving kickbacks from insurers. In addition, a variety of other Missouri insurance laws will likely apply to the sale of insurance products to Alliances, including laws mandating benefits and those regulating rating of small employer groups. These laws may inhibit the realization of significant savings from group alliance purchasing.

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## APPROACHES TO EXPANDING COVERAGE: SIMILARITIES AND DIFFERENCES

The three pieces of legislation discussed here present three approaches to expanding insurance coverage. But, in general, how are these approaches comparable and how do they differ?

- All three bills focus on expanding coverage with the strategy of reducing the costs of insurance to small employers.
  - One bill [SB622] would do this by providing a tax subsidy, providing a direct offset of the premium. The other two bills seek to reduce the costs of health insurance premiums by putting small employers into larger pools and thus theoretically taking advantage of economies of scale and other advantages of pooling -- with other small employers in the Missouri Consolidated plan or through Health Alliances.
  - Since SB593 and SB663 try to accomplish the same goal of creating a larger insurance pool that smaller employers can buy-in to for their workers, these pieces of legislation can be seen as substitutes for each other. In the case of SB622 the preferred tax treatment of health insurance might be viewed as complimentary to either of the other bills.
  - However, in all three cases, the reductions in the costs of insurance are modest. This is typical of approaches in states with low tax rates, thus limiting the ability of the state to provide incentives that will significantly expand employer coverage without federal assistance.<sup>19</sup>
- All three pieces of legislation focus on employees in small firms with less than 50 employees.
  - The uninsurance rates are highest (28.4% in Missouri) in very small firms (less than 10 employees) and that the rate of uninsurance is very similar for workers in firms with 10-50 employees (11.7%) as compared to workers in slightly larger firms of 51-100 employees (12.2%).<sup>20</sup> This raises the question of appropriate targeting of legislation aimed only at workers in firms with fewer than 50 employees.
- All of the bills are more likely to target full-time permanent workers rather than part-time or temporary workers, who have higher uninsurance rates than workers who are more permanently employed.<sup>21</sup>
- While focusing on the problem of the uninsured, all three bills focus on workers, as opposed to targeting other groups of the uninsured (e.g., nonworkers, children). A significant share of the uninsured in Missouri (over 33%) were either nonworkers or children in 2004.<sup>22</sup>
- While the legislation discussed here is targeted at the previously uninsured, the bills may not necessarily reduce the number of uninsured in the state because workers may simply change the type of insurance coverage for employees of small firms.
  - A shift from individual policies to employer sponsored health insurance. About 100,000 workers in small firms directly purchase individual health insurance policies. Some of these workers might shift to employer sponsored health insurance their employers began offering more affordable insurance, by using expanded tax deductions they are not currently receiving, or by enrolling in Employer Purchasing Alliances or the Missouri Consolidated Health Plan
  - A shift to Alliances or the Consolidated Health Plan. About 719,000 insured workers with employer-sponsored health insurance are also in small firms (see Table 1). These firms could take advantage of the provisions described here and simply shift to a different form of insurance.
  - A shift from Medicaid to employer sponsored health insurance. About 50,000 workers in small firms are covered by Medicaid (Table 1). To the extent that any of these pieces of legislation encourage firms to offer coverage, or more affordable coverage, it is possible that some current Medicaid enrollees would leave the Medicaid rolls;
  - Preventing employers from dropping employer sponsored health insurance. While increasing affordability of health insurance for employers in small firms that are already insuring their

workers does not achieve the goal of expanding coverage, in recent years many firms have been dropping health insurance coverage for their workers, largely because small firms cannot afford rising health insurance premiums.<sup>23</sup> So, to the extent that any of these proposals reduce health insurance premium costs, this would reduce further increases in the uninsured in Missouri. In addition, reducing state Medicaid expenditures and expanding employer coverage of workers now on Medicaid are policy goals for the state of Missouri.

- Although the goal of these proposed bills is to increase health insurance coverage of the uninsured and/or decrease public insurance, doing so through employment-based health insurance is not without its problems. In particular, obtaining health insurance through a person's own employment or that of a family member could lead to decreased job mobility and less choice regarding full-time versus part-time employment, more widely known in the economics literature as job-lock.<sup>24</sup>

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## CONCLUSIONS

This Brief compares and contrasts three approaches to expanding insurance coverage for Missouri workers in small firms. These three approaches represent similar approaches that attempt to encourage employers to offer insurance coverage to their employees by reducing the costs of health insurance. Drawing upon the evidence available from other states where these approaches have been tried, it is shown here that it is likely all three approaches would at best only modestly expand the insurance coverage rates for insured workers, though they may prevent uninsurance rates from rising higher than they otherwise would.

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- <sup>1</sup>The Saint Louis University State Health Policy Legislative Analysis team consists of 16 analysts from the Schools of Public Health, Law, Business, Public Service, and Medicine. The analysts are: Timothy McBride, Heather Bednarek, Michael Counte, Kanak Gautam, Daniel Gentry, Barbara Gilchrist, Kathy Gillespie, Thomas Greaney, Muhammad Islam, Heidi Israel, Richard Kurz, Ana Maria Lomperis, Doug Luke, Nicolas Terry, Sidney Watson, and Kathleen Wyrwich. The work of the Saint Louis University Health Policy Legislative Analysis Team is funded by the Missouri Foundation for Health (MFH) but the views represented here are those of the analysts and do not represent the views of the Missouri Foundation for Health or Saint Louis University.
- <sup>2</sup>Timothy D. McBride, "Comparison of Missouri Uninsurance Survey Data Sources," Missouri Foundation for Health, October 2005.
- <sup>3</sup>Catherine Hoffman, Alicia Carbaugh, Hannah Yang Moore, Allison Cook, "Health Insurance Coverage in America: 2004 Data Update," *Kaiser Commission on Medicaid and the Uninsured*, November 2005, <http://kff.org/uninsured/upload/Health-Coverage-in-America-2004-Data-Update-Report.pdf>
- <sup>4</sup>Hoffman et al., "Health Insurance Coverage in America: 2004 Data Update," Table 16.
- <sup>5</sup>Full text of these proposals is available from the Missouri Legislature's web site: SB539 [http://www.senate.mo.gov/06info/BTS\\_Web/Bill.aspx?SessionType=R&BillID=135](http://www.senate.mo.gov/06info/BTS_Web/Bill.aspx?SessionType=R&BillID=135)], SB622 [http://www.senate.mo.gov/06info/BTS\\_Web/Bill.aspx?SessionType=R&BillID=25](http://www.senate.mo.gov/06info/BTS_Web/Bill.aspx?SessionType=R&BillID=25)], SB663 [http://www.senate.mo.gov/06info/BTS\\_Web/Bill.aspx?SessionType=R&BillID=54](http://www.senate.mo.gov/06info/BTS_Web/Bill.aspx?SessionType=R&BillID=54)].
- <sup>6</sup>Two of these proposals -- SB622 and SB539 -- were proposed in previous Legislative sessions.
- <sup>7</sup>Missouri Medicaid Reform Commission, "Report," December 22, 2006, p. 51-52.
- <sup>8</sup>Although these numbers focus on the number of workers in firms with less than 100 workers, the proposals discussed here focus in general on firms with less than 50 workers. Precise estimates of the number of workers in firms with less than 50 workers are not available, because the Current Population Survey (CPS) does not report separate estimates of the number of workers in firms with 24-49 workers, as compared to the number of workers in firms with 50-99 workers.
- <sup>9</sup>Barbara Yondorf, Laura Tobler and Leah Oliver, "State Options for Expanding Health Care Access," National Conference of State Legislatures, March 2004, pp. 8-9.
- <sup>10</sup>In order to induce an employer to offer insurance coverage, premium subsidies (including tax incentives) must be 60% or higher. (See Michael Chernew, Kevin Frick, and Catherine G. McLaughlin, "The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?" *Health Services Research* 32:4, 1997, and M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14, 1995.)
- <sup>11</sup>In 2002, 30 state employee health plans covered public universities and colleges, 20 covered public school, and 22 covered cities and counties. Connecticut and West Virginia allow small employers to participate in the state employee plan (see Yondorf et al. "State Options for Expanding Health Care Access," , p. 27)
- <sup>12</sup>Yondorf et al, *State Options for Expanding Health Care Access*, p. 27.
- <sup>13</sup>Among state employees, the Department of Conservation, Department of Transportation, and Highway Patrol do not participate in the plan. Among eligible Public Entities, the state's colleges and universities have declined to participate but some local school boards and local governments have joined the plan. (Lincoln University was enrolled for several years.
- <sup>14</sup>Elliot Wicks, , "Health Insurance Purchasing Cooperatives," Commonwealth Fund Issue Brief, March 2002, ([http://www.cmwf.org/usr\\_doc/wicks\\_coops.pdf](http://www.cmwf.org/usr_doc/wicks_coops.pdf)).
- <sup>15</sup>Over 20 states had enacted legislation authorizing the formation of purchasing cooperatives as of 2001, but not all of those states have operating cooperatives today and cooperatives in several states (Florida, Colorado, North Carolina and Texas) have discontinued operations (see Wicks, "Health Insurance Purchasing Cooperatives," 2002; or Yondorf et al., *State Options for Expanding Health Care Access*, p. 15.) In an analysis of the three largest statewide small-group health insurance purchasing alliances—in California, Connecticut, and Florida—Long and Marquis concluded that these alliances did not lead to increased coverage for small business, did not reduce small-group market health insurance premiums, and they did not raise small-business health insurance offer rates (Stephen H. Long and M. Susan Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20(1, January 200): 154-163.
- <sup>16</sup>Jill M. Yegian, et al., *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience* (Oakland: California HealthCare Foundation, May 1998).
- <sup>17</sup>Government Accountability Office, *Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses*, Washington: GAO-03-1133, September 2003, <http://www.gao.gov/new.items/d031133.pdf>
- <sup>18</sup>Congressional Budget Office, "Increasing Small-Firm Health Insurance Coverage Through Association Health Plans And Healthmarts," Washington: GPO, January 2000.

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- <sup>19</sup> RAND Health Research Highlights, "State Efforts to Insure the Uninsured: An Unfinished Story," 2005.
- <sup>20</sup> The source for these numbers is analysis done for the Missouri State Planning Grant committee, 2004.
- <sup>21</sup> For instance, the Kaiser Family Foundation survey found that only 28% of part-time workers, and 3% of temporary workers, were offered health insurance in 2005 (Kaiser Family Foundation and Health Research Educational Trust, "2005 Annual Survey," <http://kff.org/insurance/7315/upload/7315.pdf>)
- <sup>22</sup> Catherine Hoffman et al., "Health Insurance Coverage in America: 2004 Data Update"
- <sup>23</sup> According to the Kaiser Family Foundation's annual survey, the percentage of firms offering health benefits has dropped from 69% in 2000 to 60% in 2005, and this drop was driven largely by a significant decline in the percentage of small firms (3–199 workers) offering coverage, which has fallen from 68% to 59% over the same period (Kaiser Family Foundation and Health Research Educational Trust, "2005 Annual Survey," <http://kff.org/insurance/7315/upload/7315.pdf>)
- <sup>24</sup> See, for example, Adams, S. 2004. "Employer-provided health insurance and job change." *Contemporary Economic Policy* 22(3): 357-369; Buchmueller, T., Valletta, R. 1999. "The effect of health insurance on married female labor supply." *Journal of Human Resources* 34(1): 42–70; Cooper, P., Monheit, A. 1993. "Does employment-related health insurance inhibit job mobility?" *Inquiry* 30(4): 400-416; Gruber, J., Madrian, B. 1994. "Health insurance and job mobility: The effects of public policy on job-lock." *Industrial and Labor Relations Review* 48(1): 86-102; and Kapur, K. 1998. "The impact of health on job mobility: A measure of job-lock." *Industrial and Labor Relations Review* 51(2): 282–298.