September 2009

Issue Brief

Out of Options: Why So Many Workers in Small Businesses Lack Affordable Health Insurance, and How Health Care Reform Can Help

Findings from The Commonwealth Fund Biennial Health Insurance Survey, 2007

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ABSTRACT: Although employer-sponsored health insurance forms the backbone of the health insurance system in the United States, small businesses are finding it increasingly difficult to provide their workers with comprehensive coverage. In 2007, only 25 percent of employees in small businesses had coverage through their own employers, compared with 74 percent of workers in large firms. Because there are few sources of affordable coverage outside the employer-based system, millions of employees in small businesses are uninsured or have inadequate health insurance. In 2007, 52 percent of workers in small businesses were uninsured or underinsured during the year, compared with half as many employees in large businesses. Congressional bills to reform the health system include provisions specifically aimed at helping small businesses and their employees gain access to affordable, comprehensive coverage.

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OVERVIEW

Although an estimated 162 million Americans have health insurance coverage through employers, many workers in small firms—particularly low-wage workers—are left out.[1] Health care cost growth has outstripped overall economic growth and has increased health insurance premiums for all employers. Small businesses have been particularly hard hit.[2] On average, small firms pay up to 18 percent more in premiums than large firms do for the same health insurance policy.[3] This reflects higher per-employee costs of writing and administering insurance plans in small companies, increased insurance broker fees, and, in some states, underwriting that leads to more costly premiums for sicker or older workforces.[4]

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Commonwealth Fund pub. 1316
Vol. 67

Rising premiums have weakened small businesses' ability to offer comprehensive coverage or have led them to drop coverage altogether. In 2008, less than half of firms with fewer than 10 employees offered health benefits, compared with nearly all firms with more than 200 employees. When small employers do offer health insurance, their workers pay substantially higher premiums for family coverage and face higher deductibles, on average, compared with those working for larger businesses.[5] As a result, millions of small-business workers are either uninsured or, when they have health benefits, spend a large share of their income on out-of-pocket health care expenses.[6]

Drawing from the Commonwealth Fund 2007 Biennial Health Insurance Survey, this analysis examines the health insurance experiences of workers in small firms (i.e., those with fewer than 50 employees) compared with those in large firms (i.e., those with 50 or more employees). It also considers how the health reform proposals under discussion in Congress would increase the ability of small firms and their workers to gain access to affordable health insurance.

The study finds that in 2007, only 25 percent of employees in small businesses had coverage through their own employers, compared with 74 percent of workers in large firms. Many employees of small businesses gain coverage through another employer, typically a spouse's employer. However, more than half (52%) were either uninsured or had such high out-of-pocket costs relative to income that they were effectively underinsured, compared with 28 percent of workers in large companies. The analysis also finds that between 2003 and 2007, the share of workers in small companies who were offered health benefits and also eligible for those benefits declined from 45 percent to 36 percent. Workers in large firms experienced no change over the same period: 87 percent to 88 percent were offered and were eligible for employer benefits.

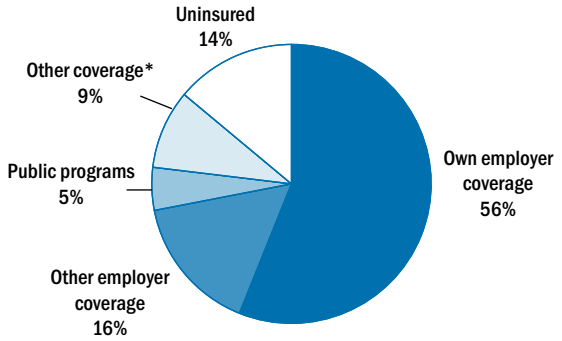
The downturn in the economy, coupled with persistent high rates of growth in health care costs, has likely further burdened small businesses, leaving more workers without access to coverage or with high out-of-pocket costs. Health care reform bills under discussion in Congress include provisions specifically designed to help small businesses afford and maintain health insurance for their workers and enable workers without employer coverage to gain access to affordable, comprehensive health insurance.

SURVEY FINDINGS

Employees of Small Businesses and Those with Low Wages Are Least Likely to Have Employer Health Benefits

Employer coverage is the predominant form of health insurance for most U.S. working adults and their families. In 2007, 72 percent of workers under age 65 had coverage through employers. Fifty-six percent obtained health insurance coverage through their own employers

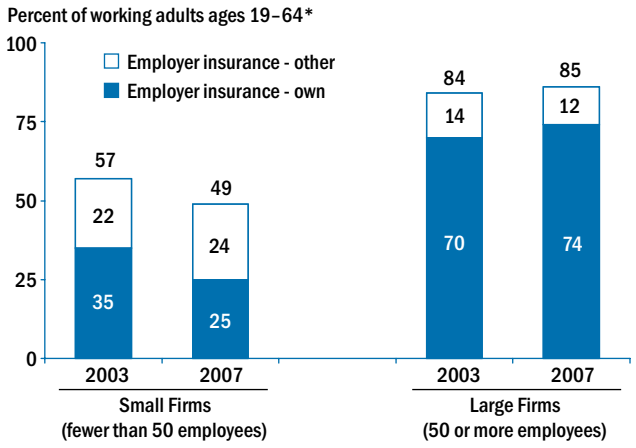
Figure 1. Majority of U.S. Workers Get Health Insurance Through Employers, 2007



122.2 Million Full- and Part-Time Workers Ages 19–64

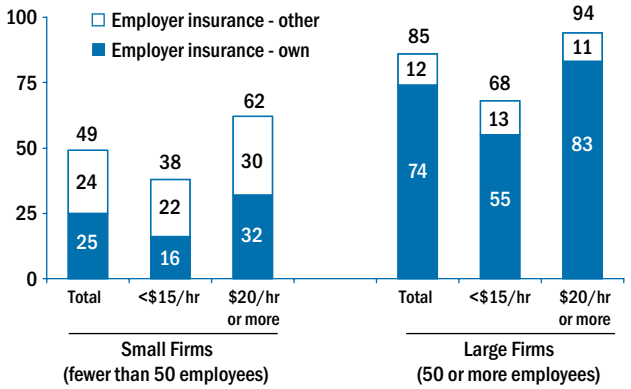
*Includes those with individual insurance and "other" responses.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Figure 2. Employer-Sponsored Insurance Coverage Declined Among Small-Firm Employees, 2003–2007



*Includes both part-time and full-time workers.
Note: Subgroups may not sum to totals because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

Figure 3. Low-Wage Employees in Small Firms Are Less Likely to Have Employer-Sponsored Insurance Coverage



*Includes both part-time and full-time workers.
Note: Subgroups may not sum to totals because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

and another 16 percent had employer-sponsored coverage through family members (Figure 1). Still, many workers are left out of the employer based health insurance system: nearly three of 10 workers (28%) do not have job-based benefits, with 14 percent lacking any coverage at all.

Employees of small businesses are the least likely to have coverage through employers (Figure 2). Only 25 percent of employees in small businesses had coverage through their own employers in 2007, compared with 74 percent of workers in large firms. The disparity in health benefits between large- and small-firm workers widened considerably between 2003 and 2007: small-firm employees with coverage through their companies fell from one-third (35%) in 2003 to one-quarter in 2007, while coverage actually increased slightly over that period among large-firm employees. While many small-business employees can gain insurance through a family member's job, they have a much lower rate of employer coverage than employees of large firms. Only half (49%) of workers in small businesses had employer-based insurance from any source in 2007, compared with 85 percent of employees in large firms.

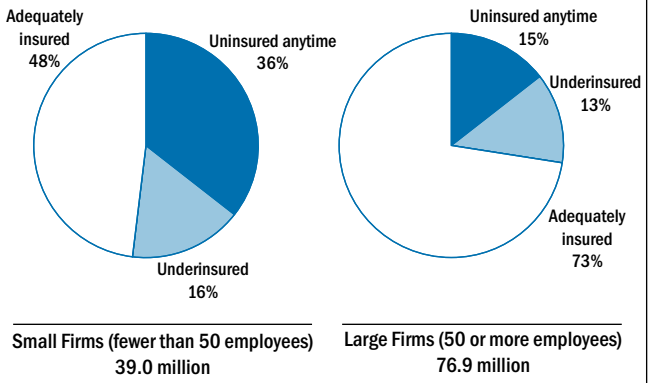
Workers employed by small firms and earning low wages fare the worst in terms of job-based health benefits (Figure 3). Only 16 percent of small-company workers who earn less than $15 per hour have coverage through their own employers, and less than two of five (38%) have coverage through any employer. In contrast, while lower-wage workers in large companies fare worse than higher-wage workers in large companies, they are far more likely to have employer-based insurance than low-wage employees of small companies.

Workers in small companies are at higher risk than are large-firm employees of being uninsured and of facing higher out-of-pocket costs and deductibles. In 2007, more than one-third (36%) of workers in small businesses were uninsured for all or part of the year, compared with just 15 percent of workers in large businesses (Figure 4). An additional 16 percent of workers in small businesses were underinsured—that is, even though they were continuously insured, they had coverage that did not adequately protect them from medical expenses.[7] In total, 52 percent of workers in small businesses were uninsured or underinsured, compared with 28 percent of workers in large firms.

Many Workers in Small Businesses Are Ineligible for Their Employer Plans or Are Not Offered Coverage

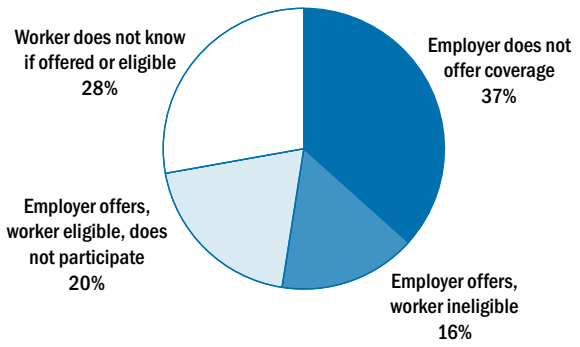
The primary reasons workers do not have health benefits through their employers are: 1) they are not offered coverage, or 2) they are ineligible to participate in their employer's plans. Employers offering health insurance may limit eligibility to employees who have worked for a minimum number of months, to permanent

Figure 4. Over Half of Working Adults in Small Firms Were Uninsured or Underinsured During the Year, 2007



^Includes both part-time and full-time workers.
Underinsured is defined as having continuous health insurance coverage and spending 10 percent or more of income on out-of-pocket health care costs (or 5 percent or more if low income), or having deductibles of 5 percent or more of income.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Figure 5. More Than Half of Uninsured Workers Are Ineligible for Their Firm's Plan or Employed by Firms That Do Not Offer Health Benefits

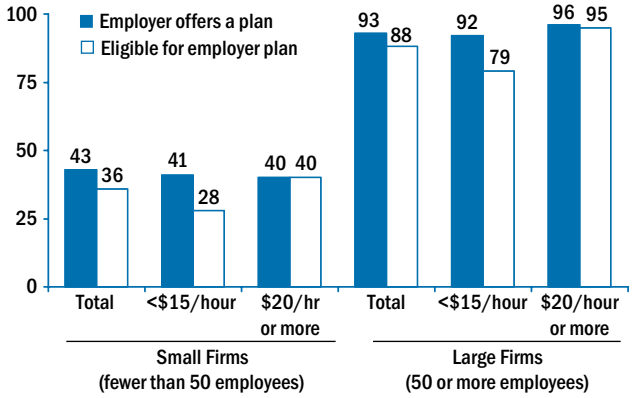


17.3 Million Uninsured Workers Ages 19–64

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Figure 6. Workers in Small Firms Are Less Likely to Be Offered and Eligible for Health Insurance from Their Employer

Percent of working adults ages 19–64*



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

(versus temporary) workers, or to those who work a minimum number of hours per week.[8] More than half (53%) of uninsured working adults either work for companies that do not offer health insurance coverage or are ineligible to participate in the health plans offered (Figure 5).

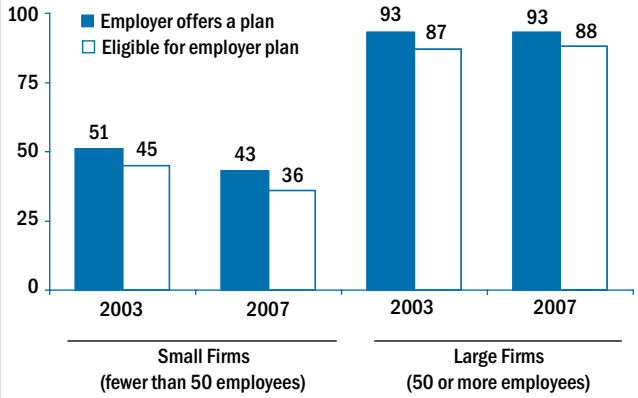
Adults working in small businesses are far less likely than workers in large firms to be offered coverage by their employers and to be eligible to participate (Figure 6). In 2007, only 43 percent of employees in small businesses worked for companies that offered health benefits, and just over one-third (36%) were eligible to participate in their employers' plans, compared with the vast majority of employees working in large companies (93% worked in companies that offered coverage and 88% were eligible). Lower-wage workers in both large and small firms were less likely to be eligible for benefits than higher-wage workers.

Between 2003 and 2007, the health benefit gap between small and large firms grew wider. In 2003, 51 percent of employees in small businesses worked for companies that offered health benefits, compared with 43 percent in 2007 (Figure 7). The percentage of small-firm employees eligible for their employer health benefits also dropped: 45 percent in 2003 versus 36 percent in 2007. In contrast, the share of large businesses that offered coverage to their employees and the share of employees who were eligible for health benefits did not change significantly.

In businesses of any size, the majority of workers who are offered and eligible for employer-based health plans enroll. About 70 percent or more of employees in small and large businesses who were offered coverage and were eligible to participate got coverage through their employers (Figure 8). Low-wage workers, however, had lower take-up rates than higher-wage workers: two-thirds of low-wage workers (i.e., those earning less than $15 per hour) who were offered coverage and were eligible to participate enrolled in coverage through their own employer, compared with 85 percent or more of higher-wage earners (Table 1).[9]

Figure 7. Share of Small Firms Offering Benefits To Employees and Employee Eligibility Declined, 2003–2007

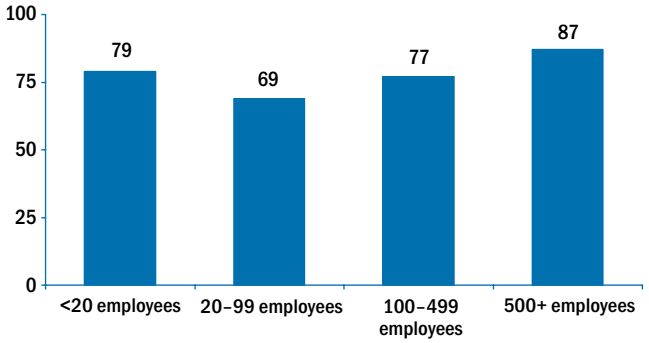
Percent of working adults ages 19–64*



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

Figure 8. When Employees in Small Firms Are Offered and Eligible for Employer-Sponsored Coverage, Take-Up Rate Is High

Percent of working adults ages 19–64 who are eligible for and take up employer-sponsored insurance*



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Limited Insurance Options Exist Outside the Employer-Sponsored System

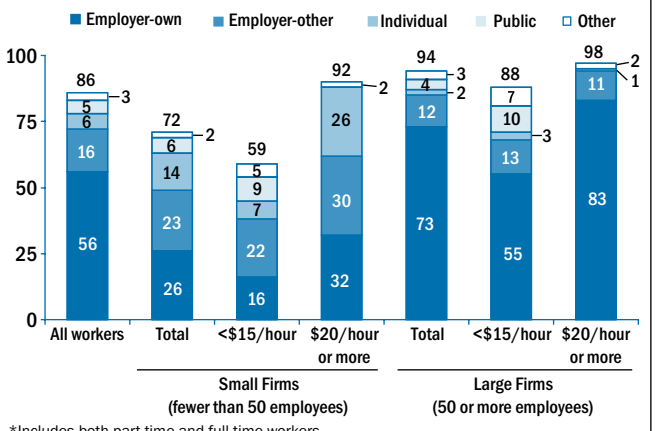
Few affordable insurance options exist for workers who do not have access to health insurance through employers. Indeed, only 5 percent of all workers were enrolled in public insurance programs, including Medicaid or Medicare.[10] To be eligible for Medicaid, an individual must meet both categorical and income eligibility criteria.[11] In most states, income eligibility criteria for adults in Medicaid are very low. And, in general, although requirements vary from state to state, categorical requirements limit Medicaid eligibility to children under age 19, parents of dependent children, and the disabled. Although several states have expanded eligibility for parents of dependent children who meet a categorical eligibility requirement above the federal poverty level, in most states income eligibility thresholds are well below the federal poverty level (Table 2). Childless adults in most states are not eligible for Medicaid, regardless of their income levels.[12]

The individual insurance market is the sole option for working adults who do not have access to employer-based insurance and who do not qualify for public insurance programs. In 2007, only 6 percent of all workers had coverage through the individual market (Figure 9). A greater share of employees in small businesses than those in large businesses is insured through the individual market (14% versus 2%). Higher-wage workers in small businesses have the highest rate of individual market coverage (26%).

Workers in small firms are more likely to search for coverage on the individual market than are workers in large firms. The survey found that 38 percent of workers in small firms either had individual market coverage or had tried to buy it over the past three years, compared with 18 percent of those working for large firms (Figure 10). But more than two-thirds of workers in small firms who sought coverage in the individual market over a three-year period never ended up purchasing a plan, either because they were dissuaded by inadequate coverage options or unaffordable premiums or they were turned down or had a coverage exclusion because of a health problem. Low-wage workers were also particularly unlikely to purchase coverage: 78 percent of low-wage employees who investigated buying a plan did not purchase coverage versus 55 percent of higher-wage employees. More than four of 10 (44%) small-firm workers who bought, or tried to buy, a policy in the individual market in the past three years said it was very difficult or impossible to find coverage they needed, and 57 percent reported it was somewhat or very difficult to find a plan they could afford. One-third (33%) were either turned down, charged a higher price because of their health status, or had a specific health problem excluded from coverage.

Figure 9. Low-Wage Workers in Small Firms Are Less Likely to Have Health Insurance Than High-Wage Workers in Small Firms

Insurance sources for working adults ages 19–64*



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Figure 10. The Individual Insurance Market Is Not an Affordable Option for Small-Firm Workers*

Working adults ages 19–64:	Total	<50 employees	50+ employees	<$15/hr	$20/hr+
Has individual coverage or tried to buy it in past three years	25%	38%	18%	25%	25%
Among those:					
Found it very difficult or impossible to find coverage they needed	39%	44%	34%	43%	34%
Found it very difficult or impossible to find affordable coverage	54	57	50	63	36
Were turned down, charged a higher price, or had a specific health problem excluded from coverage	26	33	19	23	23
Any of the above	62	69	54	67	50
Never bought a plan**	67	69	67	78	55

*Includes both part-time and full-time workers.
**Among those who tried to buy a plan.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

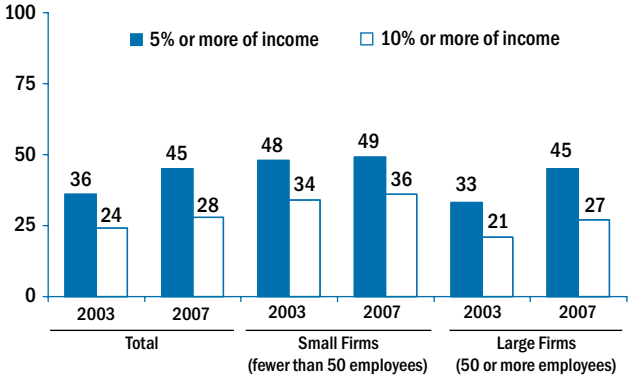
Employees with Low Wages Spend a Greater Share of Income on Out-of-Pocket Costs

Workers, regardless of the size of the company they work for, are spending more of their income on out-of-pocket health care costs and premiums. Between 2003 and 2007, the share of adults with employer-sponsored insurance who spent more than 5 percent of income on premiums and out-of-pocket costs climbed from 36 percent to 45 percent. In 2007, more than one-quarter (28%) spent 10 percent or more of their income on health care (Figure 11). Nearly half (49%) of workers in small firms spent 5 percent or more of their income on health care and one-third (36%) spent 10 percent. Even workers in large firms are increasingly reporting they spend large shares of their income on health care.

As a share of income, the cost of employee contributions for health insurance and out-of-pocket medical expenses is far greater among low-wage workers than workers with higher wages.[13] The survey found that in all firm sizes nearly six of 10 (59%) workers who earned less than $15 an hour and had coverage through their own employers spent 5 percent or more of income on out-of-pocket medical care costs and premiums; 41 percent spent 10 percent or more (Table 3). In contrast, workers earning $20 or more per hour had much lower rates: 33 percent spent 5 percent or more

Figure 11. Share of Workers Spending Large Shares of Income on Out-of-Pocket Medical Expenses Increased, 2003–2007

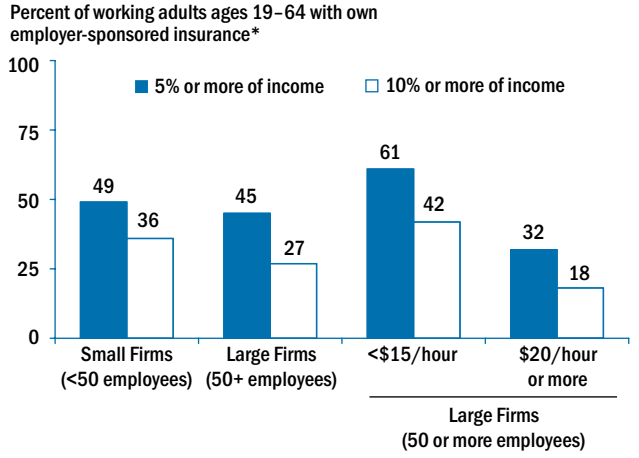
Percent of working adults ages 19–64 with own employer-sponsored insurance*



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

of their income on out-of-pocket health care costs, and 19 percent spent 10 percent or more. Premium contributions also take a larger bite out of the salaries of lower-wage workers: four of 10 (41%) workers earning less than $15 an hour devoted 5 percent or more of their income to premiums, compared with 16 percent of workers earning $20 or more per hour (Table 3). Within large businesses, the differences between low- and high-wage workers are staggering: 61 percent of low-wage employees in large firms spent 5 percent or more of their incomes on health care expenses and premiums, compared with half as many (32%) higher-wage workers (Figure 12).

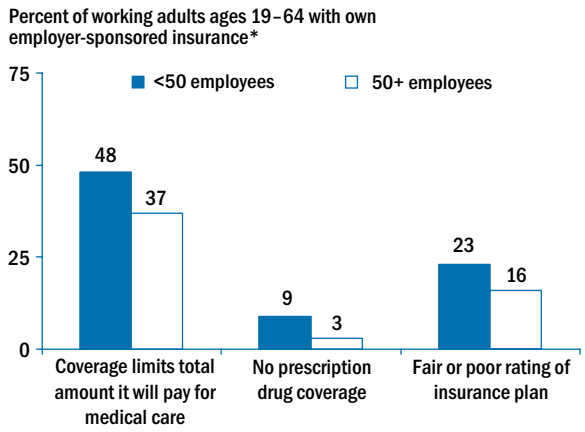
Figure 12. Workers with Lower Wages, Regardless of Employer Size, Are More Likely to Spend Large Share of Income on Out-of-Pocket Medical Costs and Premiums



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Insurance Benefits Are Less Comprehensive for Employees in Small Businesses. Employees of small firms have less-generous health care benefits than employees of large businesses. Half (48%) of workers in small businesses have health plans that limit the total amount they will pay out for medical care, potentially leaving many enrollees exposed to high medical costs if the limit is exceeded (Figure 13). One of 10 employees of small businesses (9%) does not have prescription drug coverage; far fewer of their counterparts in large companies (3%) lack this important benefit. Similarly, employees of small firms are more likely than employees of large firms, or those who earn higher wages, to rate their insurance plan as fair or poor.

Figure 13. Insurance Benefits Are Not as Generous for Workers in Small Businesses



*Includes both part-time and full-time workers.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

HOW SMALL BUSINESSES AND EMPLOYEES WOULD BENEFIT FROM HEALTH REFORM PROPOSALS

Under the bills passed by three U.S. House of Representatives committees (Ways and Means, Education and Labor, Energy and Commerce) and by the Senate Health, Education, Labor and Pensions (HELP) Committee this summer, small businesses and their employees are among those who would gain the most from health care reform (Table 4).[14] The bills aim to provide near-universal health insurance coverage by building on the strongest part of the insurance system—large-employer insurance and Medicaid and CHIP. They also seek to regulate and reorganize the weakest parts of the system—the individual and small-group insurance markets—where so many small businesses and individuals are hurt by high premiums, costly broker fees, underwriting, and a lack of transparency in the content of benefit packages. Individuals would be required to have coverage, and large employers would be required to either offer coverage or contribute to the cost of their employees' insurance. Income eligibility for Medicaid would be expanded up to 133 percent (the House bill) or 150 percent (the Senate bill) of the federal poverty level. A new health insurance exchange would provide small businesses and people without access to employer coverage or Medicaid a choice of a private or public health plan,

with premium subsidies offered on a sliding scale. A standard benefit package or set of packages would set a minimum for plans offered through the exchange, and carriers would be prevented from underwriting on the basis of health. Each bill identifies system reforms aimed at improving quality and reducing costs through provider payment reform, health information technology, simplification of insurance processes, and other approaches.

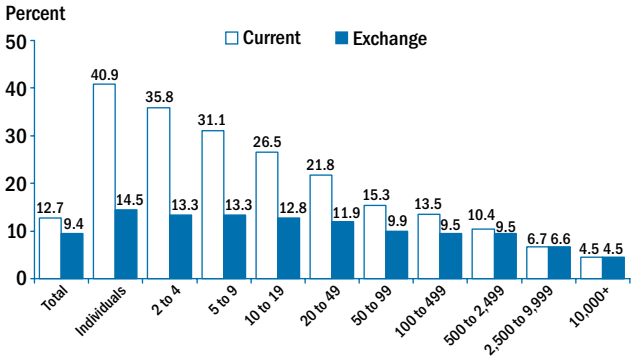
How the Bills Would Help Small Businesses

Each bill specifies provisions explicitly designed to help small businesses afford health insurance and to exempt them from requirements that they offer coverage.

Ability to Purchase Health Insurance Through the Health Insurance Exchange. Under the Senate HELP bill, small businesses with fewer than 50 employees could purchase plans through the health insurance exchange. Under the House tri-committee bill, as reported by the Energy and Commerce Committee on July 31, 2009, employers with 10 or fewer employees could purchase coverage through the exchange in the first year of implementation and those with up to 20 employees could buy plans in the exchange in year 2. An amendment adopted by the House Education and Labor Committee increased the eligibility size to 15 employees in year 1, 25 in year 2, and no fewer than 50 employees in year 3.

Plans purchased through the exchange would have a standard benefit package with no lifetime or annual limits on what they would pay, and they would vary only by the degree of cost-sharing. The plans would likely have lower premiums than those available to small employers through the small-group market because of lower administrative costs, such as broker fees and restrictions on underwriting. In addition, the choice of a public plan, featuring lower overhead and the ability to pay providers below commercial rates, would also lead to lower premiums. An analysis of a mixed private–public approach similar to the Senate and House bills found that allowing small firms to purchase coverage through an exchange that included both private and public health plan choices would lower administrative costs, as a share of claims, from the current levels of 22 percent–36 percent (depending on firm size) to 12 percent–13 percent (Figure 14).[15] In the analysis, when the public plan option that pays providers at Medicare rates was included, premiums for single coverage were estimated to fall by up to 25 percent.

Figure 14. Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Exemption from the Employer Requirement to Offer Coverage. Both the Senate HELP bill and the House bills require employers to offer coverage or pay into a fund to help finance their workers' insurance, but they exempt small employers from the requirement to offer health insurance. The Senate HELP bill requires employers to offer health coverage to their employees and contribute at least 60 percent of the premium cost or pay $750 for each full-time employee and $375 for each part-time employee who is not offered coverage, but it exempts employers with fewer than 25 employees from the mandate. The House tri-committee bill would require employers to offer coverage to workers and contribute at least 72.5 percent of the premium for single policies and 65 percent of the premium for family policies, where the premium is defined as the lowest for a plan that meets the bill's essential benefits standards. If employers opted not to offer coverage, they would be required to pay 8 percent of payroll into a health insurance exchange trust fund. Small businesses with annual payrolls of less than $500,000 would be

exempt from the 8 percent payroll tax. The penalty would phase in: 2 percent for firms with payrolls between $500,000 and $585,000, 4 percent for firms with payrolls between $585,000 and $670,000, 6 percent for firms with payrolls between $670,000 and $750,000, and 8 percent for firms with payrolls above $750,000.

Small-Business Tax Credits to Offset Premium Costs. Both the Senate HELP and House bills offer tax credits for small employers to offset their premium costs if the firms provide health insurance to their employees. The Senate HELP bill provides tax credits for up to three years for firms of 50 workers or fewer and with an average wage of $50,000 or less if they offer coverage and pay 60 percent or more of their employees' premiums. The credit is equal to $1,000 for each employee with single coverage and $2,000 for family coverage. Bonus payments are available for each additional 10-percentage-point increase in premium contributions. The House tri-committee bill provides a tax credit equal to 50 percent of the premium paid by a small employer that is in compliance with the mandate (i.e., is paying at least 72.5% of the premium for single coverage and 65% of the premium for family coverage). The tax credit is phased out for employers with 10 to 25 employees and for employers with average wages of $20,000 to $40,000 per year.

How the Bills Would Help Small-Business Employees and Low-Wage Workers

Under both the Senate and House bills, small-firm employees and low-wage workers would have improved access to affordable, comprehensive health benefits.

Incentives Could Increase the Number of Small-Business Employees with Benefits and Improve Benefits Offered. The incentives for small employers to offer health insurance coverage could increase the share of small-firm employees who have coverage through their jobs. The ability of small firms to buy coverage through the exchange and the requirement that employer benefit packages meet the standard of benefits offered through the exchange would improve the benefits of many small-firm employees who currently have limited benefits or high out-of-pocket costs. This would particularly benefit employees with low wages.

Small-Firm Employees and Low-Wage Workers Without Employer Coverage Would Have New Options for Affordable, Comprehensive, and Stable Coverage. Those small-firm employees who do not have health insurance through their jobs would, depending on their income, have new affordable options either through Medicaid or the health insurance exchange. Eligibility for Medicaid would increase to 150 percent of the federal poverty level (about $30,000 for a family of four) in the Senate HELP bill and 133 percent of poverty in the House tri-committee bill. New insurance regulations in both bills would ensure that people buying coverage through the exchange could not be charged higher premiums or denied coverage based on health status. Premiums could be up to 25 percent lower through the exchange than current levels, particularly if a public plan option is included.[16] Workers changing jobs among firms in the exchange (e.g., small restaurants or retail outlets) could retain the same coverage. Both the Senate HELP and House tri-committee bill set standards for an essential benefit package that would ensure people have access to comprehensive coverage without annual or lifetime limits. This would also ensure transparency of benefit packages: people would have far more information when choosing which package best meets their needs than what is currently available in the individual market. Sliding-scale premium subsidies would offset the premium costs for those buying coverage through the exchange, and standards regarding out-of-pocket costs would decrease the risk of excessive out-of-pocket spending and high medical bills for small-firm and low-wage workers.

CONCLUSION

The combination of unabated growth in health care costs and the severe downturn in the economy will make it increasingly difficult for small firms to offer coverage and for workers who lose their benefits or

their jobs to afford coverage in the individual insurance market. A recent Commonwealth Fund analysis found that family premiums in employer-based plans increased by 119 percent between 1999 and 2008, while median family income grew by just 29 percent.[17] If current cost trends continue, the analysis predicts that premiums will rise by 94 percent by 2020 to an average $23,842. A recent study estimates that without health care reform small businesses will pay nearly $2.4 trillion dollars over the next 10 years in health care costs for their workers and, as a result, 178,000 small-business jobs will be lost.[18] Both the Senate HELP and House bills directly address the serious economic and health implications of this cost growth by expanding access to affordable and comprehensive insurance coverage. The reforms proposed in the bills and those under discussion by policymakers and the Obama administration aim to improve the quality of health care and bring costs under control. It is critical that policymakers continue to forge ahead and form consensus around health care reform strategies that are so desperately needed by U.S. businesses and working families.

NOTES

1 P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey* (Washington, D.C.: Employee Benefit Research Institute, Sept. 2008).

2 C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums are Eating Up Middle-Class Incomes* (New York: The Commonwealth Fund, Aug. 2009).

3 J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs*, May/June 2006 25(3):832–43.

4 Henry J. Kaiser Family Foundation, *State Variation and Health Reform: A Chartbook*, (Menlo Park, Calif.: Kaiser Family Foundation, July 2009); Actuarial Research Corporation, *Study of the Administrative Costs and Actuarial Values of Small Health Plans* (Washington, D.C.: U.S. Small Business Administration, Office of Advocacy, Jan. 2003), http://www.sba.gov/advo/research/rs224tot.pdf; M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs,* March/April 2000 19(2):173–84; Council of Economic Advisors, *The Economic Effects of Health Care Reform on Small Businesses and Their Employees* (Washington, D.C.: Executive Office of the President, July 25, 2009); Gabel, McDevitt, Gandolfo et al., "Generosity and Adjusted Premiums," 2006.

5 G. Claxton, J. Gabel, B. DiJulio, et al., "Health Benefits in 2008: Premiums Moderately Higher, While Enrollment in Consumer-Directed Plans Rises in Small Firms," *Health Affairs* Web Exclusive, Sept. 24, 2008:w492–w502; S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, April 2003).

6 White House Office of Health Reform, *Helping the Bottom Line: Health Reform and Small Business* (Washington, D.C.: Executive Office of the President, April 2009).

7 "Underinsured" is defined as having continuous health insurance coverage and spending 10 percent or more of income on out-of-pocket health care costs (or 5 percent or more if low income), or having deductibles of 5 percent or more of income.

[8] P. Fronstin, *Employment-Based Health Benefits: Access and Coverage, 1988–2005* (Washington, D.C.: Employee Benefit Research Institute, March 2007).

[9] Based on an analysis of the 2005 Current Population Survey by Paul Fronstin, affordability is a critical factor. Among workers who declined an offer of employer-sponsored health insurance and who were not covered by another source of insurance, by far the most common reason given was that the employee contribution for the employer-sponsored plan was too costly; very few stated that they did not need or want coverage. Fronstin, *Employment-Based Health Benefits,* 2007.

[10] Among low-wage workers who do not have access to health insurance through their employer, 12 percent are enrolled either in Medicaid or CHIP and less than 2 percent are enrolled in Medicare. Eligibility for Medicare for the nonelderly is limited to individuals who either have received Social Security Disability Insurance benefits for at least 24 months, or who have certain very serious health conditions, such as end-stage renal disease or amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease).

[11] J. Hearne, *Medicaid Eligibility for Adults and Children* (Washington, D.C.: Congressional Research Service, Domestic Social Policy Division, Sept. 19, 2005).

[12] Henry J. Kaiser Family Foundation, *Medicaid: A Primer* (Menlo Park, Calif.: Kaiser Family Foundation, Jan. 2009).

[13] J. Gabel, J. Pickreign, R. McDevitt et al., "Trends in the Golden State: Small-Group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet," *Health Affairs* Web Exclusive, June 14, 2007:w488–w499.

[14] Henry J. Kaiser Family Foundation, *Side by Side Comparisons of the Major Health Care Reform Proposals,* (Menlo Park, Calif.: Kaiser Family Foundation, Aug. 5, 2009), available at http://www.kff.org/healthreform/sidebyside.cfm; H.R. 3200, America's Affordable Health Choices Act of 2009, July 14, 2009, 111th Congress, 1st session; "An American Solution: Quality Affordable Health Care, The House Tri-Committee Health Reform Discussion Draft Summary," Committees on Ways and Means, Energy and Commerce, and Education and Labor, July 14, 2009, available at http://energycommerce.house.gov/Press_111/20090714/hr3200_summary.pdf; H.R. 3200 America's Affordable Health Choices Act of 2009, July 14, 2009, 111th Congress, 1st session, Energy and Commerce Amendments, available at http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1722:hr-3200-americas-affordable-health-choices-act-of-2009-markup-day-5&catid=141:full-committee&Itemid=85; Affordable Health Choices Act, Senate Committee on Health, Education, Labor and Pensions, July 15, 2009, 111th Congress, 1st session; "In Historic Vote, HELP Committee Approves the Affordable Health Choices Act," Senate Health, Education, Labor and Pensions Committee Press Release and Summary, July 15, 2009, available at http://help.senate.gov/Maj_press/2009_07_15_b.pdf; *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*, Senate Finance Committee, May 14, 2009, available at finance.senate.gov/Roundtable/complete%20text%20of%20coverage%20policy%20options.pdf.

[15] C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork in the Road: Alternative Paths to a High Performance Health System* (New York: The Commonwealth Fund, June 2009); S. R. Collins, R. Nuzum, S. D. Rustgi, S. Mika, C. Schoen, and K. Davis, *How Health Care Reform Can Lower the Costs of Insurance Administration* (New York: The Commonwealth Fund, July 2009).

[16] Schoen, Davis, Guterman et al., *Fork in the Road,* 2009; Collins, Nuzum, Rustgi et al., *How Health Care Reform Can Lower Costs,* 2009.

[17] Schoen, Nicholson, and Rustgi, *Paying the Price*, 2009.

[18] The Small Business Majority, *The Economic Impact of Health Care Reform on Small Business*, June 11, 2009.

ABOUT THIS STUDY

The Commonwealth Fund 2007 Biennial Health Insurance Survey was conducted by Princeton Survey Research Associates International from June 6, 2007, through October 24, 2007. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 3,501 adults age 19 and older living in the continental United States. The analysis in this issue brief is based on the 1,716 respondents ages 19 to 64 who were either full-time or part-time workers. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental United States. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2006 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 122 million workers ages 19 to 64.

The 1,716 workers included 1,391 full-time workers and 325 part-time workers. Among the employed nonelderly respondents, 258 were uninsured, 941 had their own employer-sponsored insurance, 256 had employer-sponsored insurance through someone else, 100 had individual insurance, 115 had public insurance, and 46 had other insurance. Respondents were also grouped by wage and by employer size. Wage categories included the following: less than $15/hour (N=660), $15–$20/hour (N=259), and $20/hour or more (N=549). Employer size was grouped as follows: less than 20 employees (N=428), 20–99 employees (N=264), 100–499 employees (N=269), and 500 or more employees (N=669). Finally, respondents were categorized by employer size and wage, with 283 in small firms with low wages (fewer than 50 employees making less than $15/hour), 142 in small firms with high wages (fewer than 50 employees earning more than $20/hour), 341 in large firms with low wages (50 or more employees earning less than $15/hour), and 401 in large firms with high wages (50 or more employees earning more than $20/hour).

The survey has an overall margin of sampling error of +/– 2.2 percentage points at the 95 percent confidence level. A response rate of 45 percent was calculated consistent with standards of the American Association for Public Opinion Research.

Table 1. Availability of and Workers' Eligibility for Employer Insurance, by Wage and Size of Employer

Base: Workers[a] ages 19–64

		Hourly Wage			Employer Size			
	Total	**<$15**	**$15–<$20**	**$20+**	**<20**	**20–49**	**50–99**	**100+**
Unweighted n	1,716	660	259	549	399	145	120	951
Total (millions)	122.2	44.5	21.0	39.5	28.4	10.6	7.7	69.2
Percent distribution	100%	36%	17%	32%	23%	9%	6%	57%
Availability and eligibility of employer insurance								
Employer offers ESI	75	70	88	79	32	75	93	93
Employee eligible for ESI	69	56	84	78	27	63	86	88
Don't know if offered	10	8	4	12	31	2	0	2
Current Source of Insurance Coverage								
Covered through own employer	56	38	72	67	21	41	64	75
Covered through someone else's employer	16	16	14	17	24	22	15	12
Covered through public program	5	10	1	0	6	6	6	3
Individual	6	4	3	9	18	3	4	2
Other	3	6	1	2	2	2	1	4
Uninsured	14	26	9	4	29	26	11	6
Take-up of ESI when eligible	81	67	85	86	79	65*	74*	84

[a] Workers include both part-time and full-time workers.
*Denotes sample size is less than 100.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Table 2. Uninsured Rates and Medicaid/CHIP Income Eligibility Standards by State

	Percent Uninsured, 2006–2007		Income Eligibility for Medicaid/CHIP (Percent of federal poverty levels), 2009		
	Children (under 18)	Adults (age 18-64)	Children	Parents	Childless Adults
Alabama	7.3	18.6	200	25	NA
Alaska	10.8	22.4	175	85	NA
Arizona	15.4	24.5	200	200	100
Arkansas	7.7	24.8	200	17	NA
California	11.8	24.0	250	106	NA
Colorado	13.8	20.3	205	66	NA
Connecticut	5.6	12.7	300	191	NA
Delaware	9.6	14.8	200	121	100
District of Columbia	7.4	12.7	300	207	200[a]
Florida	19.1	26.4	200	55	NA
Georgia	12.1	22.2	235	52	NA
Hawaii	5.6	11.0	300	100	100
Idaho	12.0	18.9	185	28	NA
Illinois	8.0	18.1	200	185	NA
Indiana	6.5	15.6	250	26	NA
Iowa	5.5	13.7	200	86	200[b]
Kansas	7.5	17.1	200	34	NA
Kentucky	8.8	19.4	200	62	NA
Louisiana	14.2	26.8	250	26	NA
Maine	5.8	12.2	200	206	100[c]
Maryland	10.2	17.5	300	116	116[d]
Massachusetts	5.0	10.3	300	133	133/300[e]
Michigan	5.4	15.2	200	66	35[f]
Minnesota	7.3	10.8	275	200	200[g]
Mississippi	15.5	25.0	200	46	NA
Missouri	9.8	16.8	300	26	NA
Montana	13.5	20.6	175	58	NA
Nebraska	10.1	16.2	185	58	NA
Nevada	16.5	22.5	200	91	NA
New Hampshire	7.0	14.3	300	51	NA
New Jersey	13.1	19.4	350	200	NA
New Mexico	16.7	29.6	235	69	NA
New York	8.6	18.0	250	150	100[h]
North Carolina	13.0	22.0	200	51	NA
North Dakota	9.1	14.0	150	62	NA

Ohio	7.1	14.4	200	90	NA
Oklahoma	12.5	24.9	185	48	200[i]
Oregon	11.9	22.5	185	42	100[j]
Pennsylvania	7.4	12.7	300	36	200[k]
Rhode Island	6.5	12.6	250	181	NA
South Carolina	12.5	20.9	200	90	NA
South Dakota	8.6	14.5	200	54	NA
Tennessee	7.8	19.6	250	134	NA
Texas	21.3	30.4	200	27	NA
Utah	12.7	18.2	200	68	150[l]
Vermont	8.7	13.5	300	191	150
Virginia	10.2	17.9	200	30	NA
Washington	6.9	15.2	250	77	200[m]
West Virginia	6.6	19.1	220	34	NA
Wisconsin	5.3	11.2	250	200	200[n]
Wyoming	8.9	19.1	200	54	NA

NA: Not applicable because state does not extend Medicaid eligibility to non-parent adults.

a District of Columbia has a state-run program called DC Healthcare Alliance which provides free health care to uninsured adults below 200% FPL delivered via Medicaid managed care organizations.

b IowaCare program expands a limited set of Medicaid benefits to all adults using a limited provider network.

c MaineCare waiver program extends a more limited set of benefits to adults up to 100% FPL.

d Maryland Primary Adult Care program allows adults up to 116% FPL who are ineligible for Medicaid and Medicare to receive primary care, outpatient mental care, and pharmacy services.

e Commonwealth Care Health Insurance Program provides sliding-scale subsidies to individuals with incomes below 300% FPL. No premiums will be imposed on those individuals with incomes below 133% FPL.

f The Adults Benefits Waiver program was designed to provide new beneficiaries with a benefits package that is less broad than Michigan 's standard Medicaid or SCHIP coverage.

g Childless adults up to 200% FPL are eligible for more limited coverage ($10,000 annual limit on inpatient hospital care).

h New York Family Health Plus contracts with managed care organizations and covers comprehensive acute care benefits but not long-term care benefits of traditional Medicaid. Coverage available without premium costs to 100% for childless adults and to 150% for parents.

i The Insure Oklahoma waiver program provides limited coverage and subsidies for parents and childless adults up to 200% FPL who are either self-employed, work for a small employer, unemployed but looking for work, working disabled, full-time college student, or spouse of qualified worker.

j The Oregon Health Plan Standard benefit package, designed for Oregon's expansion population (who are adults, 19 to 64 years of age up to 100 percent FPL) is leaner in benefits and includes significant co-pays. Enrollment is closed.

k Pennsylvania has a state-funded health insurance program called adultBasic that is designed to provide health insurance for adults with incomes up to 200% FPL who do not have health coverage, but enrollment is capped and new applicants are being put on a waiting list.

l Utah's Primary Care Network provides primary care and preventive services to low-income adults under 65 who would otherwise lack health insurance.

m Washington has a state-funded health insurance program called Basic Health that provides health care coverage to adults below 200%. Monthly premiums are based on family size, income, age, and health plan choice, with a sliding-scale state subsidy.

n Childless adults up to 200% FPL are eligible for limited set of benefits under Badger Care Plus Core Plan for Childless Adults.

Sources: Uninsured rates: Employee Benefit Research Institute (EBRI) analysis of March 2007 and 2008 Current Population Surveys. Children and parent eligibility levels: Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2009" and "Income Eligibility Levels for Children's Regular Medicaid and Children's SCHIP-funded Medicaid Expansions by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2009" available online at http://www.statehealthfactsonline.org, accessed on May 10, 2009. Parents and childless adults eligibility levels: Kaiser Commission on Medicaid and the Uninsured, Expanding Health Coverage for Low-Income Adults: Filling the Gaps in Medicaid Eligibility, May 2009.

Table 3. Annual Insurance Premiums, Deductibles, Out-of-Pocket Costs and Benefit Design and Limitations by Wage and Employer Size

(Base: adult workers 19–64, insured with their own employer-sponsored insurance*)

		Hourly Wage			Employer Size	
	Total	<$15	$15–<$20	$20+	<50 Employees	50+ Employees
Total (millions)	68.7	16.8	15.1	26.5	10.3	56.4
Percent distribution	100%	24%	22%	39%	15%	82%
Unweighted n	941	248	189	369	136	765
Annual Premium Costs (All Plans)						
None	20%	16%	20%	23%	32%	18%
$1–$499	8	12	9	5	7	9
$500–$1,499	25	30	27	28	10	28
$1,500–$2,999	17	17	17	19	15	17
$3,000 or more	18	15	19	18	27	16
Premium is 5% or more of income	26	41	30	16	31	25
Annual Deductible Per Person						
Less than $500	62	64	68	59	56	63
$500 or more	23	20	21	29	28	23
Less than $1,000	74	77	79	73	67	75
$1,000 or more	11	7	9	15	16	10
Deductible is 5% or more of income	21	22	12	16	9	4
Total Household Out-of-Pocket Medical Expenses, Including Prescription Drugs and Premiums						
None	3	2	3	4	2	3
$1–$999	20	21	14	19	22	19
$1,000–$4,999	54	59	60	56	45	56
$5,000 or more	21	17	23	20	27	20
Spent annually 5% or more of income	45	59	55	33	49	45
Spent annually 10% or more of income	28	41	32	19	36	27
Insurance Benefits						
No prescription drug coverage	4	8	3	2	9	3
No dental coverage	17	28	12	12	35	13
Neither prescription drug nor dental coverage	3	6	3	2	8	2

Health Plan Limitations						
Prescription drug coverage limits the total amount it will pay or the number of different prescriptions that can be filled	27	37	37	18	25	26
Number of doctor visits per year	10	16	11	8	10	10
Number of mental health visits per year	22	20	28	21	19	23
Total dollar amount it will pay for medical care	39	49	39	34	48	37
How would you rate current health insurance coverage?						
Excellent	21	16	21	24	14	22
Very good	34	27	30	41	32	35
Good	27	30	28	23	30	26
Fair/poor	17	26	18	12	23	16

*This sample includes only those who are the primary policyholder on their employer-sponsored insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2007.

Table 4. Leading Congressional Health Insurance Reform Proposals, as of August 2009

Features	Senate HELP proposal 7/15/09[a]	House of Representatives Tri-Committee bill 7/31/09[b] (Energy and Commerce amendments)
Individual mandate	Yes—$750 penalty, exemptions if premium is not affordable (> 12.5% of income)	Yes—2.5% payroll tax penalty; exceptions for financial hardship
Premium subsidies to individuals	Premium credits on sliding scale up to 400% FPL for purchasing in exchange; subsidies based on 3 lowest-cost plans so that people pay no more than 12.5% of income; no subsidies for those with employer-based coverage that meets minimum qualifying criteria and affordability standards (premiums must be <12.5% of income)	Premium and cost-sharing credits on a sliding scale up to 400% FPL for purchasing through exchange; premium credit starting premiums greater than 1.3% of income and phasing out at 12% of income; cost-sharing credits based on actuarial value up to 400% FPL; no subsidies for those with employer-based coverage that meets minimum qualifying criteria and affordability standards (premiums must be <12% of income)
Medicaid / CHIP expansion	Expansion up to 150% FPL; Medicaid firewall	Expansion up to 133% FPL; Medicaid firewall; 100% federal financing of expansions through 2014, 90% financing 2015 and on
Shared responsibility/ employer pay-or-play	$750/year per uncovered full-time worker, $375/ year per uncovered part-time worker; or at least 60% premium contribution; first 25 employees exempt; small business exclusions (firms <25 workers); penalty indexed to CPI in 2013	Sliding scale phased-in based on payroll from 2% to 8% of payroll; or at least 72.5% contribution to premium for individuals, 65% for families; small business exclusions (firms with <$500,000 payroll)
Small Business Tax Credits	Firms with <50 employees and average wage <$50,000 eligible for tax credits for 3 years if they offer and pay 60% of premiums. Credit equals $1,000/single coverage and $2,000/family coverage. Incentives for greater contributions.	50% of amount paid by a small employer in compliance with mandate (phased out for 10-25 employees or average wage of $20,000 to $40,000 annually)
Insurance Exchange	State (can band together to form regional)	National or State
Plans offered	Private and public	Private, public and co-op
Minimum benefit standard; tiered standards; content	Three benefit tiers – Tier 1 essential health benefits covers 76% of costs, Tier 2 covers 84%, Tier 3 covers 93%; all plans must provide basic services as specified by new Medical Advisory Council	As specified by new Health Benefits Advisory Council, all plans, including employers, must provide at least the basic package inside and outside the exchange Four benefit tiers – Tier 1 essential health benefits package covers 70% of costs, Tier 2 covers 85%, Tier 3 covers 95%, Tier 4 covers 95% and adds oral health and vision care. Coverage purchased on individual market does not qualify unless grandfathered

Table 4. Leading Congressional Health Insurance Reform Proposals, as of August 2009		
Features	**Senate HELP proposal 7/15/09[a]**	**House of Representatives Tri-Committee bill 7/31/09[b] (Energy and Commerce amendments)**
Insurance market regulations	Guaranteed Issue; Rating based on age (2:1), family composition, tobacco use, plan value, and geography; no health rating National regulations apply inside and outside the exchange Participating plans provide incentives to providers to deliver care more efficiently	Guaranteed Issue; Rating based on age (2:1), family composition, and geography; no health rating Exchange replaces individual market Insurers must meet a specified medical loss ratio
Eligibility to purchase through exchange	Individuals and small businesses <50 employees; individuals with ESI >12.5% of income	Individuals, employers <10 employees in year one, <20 employees in year two; Amendment adopted by Education and Labor Committee increased the eligibility size to 15 employees in year one, 25 in year two, and no fewer than 50 employees in year three.

[a] Affordable Health Choices Act, Senate Committee on Health, Education, Labor and Pensions draft, June 9, 2009, 111th Congress, first session. Affordable Health Choices Act: Shared Responsibility of Employers, Senate Committee on Health, Education, Labor and Pensions Fact Sheet, July 2, 2009; Affordable Health Choices Act, Senate Committee on Health, Education, Labor and Pensions, additional Chairman's mark on coverage, July 2, 2009, http://help.senate.gov/BAI09F54_xml.pdf;

[b] H.R. 3200 America's Affordable Health Choices Act of 2009, July 14, 2009, 111th Congress, 1st session ; An American Solution: Quality Affordable Health Care, The House Tri-Committee Health Reform Discussion Draft Summary, Committees on Ways and Means, Energy and Commerce, and Education and Labor, July 14, 2009, available at http://energycommerce.house.gov/Press_111/20090714/hr3200_summary.pdf.

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Acknowledgments

The authors thank Karen Davis for her helpful comments.

Editorial support was provided by Deborah Lorber.


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