



Leverage Public and Private Funding

Reference Paper

Communities Connect

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Background

In Washington State many employers, specifically small employers, cannot afford to offer health benefits to their employees. However, many employers would like to contribute towards their employee's health benefits. To achieve an employer cost level that is not cost prohibitive. This can be attained by a cost-sharing or "blending" approach where contributions from employers, employees, and state subsidies are pooled together to share the cost of health coverage for low-wage workers and their families. This blending arrangement shares the cost of the health insurance premium among all parties.

With the more flexible and desirable pre-tax options, states and employers have a new opportunity for combining funds to purchase affordable coverage. There are several kinds of pre-tax health accounts available for employers and consumers. Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), and the new Health Savings Accounts (HSAs) are included and authorized under Title XII of the newly enacted Medicare Prescription Drug, Improvement and Modernization Act¹.

¹ This law went into effect January 1, 2004.

Table 1

	FSA	HRA	HSA (replaced MSAs)
Who funds	Employee only	Employer only	Employer and/or employee
Use it or Lose it	Yes (unspent funds revert to employer)	No (employer retains unspent funds)	No (account belongs to employee)
Payment for qualified medical expenses	Yes	Yes	Yes
Portable	No	Limited (remaining balance may be spent down after leaving job)	Yes
Contribution Limits	No legal limit; employer decides.	No legal limit; employer decides	Yes, in statute. The maximum for 2004 is \$2,600 for an individual and \$5,150 for a family. Contribution also may not exceed the deductible on the linked health insurance plan.
Comments			Can only be used in conjunction with a qualifying high-deductible health insurance plan (minimum deductible \$1,000 individual/\$2,000 family), but HSA's can be used by any consumer, not just those who have a work-related coverage arrangement.

Problem

75% of Washington residents who are uninsured live in a home where at least one adult works full-time. For people under 65 who are insured, 78% are covered through their (or a relative's) place of employment (2000 data), although this percent is starting to shrink each year as health care premiums increase with double-digit inflation. Among insured low-income people (under 200% of federal poverty), the percent with employment-related coverage is only about 50%². Employers in Washington State have historically been strongly opposed to employer mandates and/or employer taxes to pay for health insurance while showing high interest in voluntarily paying for coverage if it were affordable and easy to do so. At one time, the Basic Health Plan offered subsidized (reduced premium) comprehensive insurance coverage to employers, but a statewide, governmental approach was not successful with businesses because: 1) it was too complicated to determine eligibility and enroll workers; 2) individual enrollment cost less, 3) employers had little to no input on what services were covered; 4) stigma of it being the "government" or "welfare".

Many of these uninsured and those on state-subsidized insurance are working for small business. Small businesses (<50 employees) are less likely to offer health benefits to their employees than large businesses. Research reveals two key barriers that prevent employers from offering health insurance, with the overriding barrier being the cost of the product³. Lack of Education about insurance options, potential value, and administrative burden are second.

The limited range of options that exist for health insurance coverage generally frustrates small employers. Insurance premiums are unaffordable and pre-tax accounts have never really taken off with employers for a variety of reasons: 1) complexity of administration; 2) it's not what agents and brokers are trained to sell; 3) lack of financial protection for serious injury or illness; 4) "use it or lose it" limitations make unpredictable expenditures difficult to plan for; 5) concern about cash flow needs of low-wage workers; and 6) due to cost-shifting, the prices of services is higher than may be for a comprehensive insurance product. Even though the recent federal legislation authorizing Health Savings Accounts (HSAs) mitigates some of these historic problems with pre-tax accounts, pre-tax accounts that aren't tied to subsidized coverage would likely result in low voluntary employer and employee participation.

Given the number of unknowns, relying on a single statewide model (for instance, another attempt at Basic Health Plan for employers) may be too risky, too politically difficult, and too hard to sell to employers. The state will need to be flexible and financially and programmatically support a number of community-specific models. This includes a stronger public-private collaboration in order to leverage the desired non-governmental resources. Employers, individual employees and other sources of community funding or effort will be less willing to participate in something that is a "government program."

² Source: Office of Financial Management, State Population Survey, 2000.

³ Evens/McDonough Worldways Social Marketing, Telephone Survey of Small Businesses that not Offer Health Insurance Benefits, 2002. This and other research emphasizes the difficulty of achieving large increases in the coverage of low-income workers in small, low-wage firms without relatively deep subsidies (close to half the premium).

Solutions

We want to be able to cover all low-income people by encouraging voluntary increases in employers' financial participation. We also want to incorporate employers' participation, over time, in the fabric of a single community approach to what services are needed and how they will be paid for – rather than encouraging further confusing fragmentation in the services covered and mechanisms of finance. We recommend that government dollars should be used to subsidize premiums for a high deductible insurance product in coordination with pre-tax accounts (Health Savings Accounts) and earned income tax credits funded by employer and employee contributions so that low-wage workers can access care within an organized provider network where some price negotiation has taken place. These funds may be used to subsidize insurance premiums as long as they increase the number of insured and are affordable for employers and employees.

Increasing health care coverage requires leveraging all the assets available, including:

- Contributions from employers and employees; combined with
- Maximum use of federal revenue and tax savings; matched with
- Currently appropriated state and federal tax dollars.

Such blending of funds might take many forms, ranging from premium subsidies given to employers who purchase coverage to community administered programs that pool funds to finance a system of care for low-income residents.

In order to maximize expansion of coverage, this should be an approach that maintains some flexibility about the exact benefit package. However, there must be a strong primary care component, arrangements for catastrophic levels of medical services, and arrangements for/linkages with sources of client assistance and care coordination so that the fragmentation of services is minimized, more work needs to be done on the level of coverage that is affordable to small employers.

Over time the proposed model would move beyond premium assistance, administered by the state, to allow state agencies to partner with and delegate pooled funding to local efforts that have made serious commitments to expanding coverage among low-wage employees and other low-income residents. Determining criteria for approving communities ready to delegate pooling of funds beyond premium assistance is a policy issue. The organizational and governance structures of local entities would likely vary with their intent and the scope of functions they undertake, but there should be clear evidence of public purpose and a public-private partnership that involves at least one appropriate local government entity. We recommend:

1. Authorize use of public funds to subsidize employer coverage for low-wage workers⁴

Strategies include:

- Pass legislation that allows Basic Health dollars (and eventually Medicaid) to subsidize small employers’ premiums or be blended with employer contributions and tax credits for low-wage workers.
- Ask DSHS to negotiate the appropriate Medicaid/SCHIP waivers to maximize available state and federal resources.

2. Statewide support of Community Branded Storefronts

These would be community branded (and eventually community administered) programs to maximize employer and employee interest in participating. There are statewide support functions that would make it more likely to succeed at the community level. Allow an option for flexible administration through partnership with community entities that expand low-income coverage will offer additional advantages, by encouraging additional funds leverage and “storefront” points of access or service that makes sense in various geographic areas. Local outreach and marketing will be key to the success.

Community Storefronts: A Basis for Partnership

Function	Statewide	Community
Publicizing options	General publicity, information materials; limited reality of conducting intensive outreach without partnerships.	Face-to-face outreach incorporating state or local materials as most effective
Enrolling employers	Efficient toll-free number and customer service; consider teaming with agents/brokers.	On-the-ground work in communities involving agents/brokers and/or local outreach staff.

⁴ The level of the subsidy needed requires additional research and discussion. For instance, through Muskegon County Michigan’s 3-share program, small employers pay 30% of the premium. Representative Cody’s bill assumes small employers will pay 40% of the premium and Commissioner Kreidler’s request legislation assumes small employers will pay xx%.

Helping employers with plan set up/administration	Information, coaching, subsidy, discounted prices for business services.	Face-to-face visits, coaching, connection with state resources, involving agents/ brokers, outreach staff.
Helping low-income employees understand options	Even efficient toll-free number and customer service will have serious limits; probably essential to partner locally.	Group meetings and face-to-face meetings involving staff, low income tax assistance groups, possibly agents/ brokers, other local firms.
Obtaining deductible-based stop-loss and/or catastrophic coverage	Statewide purchase and policy leverage are likely to produce the best prices and broadest pooling of risk.	Retain local negotiating autonomy for variations in product to match local model, and ability to choose a preferred carrier partner.

Statewide strategies include:

- Budget for state-funded start-up grants for communities to build a provider network for both the high-deductible plan and the HSAs.
- Have OIC train, state purchasers, pay brokers and outreach workers to hold seminars throughout the state to educate employers on what they can do now for employees with pre-tax accounts (HRAs, FSAs and most recently HSAs) and help them set up and manage those accounts.
- Develop a state-sponsored and financed patient advocate program based on the SHIBA best practice to work with low-wage workers to plan for, set-up and manage their pre-tax accounts.
- Have the governor develop and launch a high visibility statewide action campaign to enroll employers and employees.
- Have the OIC operate through SHIBA or arrange for efficient toll-free customer service to help low-income individuals and families understand their options, enroll in coverage and carry out the paperwork necessary to maximize federal income tax benefits (including leverage of Earned Income Tax Credits).
- Have OIC and state purchasers encourage health plans to develop high deductible insurance products to augment HSAs. This could include negotiating and selecting one or more low-cost group options for higher deductible medical coverage and/or stop-loss insurance for employers and community groups.

Local strategies include:

- Use Communities Connect members to negotiate discounted prices for services paid through pre-tax accounts to increase the value.
- Organize and train brokers, outreach workers and patient advocates as the work force to educate and enroll employer groups.

3. Creation of a formal process and technical assistance for delegating administration of small employer programs to organized communities

Strategies include:

- Have the Health Care Authority (HCA) develop criteria for greater delegation of administration to communities over time. This includes specific pathways for the flow of funds and the capacity to transmit funds to employers, employees, community entities and/or other fiduciary agents. It also includes providing technical assistance to communities on insurance law, federal tax law, options for obtaining Medicaid match, etc.

4. Formal legislative and public oversight and accountabilities for the public/private (state/community) partnership

Strategies include:

- Have the Governor's Health Policy Office study the contribution that coverage makes to economic development and worker productivity; However, this should only be undertaken if it is properly funded.
- Have the HCA study and report to the legislature on whether appropriate state and local governmental authorities exist; including through special districts and special intergovernmental arrangements, for collaborating local communities to take on direct fiduciary roles (holding funds for the purpose of coverage or direct payment for health services).