

STATE-SPONSORED HEALTH INSURANCE PLANS FOR SMALL BUSINESS

EMPLOYERS: POLITICAL AND ECONOMIC FACTORS FOR SUCCESS

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JAMES THOMAS STRONG

ADVISOR DR. DANIEL REAGAN

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ABSTRACT

THESIS: State-Sponsored Health Insurance Plans for Small Business
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STUDENT: James Strong

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The purpose of this study was to examine three state-sponsored health insurance programs targeted at small businesses and identify the political and economic factors that contributed to their success. I evaluated the success of each states program using three criteria: reducing the number of uninsured, program participation, and providing portability. In my analysis, I examined factors which may have played a role in the varying levels of success that were observed. I found that the success of a program depended largely on two factors: economic conditions within the state and the quality of the program.

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CHAPTER I

Introduction

Health insurance has become an important topic in this country over the last few decades, in part, because of the increasing number of Americans who are uninsured. At last count, over 46 million Americans are without health care coverage (DeNavas-Walt, Proctor, & Smith, 2008). This figure represents an increase of 682,000 from the 2007 number of 45.7 million uninsured Americans (DeNavas-Walt, Proctor & Smith, 2008). Due to many of the uninsured working for small businesses, many states have begun taking steps towards reducing the number of uninsured. This thesis will examine state-run small business health insurance programs offered in several states to identify the political and economic factors that contribute to their success.

Statement of the Problem

Uninsured individuals do not normally receive the preventative care they need for early diagnosis of many controllable diseases, such as diabetes and high blood pressure. It is usually only after a major medical incident that many of these uninsured people seek medical treatment. This treatment is often provided in emergency rooms where it is the most expensive. The problem with the uninsured seeking medical treatment at hospitals is that it is costly. In 2004, for instance this produced a 40.7 billion dollar uncompensated care debt (Hadley & Holahan, 2004).

Of the 46 million Americans who lack health coverage, about 13 million are small business employees (Health Reform, 2009). In the early 1990's roughly 61 percent of all small businesses offered health insurance. This percentage has dropped to around 38 percent during the last 15 years (Landrieu, 2009). This decline in coverage represents a problem that is becoming all too common, small businesses today are less likely to offer health insurance than larger businesses.

The cost of health insurance is hurting many small businesses. Owners are faced with tough decisions like shutting down and closing their doors or ceasing to provide health insurance benefits. This pressure is unfortunate because small businesses are the engines that drive our economy. Over the last two decades, small businesses with fewer than 20 employees have been responsible for creating more than 80 percent of the net new jobs in this country (Small Business Technology Council, 2007). Some of the nation's biggest and most prosperous companies such as Apple, Google and Hewlett-Packard began as small businesses. Reform that provides health insurance to smaller businesses could expand health insurance coverage, but also stimulate the creation of more small businesses.

Several states have enacted programs to increase insurance coverage among small business and their employees, with varying levels of success. In this study I will investigate why some state-sponsored health insurance programs have been more successful than others.

Chapter 2 of this thesis will cover the history of health insurance and describe the status of health insurance reform today. This chapter also describes the steps some states have taken as a way to provide health insurance to many of its small business employees. Chapter 3 examines three states and evaluates the success of their programs. Chapter 4

presents an analysis of the data gathered in Chapter 3 and draws conclusions about factors contributing to success.

CHAPTER II

Literature Review

Introduction

The federal government has made several attempts in the past to provide universal health insurance to its citizens, only to be met with resistance from the American Medical Association, physicians, and insurance companies (Oberlander, 2007). As a result of this continued resistance and failure at the federal level, many states have started their own programs aimed at reducing the number of uninsured.

History of Health Insurance Reform

The history of health insurance has been characterized by periodic attempts through government intervention to make health insurance more widely available. Health insurance reform as a political issue in the United States can be traced back to the early twentieth century. In 1914, the American Association for Labor Legislation became involved in trying to pass legislation to provide workers with free medical care. Physicians strongly opposed the legislation, fearing a government takeover and regulation of doctors' fees (Daschle, 2008). By the end of the decade, all efforts to pass the bill stopped.

During the Great Depression of the 1920's many hospitals experienced a dramatic decrease in the number of patients. To avoid going bankrupt, hospitals implemented a prepayment plan. The prepayment plan was the creation of health insurance. The plan was initially directed towards teachers, firefighters and hospital employees. For a

monthly fee, members of the plan were guaranteed free hospital care when needed (Daschle, 2008). The prepayment plan became very popular; and as a result, the prepayment plan developed into the Blue Cross system (Anderson, 1975).

World War Two accelerated the growth of employer based health insurance. After the National War Labor Board froze wages, employers began offering health insurance in lieu of pay as a way to retain employees (Fronstin, 2001). Workers were attracted to health insurance for two main reasons: unions supported employment based health insurance and health benefits were not subject to income or social security taxes (Fronstin, 2001).

During President Truman's administration, efforts to bring a single payer system to the agenda were quickly stopped. The American Medical Association (AMA) began communicating to doctors, insurance company employees, and employers that the federal government was taking steps towards communism. The AMA's efforts worked because polls showed that in 1945, 75 percent of Americans supported Truman's plan of universal health insurance but within four years that support had dropped to 21 percent (Quadagno, 2005). All efforts towards reform ceased for the next twenty years.

In 1965, the United States made progress towards insuring all Americans when President Johnson signed Medicare and Medicaid into law. Medicare is health insurance that was created for adults age 65 and older or who have certain disabilities. Medicare is funded through the Federal Insurance Contributions Act (FICA) as a payroll tax paid by both employers and employees. When Medicare was initially created there were two parts to it. Part A is referred to as hospital insurance which covers hospital stays, skilled nursing homes and some home health care. Part B is referred to as Medical Insurance. Under Part B, most participants pay a premium to receive benefits. Some services

included under Part B Medicare include doctor's visits, outpatient services and preventative care (Chambers, n.d.). Currently, 45 million Americans receive Medicare benefits (Centers for Medicare and Medicaid Services, 2009). Due to the 76 million baby boomers that were born between 1946 and 1964 and who are planning on retiring within the next decade, a lack of funding is foreseen in the future (Zimmerman, 2009).

The federal government has taken some steps to improve Medicare by creating Parts C and D. Created in 2003, Part C is referred to as the Medicare Advantage Plan. Part C Medicare is a combination of Part A and B Medicare. Part C, however, is provided through private health insurance companies that Medicare has approved. Finally, Part D was created in 2006 to provide prescription coverage to Medicare enrollees (Chambers, n.d.).

Medicaid is a program created as a state and federal partnership to insure low income families and individuals. Primary oversight of Medicaid is at the federal level, but states are given discretion to determine eligibility standards, rate of payment for services, and the type, amount, and duration of services (Medical News Today, 2010). Service providers are paid by the state; the state is then reimbursed for a portion of the cost by the federal government (Medical News Today, 2010). Currently, Medicaid covers 46 million Americans at an estimated cost of \$338 billion per year (Office of Management and Budget, 2006). As a result of the high cost associated with funding Medicaid many states have had to cut programs due to increases in medical costs.

After the passage of Medicare and Medicaid, efforts to enact universal health insurance ceased until 1993, when President Clinton proposed a major health reform bill to Congress. This overhaul sought to build on the public-private health care system. Initially, Clinton's plan gained strong support but over the course of a year public support

fell from 71 percent to 43 percent (Blendon, Brodie, & Benson (1995). Again, health reform stalled.

Clinton's plan failed due to many obstacles. First, Clinton attempted to simultaneously secure universal coverage, regulate the private insurance market, create employer mandates, enforce costs through a national health board, and deliver healthcare through a managed care system (Oberlander, 2007). Achieving any one of these goals would have been a difficult task.

Second, Clinton underestimated the opposition to reform. Resistance came from the National Federation of Independent Business, which opposed the employer mandate and the Health Insurance Association of American, which opposed regulating insurance. Initially, Clinton had the support of the public but this quickly changed because, in general, Americans with medical coverage are satisfied with their health insurance arrangements. Americans become unsettled when reform threatens to change those arrangements (Oberlander, 2007).

Although the Clinton health care plan for comprehensive reform failed, Congress succeeded in expanding health insurance coverage to low income families by passing the State Children's Health Insurance Program (SCHIP) in 1997. SCHIP allows states to insure children from low income families that receive income above the Medicaid eligibility levels (Herz, Fernandez, & Peterson, 2005). As a result, SCHIP has covered 6.6 million children and has been the largest expansion in health care since the inception of Medicare and Medicaid (American Medical Association, 2010).

Resistance is a major reason health reform stalls. The American Medical Association, insurance companies and doctors have consistently opposed major healthcare reform. Because of this opposition, the American Association for Labor

Legislation Compulsory Health Insurance plan in the 1910s. President Truman's plan after World War Two, and President Clinton's universal health care proposal all met the same fate.

Yet not all attempts of health reform have failed. Programs such as Medicare, Medicaid, and SCHIP have successfully extended coverage to the previously uninsured. The passage of these programs indicates that when reform benefits a sympathetic population such as the elderly, poor, or young, then resistance from interest groups is reduced and the reform can pass.

During the Obama administration, health reform has become a top issue on the agenda. During the 2008 presidential campaign, Barack Obama made specific promises to the American people regarding health care reform. These promises included passing a comprehensive health care reform bill by the end of his first presidential term, providing tax subsidies for the poor, creating tax credits for small businesses and increasing funding towards prevention and wellness programs (Condon, 2009). The Obama plan focused on families and small businesses by providing additional tax credits, and eliminating discrimination against Americans with pre-existing medical conditions.

On March 22, 2010 President Obama signed the *Patient Protection and Affordable Care Act* into law, ending nearly one hundred years of failed attempts at comprehensive healthcare reform. Resistance to Obama's health reform plan has not come from the same interest groups as in the past. Instead the American Medical Association (AMA), insurance companies, and doctors supported health reform.

The AMA historically advocated against universal health reform, but changed its tone and supported the Obama health initiative. Although the AMA is supporting the reform bill, the AMA does disagree with sections of the bill which include banning

physician-owned hospitals, penalties for physicians unwilling to participate in Medicare's physician quality reporting initiative, and creating a payment advisory board for Medicare that could incorrectly reimburse doctors based off the current design (Lowes, 2010).

The AMA recognizes that not taking action will result in an increase in the uninsured as well as higher health care costs. In addition to the AMA's support, other medical professionals also supported the Obama proposal, including the American College of Physicians, American Academy of Pediatrics, and many individual physicians (Lowes, 2010).

Opposition to health reform has also come in the form of partisan politics. Republicans in Congress unified in opposition to Democratic health care reform proposals. The bottom line is that passing health reform is a major party victory with strong implications for years to come and neither party is willing to take a stance that will not benefit the party. Therefore, Republicans will try everything to stop the current reform bill from being passed.

Certain members of the general public also strongly oppose health reform. Many Americans are confused, and uneducated at how health reform may benefit them. Instead of focusing on facts, many citizens listen to the rumors (Benen, 2009). The spreading of rumors to certain groups in the general public and directing messages that discuss socialism and healthcare in the same sentence makes many Americans angry. This anger tends to turn to action and in the last few years this anger has come out in public town hall meetings.

Opposition has also come from business organizations such as the U.S. Chamber of Commerce, which believes the employer mandate is unfair towards small businesses

(Josten, 2010). The reasoning behind these claims is that the Chamber believes the new mandate forces small businesses to provide every employee with health insurance whether or not they are able to afford it. The penalty for not following the mandate is a fine of up to \$2,000 dollars per employee, money that many businesses cannot afford to pay (U.S Chamber of Commerce, 2010).

The federal governments numerous failed attempts to reduce the number of Americans without health insurance has lead some states to take action by implementing health insurance programs through premium assistance and health insurance exchanges.

State Level Reform

Small business owners and their employees have been affected by high costs more than other employment sectors. This is due, because small business have less purchasing power (National Conference of State Legislatures, 2009). As a result, many owners of small businesses cannot afford health insurance for their employees, which increases the number of uninsured Americans.

Many states have implemented policies to reduce the number of uninsured citizens in their state. Many of these programs target assistance to small businesses and their employees. These programs can be grouped into two general categories: premium assistance plans and health insurance exchanges.

Premium Assistance Plans

Premium assistance plans use state funds to purchase private health insurance for small business employees. Premiums assistance allows for two methods of payment, depending on state requirements; employers either pay a portion of the monthly premium or receive a credit on their taxes. Many states have become increasingly

interested in premium assistance because a majority of lower income families that do have access to employer sponsored health insurance are not able to afford coverage. Premium assistance helps these families afford health insurance (Williams, 2003).

Premium assistance eligibility also depends upon the state that is providing the program. For example, Tennessee puts restrictions on maximum income eligibility limits for businesses while Massachusetts does not.

States adopt premium assistance because of their advantages. They create incentives for employers to offer or continue to offer health insurance to their employees. These incentives also encourage SCHIP and Medicaid recipients to shift to private insurance by making it more affordable (McAuliffe, 2007).

Premium assistance, however, also has disadvantages. The program does not help SCHIP and Medicaid members who do not have access to employer based health insurance. If income eligibility levels are set too low then only a small portion of people would actually qualify for the program. If the eligibility levels are set too high, then employers and employees will change their plans and instead take the subsidy. Finally, public costs of these programs rise over time due to rising premiums. (McAuliffe, 2007).

Eighteen states have used premium assistance to reduce the number of uninsured small business employees (National Conference on State Legislatures, 2009). Table 1 lists the states that have implemented a premium assistance program.

Table 1. States with premium assistance plans.

Arizona	Arkansas	Georgia
Idaho	Kansas	Kentucky
Maine	Maryland	Massachusetts
Montana	Nevada	New Mexico
New York	Oklahoma	Tennessee
Washington	Virginia	West Virginia

Source: National Conference on State Legislatures, 2009

Health Insurance Exchanges

Currently, larger employers are more attractive to insurance companies because insurance companies are able to better assess the risk pool, allowing the insurance companies to reduce insurance premiums. Small businesses lack this bargaining power when shopping for insurance. Health insurance exchanges seek to give small businesses the chance to offer their employees a wider range of insurance choices at a price they can afford (Underwood, 2009).

A health insurance exchange is a government regulated market that brings buyers and sellers together for the purchase of health insurance. The state acts as a clearinghouse for health insurance products, which collects and forwards payments to the insurance companies (Chambless, 2007). The state also plays a significant role in health insurance exchanges by protecting consumers with insurance regulations that prevent unfair businesses practices.

The advantages of health insurance exchanges include portability, which allows consumers to retain their health plan in the event they lose or switch jobs. Health insurance exchanges are also beneficial because they offer a variety of plans with varying benefit levels and price tags, which gives the employee more options (Klein, 2009).

Health insurance exchanges also have shown to have some disadvantages which include erosion of coverage due to employers losing control over health care options. In some cases, an employee may choose a plan that does not adequately cover his or her healthcare needs (Chambless, 2007).

Only two states, Utah and Massachusetts, have implemented a health insurance exchange (National Conference on State Legislatures, 2009). More are expected in the future, however, the recently passed health reform bill requires all states to establish a health insurance exchange by 2014.

Impact of health care on small businesses

Health care has impacted small businesses in many ways. Aside from rising health care costs and high premiums, job lock has become a major issue with small businesses. Job lock occurs when an employee refuses to change jobs in order to maintain health insurance, even though he or she may be more satisfied and productive at another job or self employed (Gerencher, 2010).

Job lock also affects employers, because the employees that an employer retains through job lock is typically the type of employee who values health insurance the most, and is not necessarily the best employee for the company (Wellington, 2001).

Finally, job lock hinders the possible growth of many small businesses and the creation of others. Many of tomorrow's entrepreneurs are today's employees at companies that offer health insurance. The problem is these same employees are fearful of not being able to access affordable health insurance when they do leave their current employer (Wellington, 2001).

Conclusion

This chapter has reviewed many key topics that describe why the current health insurance system is where it is today. Resistance from certain groups has been the overwhelming reason that several attempts at health reform have stalled. As a result, many states began taking steps as a way to provide health insurance to small business employees. The impact of health care on small businesses has also created problems such as job lock. Job lock affects everyone because employees have to settle for jobs that may not match their interest which may hinder productivity and quality and employers are not able to retain the types of employees that may benefit their business because they may not be able to offer health insurance. The following chapter will take an in depth look at different levels of success some of these states have seen by creating programs aimed at providing health insurance to small business employees.

CHAPTER III

Analysis

Introduction

The previous chapters discussed some of the various issues involved with employees not having health insurance. Some of these issues include not receiving the preventative treatment that could possibly lead to a more manageable medical prognosis. The federal government has made several attempts to offer universal health insurance with limited success. As a result, some states have taken steps towards implementing their own health insurance programs aimed at providing health insurance to small businesses and their employees.

In this study, I compare two states offering similar premium assistance programs: Tennessee and Oklahoma. These two states make a good comparison because they implemented their programs about the same time and were similar in terms of relevant statistics such as the median household income and unemployment rate. The information presented in Table 2 illustrates these similarities.

Table 2. Economic conditions of Tennessee and Oklahoma, 2006.

State	Unemployment Rate	Median Household Income
Tennessee	4.8%	\$43,438
Oklahoma	4.1%	\$42,716
Difference	0.7%	\$722

Source: Bureau of Labor Statistics, 2010 and Henry J. Kaiser Foundation, 2010

It would have been ideal to also compare two states with health insurance exchanges, but there are not two states suitable for comparison. The only two operating

state health insurance exchanges are in Utah and Massachusetts. The Utah health insurance exchange lacks sufficient data due to being only a year old and the Massachusetts reform included many more elements than just an exchange, such as the required mandate to purchase health insurance. Therefore, I will compare the programs implemented by Tennessee and Oklahoma and compare both of them to Massachusetts, which enacted a more comprehensive approach. The information presented in Table 3 summarizes important characteristics of the three programs. The three programs are described in more detail in the sections discussing their performance.

Table 3. Overview of state health insurance program characteristics.

Feature	Tennessee	Oklahoma	Massachusetts
Type of Program	Premium Assistance	Premium Assistance	Premium Assistance/Health Insurance Exchange
Program Established	2006	2005	2006
Age Requirement	19 or older	19-64	All residents over 18
Business Size Requirement	50 or fewer full-time employees	Fewer than 99 employees	11 or more employees
Income Eligibility	Must earn \$55,000 or less	Must earn less than \$24,540 for individual	All incomes allowed. Mandate
Average Individual Monthly Premium	Approximately \$50 dollars per month	\$0-119.62 dollars per month	\$0-354.00 dollars per month for single individual

Defining Success

My evaluations of these three programs are based on three criteria: reducing the number of uninsured, program participation, and providing portability. This section describes how I measure each program's performance with respect to these criteria.

Reducing the number of uninsured

Reducing the number of uninsured has benefits both for society as a whole and for the insured. As stated in Chapter 1, the uninsured are responsible for \$40 billion in uncompensated care annually (Hadley & Holahan, 2004). Research shows that people who have health insurance live longer than individuals who do not have health insurance. The uninsured are more likely not to be seen for treatable and controllable health conditions, which accounts for 44,789 preventable deaths per year (Wilper, Woodhandler, Lasser, McCormick, Bor & Himmelstein, 2009). Expanded coverage is better for the health of the economy because individuals will live healthier and more productive lives. If a program contributes to significantly reducing the number of uninsured then the program has met one of the criteria for success.

Program Participation

The percentage of small businesses offering health insurance to their employees has been considerably smaller than large businesses over the last decade. For example, 49 percent of small businesses with 3 to 9 employees and 78 percent of small businesses that employ 10 to 24 employees offered health insurance benefits to their employees in 2008 (Council of Economic Advisors, 2009). In contrast, 99 percent of businesses with more than 200 workers offered health insurance (Council of Economic Advisors, 2009).

Increasing the number of small businesses that participate in health insurance programs is good for the economy. Small businesses may attract better employees if they offer health insurance which may increase productivity and revenue. Employees also benefit because they find employment with a job that matches their interests raising morale. Therefore, if a program helps increase the number of small businesses that offer health insurance then criteria for success has been met.

Providing portability

One problem with the current insurance market is that when an employee changes jobs, they cannot retain their health insurance. Most employers require a new employee to wait a probationary period before they are eligible to purchase health insurance benefits from the employer. Within a period of months, however, medical catastrophes can occur. Uninsured medical catastrophes contribute to uncompensated health costs.

Additionally, a lack of portability for health insurance is also linked to ‘job lock’ as discussed in the previous chapter. Providing portability of health insurance allows employees to find jobs that meet their personal interest. As stated in Chapter 2, finding a job that matches an employee’s personal interest produces better morale and motivation among co-workers which possibly leads to more revenue for employers since employees are not calling in sick as much and are more productive. Therefore, if a health insurance plan allows for continued health coverage in the event an employee loses his or her job, becomes laid off, or decides to find employment at another employer then a step towards success has been met.

Tennessee Program Performance

Created in 2006, Cover Tennessee is a premium assistance program aimed at providing health insurance to small businesses at an affordable cost. Currently, the total monthly premium under the Cover Tennessee program averages about 150 dollars per month. The state, employer, and employee are each responsible for paying a third of the monthly premium. Self employed individuals pay two thirds of the monthly premium and the state pays a third (Cover Tennessee, n.d.). The program is open to working Tennesseans who are 19 or older and businesses must employ fewer than 50 full time employees and 50 percent of the employees must earn less than \$55,000 dollars per year

(Cover Tennessee, n.d.).

Reducing the number of uninsured

In 2006, Tennessee had 809,000 uninsured Tennesseans which represented 13.6 percent of the total population. The number of uninsured has continued to increase. In 2007, the percentage of uninsured rose to 14.4 percent. The most recent statistics show that in 2008 Tennessee had 931,000 uninsured residents, accounting for 15.1 percent of the population (Physicians for National Health Program, 2010). This information, presented in Table 4 shows that since the Cover Tennessee program has been in existence, the number and percentage of uninsured has continued to rise.

Table 4. Number and percentage of uninsured individuals, Tennessee, 2006-2008.

Year	Number of uninsured	Percentage of uninsured
2006	809,000	13.6%
2007	883,000	14.4%
2008	931,000	15.1%

Source: Physicians for National Health Program, 2010

Program Participation

In 2006, when Cover Tennessee was created, the number of Tennessee small businesses employing 1 to 49 employees was 126,523 (U.S. Census Bureau, 2010). During the same year, 1,046 small businesses participated in Cover Tennessee, 0.8 percent of eligible businesses (Johnson, Personal Communication, 2010). Over the next two years, the number of small businesses increased in 2007 to 129,280 but then decreased in 2008 to 127,978 (U.S. Census Bureau, 2010). The number of participating businesses continued to increase to 3,687 or 2.9 percent of eligible businesses (Johnson, Personal Communication, 2010). Small business and program participation statistics for Tennessee are presented in Table 5.

Table 5. Number of small business and program participation, Tennessee, 2006-2008.

Year	Number of Small Businesses (1-49 employees)	Number of Small Businesses in Program	Percentage of Small Businesses in Program
2006	126,523	1,046	0.8%
2007	129,280	2,791	2.2%
2008	127,978	3,687	2.9%

Sources: U.S Census Bureau, Cover Tennessee

Providing portability

Cover Tennessee was developed on two simple principles: affordability and portability. Governor Bredeson helped develop the program wanting the individual to own the health insurance policy and not the employer or state government (Bredesen, 2006). Portability through Cover Tennessee begins when an individual is employed for a small business and signs up to the program. If the employee is laid off or quits after signing up, then the employee will be able to retain their health insurance. The individual would then be responsible for two-thirds of the premium (Bredesen, 2010). Overall, Cover Tennessee provides greater portability than the other programs evaluated in this study.

Oklahoma Program Performance

Created in 2005, Insure Oklahoma is a premium assistance program which is similar to Cover Tennessee, with the state paying a portion of the monthly premium. Insure Oklahoma is open to employees from 19 to 64 years of age who work for employers that are enrolled in the program. The program is voluntary but income requirements mandate that an employee earn less than 24,540 dollars per year for a single individual. Additionally, only employers with fewer than 99 employees may enroll in the program (Insure Oklahoma, 2010).

Insure Oklahoma premiums are shared among the state, employer, and employee. The state pays 60 percent, the employer pays 25 percent, and the employee pays the remaining 15 percent (Insure Oklahoma, 2010). The total premium per month is around 220 to 240 dollars per month (Podrazik & Winter, 2008). As a result, the state pays about 132 to 144 dollars per month on a single premium. The employer would then pay 55 to 60 dollars, leaving the employee to pay approximately 35 dollars per month.

Reducing the number of uninsured

Since the Insure Oklahoma program began the number of uninsured has consistently decreased. In 2006, Oklahoma had 661,000 uninsured residents which represented 18.9 percent of the total population. The most recent statistics show that in 2008 Oklahoma had 498,000 uninsured residents, accounting for 14 percent of the population (Physicians for National Health Program, 2010). This information, presented in Table 6 shows that since the Insure Oklahoma program has been existence, the number of uninsured has continued to decrease.

Table 6. Number and percentage of uninsured individuals, Oklahoma, 2006-2008.

Year	Number of uninsured	Percentage of uninsured
2006	661,000	18.9%
2007	631,000	17.8%
2008	498,000	14.0%

Sources: Physicians for National Health Program, 2010

Program Participation

In 2006, the number of Oklahoma small businesses employing 1 to 99 employees was 87,778 (U.S. Census Bureau, 2010). During the same year, 677 small businesses participated in Insure Oklahoma, 0.8 percent of eligible businesses (Insure Oklahoma, 2010). Over the next two years, the number of small businesses increased in 2007 to 89,344 and then again in 2008 to 89,426 (U.S. Census Bureau, 2010). The number of

participating businesses continued to increase to 3,649 or 4.1 percent of eligible businesses (Insure Oklahoma, 2010). Small business and program participation statistics for Oklahoma are presented in Table 7.

Table 7. Number of small business and program participation, Oklahoma, 2006-2008.

Year	Number of Small Businesses (1-99 employees)	Number of Small Businesses in Program	Percentage of Small Businesses in Program
2006	87,778	677	0.8%
2007	89,344	1,539	1.7%
2008	89,426	3,649	4.1%

Sources: U.S. Census Bureau, Insure Oklahoma

Providing portability

Insure Oklahoma does not offer the same portability as Cover Tennessee.

Under the Insure Oklahoma plan if a participant finds employment at another employer and that employer offers Insure Oklahoma then the participant can automatically enroll under the new employees insurance without having to wait a probationary period.

However, if that same employee decides to find a job at an employer that does not offer Insure Oklahoma or becomes unemployed, then that employee is no longer eligible for Insure Oklahoma benefits (Altobello, Personal Communication, 2010).

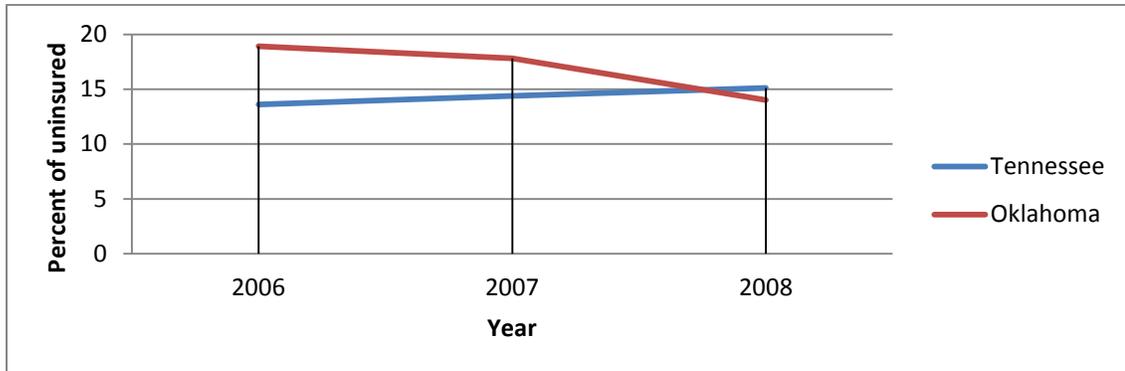
Comparing Tennessee and Oklahoma Program Performance

According to the criteria described in this chapter, Insure Oklahoma has been more successful than Cover Tennessee. Oklahoma has experienced a greater decrease in the uninsurance rate, whereas Tennessee experienced an increase. Oklahoma also experienced greater small business participation in their state sponsored health insurance program.

In 2006, Tennessee had a 13.6 percent uninsurance rate while Oklahoma's rate was 18.9 percent. By 2008, however, Tennessee's uninsurance rate had increased 2.5

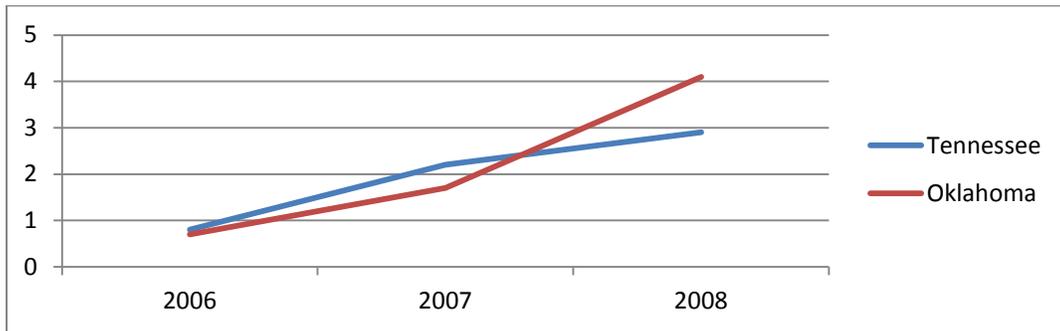
percent to 15.1 percent while Oklahoma's uninsured rate had declined to 14 percent, a decrease of almost 5 percent. Clearly, Oklahoma has been able to have a greater impact at reducing the number of uninsured than Tennessee. These changes in uninsurance rates are illustrated in Figure 1.

Figure 1. Comparison of uninsurance rates, Tennessee and Oklahoma, 2006-2008.



Oklahoma also experienced greater small businesses participation in its state sponsored health insurance program. In 2006, both Tennessee and Oklahoma had 0.8 percent of qualifying small businesses participating in their programs. Over the course of the next two years the percentage of qualifying small businesses in Oklahoma and Tennessee enrolled in these programs changed greatly. Tennessee ended 2008 with 2.9 percent of small businesses enrolled in Cover Tennessee while Oklahoma had 4.1 percent in Insure Oklahoma. These results are illustrated in Figure 2.

Figure 2. Program participation, percentage of eligible small businesses, Tennessee and Oklahoma, 2006-2008.



Portability was the final measure of success used to evaluate the success of these programs. Tennessee provides program participants with better portability of health insurance. This is because the Cover Tennessee program allows the participant to own their health insurance. If an employee of a small business decides to leave his or her job, they can still retain their health insurance but instead pay the other third of the month premium. Whereas with Oklahoma if an employee leaves an employer who had been offering Insure Oklahoma benefits then that employee is no longer covered. Although, Cover Tennessee offers better portability of health insurance when compared to Oklahoma, the benefit of this option is very limited. This is due, in part, because very few people are enrolled in the Cover Tennessee program.

Despite the similarities of the premium assistance programs in these two states and the initial similarities in the two states' economic conditions, they experienced different levels of success. Oklahoma experienced a decrease in the percentage of uninsured whereas Tennessee experienced an increase. Oklahoma also experienced a greater increase in the percentage of qualifying small businesses participating in the program than Tennessee.

Differences in economic conditions seem to be the main reason why Tennessee and Oklahoma experienced different levels of success within their programs.

In 2005 and 2006, when these two programs started, the economy was still growing but in December of 2007 the recession began (Vlasenko, 2008). It was during the recession where many of the similarities that Tennessee and Oklahoma once shared, became notable differences.

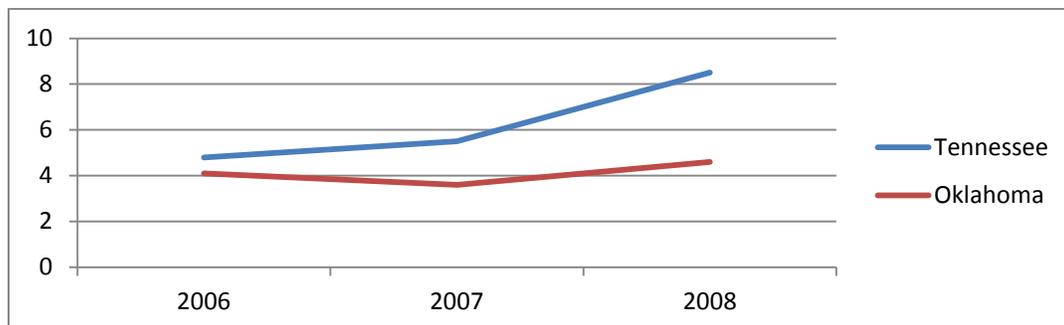
Tennessee's economy is built mainly on manufacturing work which was significantly affected by the recession (Murray, 2010). In 2008, Tennessee produced job losses in each quarter affecting every aspect of the state's economic growth (Murray, 2010). This lack of economic growth may have prevented many potential small business owners from opening up businesses. Additionally, the declining economy may have also caused many small business owners to not enroll in any additional programs, such as Cover Tennessee, as a way to contain costs and keep their businesses running. All of these scenarios are possible contributing factors as to why Cover Tennessee may have seen lower participation percentages within their program when compared to Oklahoma.

Oklahoma on the other hand, was not as greatly affected by the recession as Tennessee because Oklahoma is considered an energy state. The consistent boost from oil and gas activity has provided the state with constant income during a recession allowing Oklahoma to be listed in the top ten among states for the most job growth in 2008 (Snead, 2008).

In 2006, Tennessee saw an annual unemployment rate of 4.8 percent as compared to the annual rate of 4.1 percent in Oklahoma. Although these rates were relatively close in 2006, by 2008 they were very different. In 2008, Tennessee's unemployment rate had increased to 8.5 percent while Oklahoma's unemployment rate had only risen to 4.6

percent (Bureau of Labor Statistics, 2010). This information, presented in Figure 3 illustrates that since the Tennessee and Oklahoma programs have been in existence, the unemployment rates of both states has increased, but Tennessee's has increased much more.

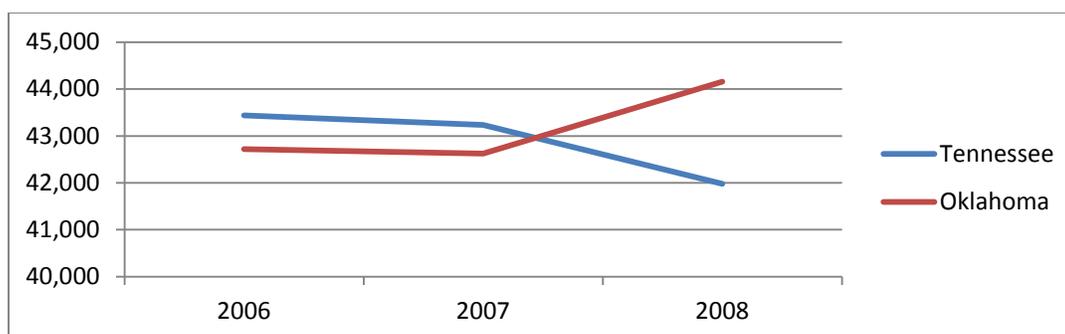
Figure 3. Unemployment rates. Tennessee/ Oklahoma, 2006-2008.



Source: Bureau of Labor Statistics, 2010

At the beginning of the study period, Tennessee and Oklahoma also were comparable in terms of their real median annual household income. In 2006, Tennessee households averaged 43,438 dollars a year and Oklahoma residents averaged 42,716 dollars a year (Henry J. Kaiser Foundation, 2010). The following year these figures remained relatively stable as Tennessee's median household income was 43,231 dollars and Oklahoma's was 42,623. In 2008, a greater difference can be seen as Tennessee's median household income level had decreased to 41,978 dollars while Oklahoma's had increased to 44,154 dollars (Henry J. Kaiser Foundation, 2010). Median annual household incomes for Tennessee and Oklahoma are presented in Figure 4.

Figure 4. Median annual household income, Tennessee/Oklahoma, 2006-2008.



Source: Henry J. Kaiser Foundation, 2010

While the economy may have played a contributing factor in the different levels of success between Tennessee and Oklahoma, there are other factors, such as the quality of the program, which may also explain why the Tennessee program was not as successful as Oklahoma's. Cover Tennessee is considered inadequate and falls short of meeting many people's health needs because the program sets many limits on the number of visits one may receive in a year. For example, an individual covered under Cover Tennessee may only receive two emergency room treatments per year. An individual with cancer can receive only six chemotherapy treatments per year. These restrictions do not help many in the target population and so many people will choose to opt for services in a clinic that charges on a fee for service scale instead. Small business employers have also been very hesitant to offer Cover Tennessee to their employees because they worry about the quality of coverage and numerous restrictions. One employer stated that he was too embarrassed to offer this program to his employees because of its inadequacy and its inability to meet the needs of his employees (Mc Andrew, 2009). Enrollment was projected to reach over 100,000 by 2010 but due to a program that offers restrictive

benefits and inadequate coverage many have chosen to bypass Cover Tennessee (McAndrew, 2009).

Massachusetts Program Performance

Massachusetts developed a comprehensive health insurance program that includes a health insurance exchange and a premium assistance option. Created in 2006, the Massachusetts Connector program also mandates that all residents who can afford health insurance must purchase it, or pay a fine. The program is open to all individuals 18 years of age or older and has no income eligibility limits but does offer an exemption from the mandate if an individual can not afford health insurance. The program currently insures over 400,000 residents (Massachusetts Connector, 2010).

Reducing the number of uninsured

In 2006, Massachusetts had 657,000 uninsured residents which represented 10.3 percent of the total population. The number of uninsured sharply reduced over the next two years. In 2007, the percentage of uninsured decreased to 5.4 percent. The most recent statistics show that in 2008 Massachusetts had 352,000 uninsured residents, accounting for 5.5 percent of the population (Physicians for National Health Program, 2010). Since the Massachusetts Connector began, the number of uninsured has dropped dramatically, a reduction of 305,000 uninsured residents between 2006 and 2008. This information, presented in Table 8 shows that since the comprehensive health reform program in Massachusetts has been existence, the number of uninsured has decreased.

Table 8. Number and percentage of uninsured individuals, Massachusetts, 2006-2008.

Year	Number of uninsured	Percentage of uninsured
2006	657,000	10.3%
2007	340,000	5.4%
2008	352,000	5.5%

Source: Physicians for National Health Program, 2010

Program Participation

In 2006, when the Massachusetts Connector was created, the number of small businesses employing 1 to 49 employees was 165,269 (U.S. Census Bureau, 2010). During the same year, 535 small businesses participated in the Massachusetts Connector program; 0.3 percent of eligible businesses (Albright, Personal Communication, 2010). Over the next two years, the number of small businesses increased in 2007 to 166,543 but then decreased in 2008 to 164,054 (U.S. Census Bureau, 2010). The number of participating businesses continued to increase to 618, or 0.4 percent of eligible businesses (Albright, Personal Communication, 2010). Small business and program participation statistics for Massachusetts are presented in Table 9.

Table 9. Number of small business and program participation, Massachusetts, 2006-2008.

Year	Number of Small Businesses (1-49 employees)	Number of Small Businesses in Program	Percentage of Small Businesses in Program
2006	165,269	535	0.3%
2007	166,543	569	0.3%
2008	164,054	618	0.4%

Sources: U.S. Census Bureau, Johnson

Providing Portability

Currently, the Massachusetts Connector program does offer participants portability of their health insurance. Participants in the program who are laid off or become unemployed can instead purchase health benefits through the Connector program as an individual. Of course, the premium would be higher as compared to buying health insurance through an employer but the individual would at least maintain their legal obligation to the mandate.

Comparing Massachusetts Performance to Tennessee and Oklahoma

Unlike Tennessee and Oklahoma, which enacted programs focused on small businesses, Massachusetts passed a comprehensive set of health insurance reforms. The Massachusetts program included a health insurance exchange, premium assistance component, and individual insurance mandate. Comparing the outcomes in Massachusetts to those in Tennessee and Oklahoma can provide additional insight into the factors contributing to the success of the more limited programs.

Massachusetts was able to decrease the number of uninsured more than any other state due to the required mandate, but also experienced the lowest small business participation rate when compared to Oklahoma and Tennessee. Tennessee was able to enroll 2.9 percent of the qualifying small businesses and Oklahoma was able to enroll 4.1 percent of the qualifying businesses in their programs in 2008. Massachusetts enrolled only 0.4 percent in that same year.

The information clearly shows that residents of Massachusetts are enrolled in the Connector program; this is evident from the decreasing number of uninsured. What is not clear is why Massachusetts, which mandated businesses to provide their employees with insurance, had lower participation rates than Tennessee and Oklahoma, which created voluntary programs.

A possible answer to the problem of low program participation within Massachusetts may revolve around the existence of the exchange. The exchange may be acting as a catalyst for open market health insurance companies to lower their prices in order to compete with health insurance programs within the exchange. Thus, small businesses are the ones benefiting from exercising choice in the market.

Since they are not required to purchase health insurance through the Connector program, another possible answer to the low participation rate is that many employers are purchasing health insurance in the open market. Additionally, a factor that could be causing employers to choose the open market versus the Connector program could be lower costs and better benefits that meet the needs of their employees.

Conclusion

Oklahoma's program has been able to achieve better overall results than Tennessee's because of its more favorable economic conditions. The Insure Oklahoma program now boasts a higher enrollment number, provides participants with better services, has reduced the number of uninsured the most, and experienced a greater percentage in the number of qualifying small businesses who participated in the program over the research period. Tennessee experienced an increase in the number of uninsured, and experienced lower program participation than Oklahoma.

The decrease in the number of uninsured in Massachusetts was probably because of the mandate which forced residents of the state to purchase health insurance causing the uninsurance rate to reduce rapidly. Without this mandate, the results Massachusetts has seen would likely be similar to the results Tennessee and Oklahoma experienced with respect to the number of uninsured.

The success of future state sponsored health insurance programs depends on many factors. My research suggests that the economy played a significant role in the varying levels of success. The economy has the potential to limit many states' ability to address health care issues successfully, especially if they are not wealthy like Massachusetts, or have an economy based on oil and gas that protects them in a recession like Oklahoma. Instead many states are like Tennessee and rely heavily on

manufacturing. As seen in the last recession, manufacturing was hit especially hard, which ultimately impacted Tennessee's economy and may have limited the success of the Cover Tennessee program.

Also, the quality and cost of the program for participants may be another factor that influences success. Massachusetts did an exceptional job at reducing the number of uninsured in their state by implementing a comprehensive health insurance program and requiring all residents to obtain health insurance. The problem is not all states are as wealthy as Massachusetts, limiting their ability to pass a comprehensive program. Instead, many states will need to focus on a smaller population, such as small businesses, as Tennessee and Oklahoma did. Additionally, in order for states to see positive results with small business participation, states may have one of two options in order to succeed: mandate that all small business employers provide health insurance to employees of all sizes or provide a voluntary program of high enough quality that small businesses want to enroll.

Since the passing of the national healthcare reform bill in 2010, much uncertainty has revolved around whether there will be a need for state sponsored health insurance programs or if there will be a role for states in national health reform. I believe states will continue to have a role because states will be given a lot of discretion in implementing the new health reform bill. For example, the federal government will ultimately be responsible for the program, but states will be responsible for creating the exchanges and setting premium levels. Much like Medicaid, the federal government will be in charge of the overall program but the states will be responsible for implementing much of it. Additionally, states will be held responsible for enforcing the basic federal rules and regulations as well (Khim, 2010).

Providing states with discretion in the design of their programs will allow for flexibility that can target specific groups in the population who are greatly affected by the lack of health insurance, such as small businesses and their employees. The states' ability to attack this area shows that states can be a key component to health care reform and possibly be the solution we have been seeking with regards to providing universal health insurance. Although the current economy may hinder many states' ability to implement such policy changes, federal assistance can alleviate this financial burden. Thus, it is appropriate to conclude that there is a role for both the federal government and states in creating universal health insurance.

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