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Small Business and Access to Health Insurers, Particularly HMOs

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EXECUTIVE SUMMARY

The project goal was to provide information on health insurance coverage, types, and costs, offered to different categories of small firms. The project focused special attention on HMO offerings to small firms. A document review of small employer health insurance legislation in all fifty United States was conducted. HMO's from ten selected states were surveyed. How health care coverage and cost by small firms is changing was addressed through focus group data collection and analysis.

Lack of coverage for employees of small employers is important for two reasons. First, about 37% of working Americans are employed by small businesses of ninety-nine or fewer workers. Secondly, many recent efforts to reform the health insurance market have included reforms in the small employer market. It is possible that these efforts may not have achieved the reforms in the small employer market or may have worsened the situation.

The focus of reform has been two fold, to control costs and improve access. The key strategy to control cost has been to strengthen managed care initiatives. The thrust to improve access has focused on employers and their coverage of workers, specifically on small businesses, since 51% of the uninsured worked for small businesses employing 99 or fewer workers (Morrisey et al. 1994). The increasing emphasis of health care reform on the small business sector reflects recent business trends in the United States. Twelve percent (12%) of workers in firms offering health insurance coverage are not eligible for coverage. Of those who are eligible, sixteen percent (16%) of workers opted not to take the coverage (Gable et al. 1999). Between 1988 and 1995, the US economy produced 12 million new jobs, of which eight to nine million were among firms that employed 499 or fewer workers (Gable et al. 1997). During this period

the overall proportion of workers in firms offering employment-based insurance coverage fell from 76.2% to 73.2% (Cooper et al. 1997). Several states undertook major policy initiatives to promote health insurance coverage by small employers, including legislation mandating specific types of benefits, facilitating purchasing alliances, and enacting small-group market reforms related to insurance rating and medical underwriting (Cooper et al. 1997; Gable et al. 1997; Helms et al. 1992).

More recently, federal legislation has superseded state policy initiatives to address access to health insurance for the small employer market. The effect of the proliferation of health reform legislation is mixed. The comprehensive review of health insurance regulations across the states did not uncover any significant patterns that could be associated with the number of uninsured in each state. The mixed results suggest a different approach to determine the impact of legislation on access to health insurance for small employers. There are a number of major factors that confound the findings in this state document review, such as individual state policies and laws concerning Medicaid coverage and eligibility, Children's Health Insurance Plan (CHIP) regulations, and welfare to work programs. In addition, each state has a unique economy, many of which are booming at this time (low unemployment, lack of qualified employees in many sectors, stable tax base), resulting in employers= willingness to provide more extensive employee benefits. As seen in the Robert Wood Johnson Foundation's, Community Snapshots Project through the Center for Studying Health System Change, communities vary tremendously in their health care markets. And the health care markets have a complex and intertwining relationship with both the small and large members of the business community. Each community, or state, has unique catalysts that impact the dynamics of the health insurance

industry and other industries. These markets also operate in the context of widely varying social and political environments. These complexities mask any discernable relationships between the numbers of uninsured and state regulations.

One approach to standardizing the various health insurance markets across states, is to have more and stronger Federal legislation as related to the small business insurance market. Of particular interest are those areas where states have tremendous latitude in setting their own regulations, such as establishing a national reinsurance guidelines for small groups, and establishing purchasing pools at a state level and providing support of the administration of those pools.

HMOs in ten selected states were surveyed. HMOs were asked about specific features and options of their three most popular plans in the small business sector. Of the most popular HMO plans in the small business sector, 68% (34 out of 50 plans) had specifically assigned primary care physicians for members, 78% (39) had their primary care physicians function as gatekeepers to control service utilization, 44% (22) paid their physicians/practices on a capitated per-diem basis, and 72% of the plans (36) paid physicians/practices on a contracted (discounted fee-for- service) basis, although most of these were specialists. Thirteen (13) out of 20 HMOs required at least 75% employee participation to enroll a small business in a health plan, and 13 out of 20 required a minimum employer contribution of 50% to the employee premium.

When asked specifically about preventive services, 92% (46 out of 50) of the plans required a minimum or no co-pay for immunizations, 86% (43 out of 50) offered free or nominal co-pay mammography services, 48% (24) had free or nominal co-pay mammography services. 69% (31) offered free or nominal co-pay prenatal care services, 60% (30) offered free or nominal

co-pay childhood immunizations. Ninety-four percent of the plans (47 out of 50) offered disease prevention or health promotion activities to enrollees, and an equal percentage actively attempted to educate enrollees on how best to use the plan benefits.

The respondents were also asked a series of questions on their perspective of the issues concerning small employers and the small employer insurance market. They gave the following reasons why they believed small employers provide health insurance benefits to their employees: 1) need to attract and retain employees (21); 2) respond to employee demands for coverage (17); 3) the tight labor market (10); and 4) to get coverage for only the owner and family(14). Of these reasons, attracting and retaining employees was indicated as the single most important reason.

Most respondents indicated that cost was the major reason for employers not offering health insurance coverage. Most felt there are adequate choices for plans in the market, and also believe small employers are being provided adequate information about plans and options.
In response to the perceived effect of such state legislation on the small employer market, fifty percent of HMOs believe that flexibility had decreased and adversely impacted their market share. All respondents indicated increased costs, decreased affordability, and decreased real access associated with recent state and federal legislation.

Survey respondents were asked about pooled purchasing in their respective state and the degree to which they felt it was an effective mechanism for improving access to health insurance for the small employer. Nine respondents indicated the presence of pooled purchasing mechanisms for small businesses in their state, and only six thought it had been helpful for small businesses in accessing health insurance for their employees.

Significant differences between states= definition and HMOs= definition of a small

business were found. In Missouri, 75% of the respondents defined a small business as Aan employer with 1-50 employees, and 25% defined a small business as 2-99 employees, while the state of Missouri defined it as 3-25 employees. In California the HMOs defined a small business as one with less than 50 employees, although the state regulation defined it as 3-25 employees.

The HMO survey indicated that the non-renewal rate at the initiative of the HMO, (apart from reasons of non-payment of premium) was negligible, ranging from 1-22 policies in the last year for the ten states surveyed. The guaranteed renewal provisions appear to be effective in limiting involuntary terminations of small business health insurance.

Recent published research findings and the results of this study draw an emerging picture of small businesses finding it more and more difficult to obtain affordable health insurance for their workers. This is especially so for those small businesses that have less than 25 employees and have a disproportionate share of low-wage earning employees. This is occurring in spite of ongoing state and federal efforts to address this problem through legislation. Gabel et. al, (1997) found similar results even though states have been consistent in adopting regulations that limit ratings practice use. At the same time, findings indicate that low-wage earners are less likely to be eligible for health benefits and less likely to take them up (take-up rate). When they do take up health benefits, they are more likely to pay a greater share of the premium for single and family coverage and have a benefit package that requires a greater sharing of expenses in the form of higher deductibles and co-payments, as well as restricted benefits.

This project was devoted to examining the supply side of the health benefit equation. An integrated review of these findings in conjunction with the focus group findings and document review suggests that regulation at best has been only partly successful in achieving its goal, which

is consistent with earlier studies (Nichols et. al, 1998). This study has shown that discrepancies between explicit legal provisions and practice do exist, such as the definition of a small business.

Mandated benefits appear to be implemented by the HMOs, which is illustrated by universal offering of maternity and mental health benefits in line with state regulations. Other regulations such as mandates for fair marketing of low cost plans, are being implicitly breached. Built-in adverse marketing incentives mitigate against fair marketing of low cost plans, revealing an inadequacy of current forms of legislation. Further study is required to better understand this newly identified gap between legislation and implementation.

Additional research is needed to better understand the demand side of the equation. Specifically, a detailed exploration into the reasons small businesses do or do not provide a health insurance plan, specifically an HMO option is needed. In addition, several questions from the employer perspective need to be addressed: 1) What are the barriers to offering a plan to all employees, as opposed to only high-wage, full-time employees? 2) Have the laws in the different states had an impact on a small business's ability to provide a health plan to employees? 3)What do small businesses actually know about state insurance regulation? 4) What is the impact of expanding Medicaid and CHIP programs to their employees? 5) What are the reasons (barriers) for not taking up the health insurance benefit? 6) What changes are needed to enable the employee to use the health insurance benefits offered? 7) What benefit options are most desired? 8) How do employers view HMO products and services? 9) Are employees aware of expanded Medicaid and CHIP programs in their states and do they view them as a possible alternative to employer-sponsored health insurance?

PROJECT STATEMENT

The project goal was to provide information on health insurance coverage, types, and costs, offered to different categories of small firms. The project focused special attention on HMO offerings to small firms. A document review of small employer health insurance legislation in all fifty United States was conducted. HMO's from ten selected states were surveyed. How health care coverage and cost by small firms is changing was addressed through focus group data collection and analysis.

Most Americans with private health insurance have coverage through their work. This coverage occurs as a result of the individual or a family member having access to employer-sponsored health insurance. Approximately seventy-four percent (74%) of workers are employed by firms offering health insurance coverage. Unfortunately, not all employees have access to health insurance (Gable et al. 1999). Twelve percent (12%) of workers in firms offering health insurance coverage are not eligible for coverage. Of those who are eligible, sixteen percent (16%) of workers opted not to take the coverage (Gable et al. 1999). Numerous studies have documented the lack of coverage, especially for small employers. While a number of reasons for the lack of health insurance coverage have been identified, the primary reason has repeatedly been shown to be the high cost of the available insurance products.

Lack of coverage for employees of small employers is important for two reasons. First, thirty-seven pecent of working Americans are employed by small businesses of ninety-nine or fewer workers. Secondly, many recent efforts to reform the health insurance market have included reforms in the small employer market. It is possible that these efforts may not have

achieved the reforms in the small employer market or may have worsened the situation.

The study examined small businesses= access to private insurance, plan design and benefits, particularly for health maintenance organizations (HMO's). The study design involved a comprehensive documents review of health insurance legislation at the federal and state levels, a survey of managed care organizations in 10 states representing the different regions of the United States, and focus groups of small employers. This study builds on existing literature and will provide trend data covering a period of rapidly changing health insurance markets and health care delivery systems.

LITERATURE REVIEW

The United States has experienced unprecedented increases in health care costs in the last ten to fifteen years. Between 1987 and 1993, health insurance premiums increased by 90% even though wages and salaries increased only by 28%(Cooper, et al. 1997). Escalating health care costs coupled with increasing numbers of uninsured in the late eighties and early nineties, gave a major impetus to health care reform to contain cost, increase access, and improve quality of care. Specifically, increasing costs have resulted in pricing the small employer and low wage earners out of the health insurance market, leading to corresponding increases in the uninsured rates in the US. The 1996 Medical Expenditure Panel survey showed that 15.7% of workers in the US were uninsured compared with 12.1% in 1987 (Cooper, et al. 1997). Concern about increasing numbers of uninsured has been accentuated by the concurrent tightening of resources by safety net providers due to cost control initiatives by federal and private payers. Improving health care access for the US population remains one of the primary concerns of the federal government.

The focus of reform has been two fold, to control costs and improve access. The key strategy to control cost has been to strengthen managed care initiatives. The thrust to improve access has focused on employers and their coverage of workers, specifically on small businesses, since 51% of the uninsured worked for small businesses employing 99 or fewer workers (Morrisey et al. 1994). The increasing emphasis of health care reform on the small business sector reflects recent business trends in the United States. Between 1988 and 1995, the US economy produced 12 million new jobs, of which eight to nine million were among firms that employed 499 or fewer workers (Gable et al. 1997, www.sba.gov/advo/stats.). During this period

the overall proportion of workers in firms offering employment-based insurance coverage fell from 76.2% to 73.2% (Cooper et al. 1997). Several states undertook major policy initiatives to promote health insurance coverage by small employers, including legislation mandating specific types of benefits, facilitating purchasing alliances, and enacting small-group market reforms related to insurance rating and medical underwriting (Cooper et al. 1997; Gable et al. 1997; Helms et al. 1992).

More recently enacted federal legislation has superseded state policy initiatives to address access to health insurance for the small employer market. The effect of the proliferation of health reform legislation is mixed. Most research that has been conducted to date has examined the impact of state health insurance reform.

Nichols et al. examined the effectiveness of insurance market reforms in increasing coverage. Their study specifically focused on state-level health reforms and made inferences concerning the impact of the Health Insurance Portability and Accountability Act (HIPAA) on uninsurance, private insurance coverage, and Medicaid coverage rates. Their findings suggest that comprehensive small group insurance reform has resulted in some success but falls short of generating large changes in the numbers of uninsured (Nichols et al. 1998). McCall et al. focused on small group health insurance reform in the state of New Hampshire and concluded that establishing a community rating system, guaranteed issue, guaranteed renewal, and portability laws resulted in a decrease in the percentage of uninsured in the state and an increase in employer-based insurance (1998). Percy (1998) also found an increase in benefit offerings in the small group market in states where reform had been in place in excess of three years and for those states that had implemented all five types of reform (ratings practices, guaranteed renewal,

guaranteed issue, reinsurance, and limiting pre-existing exclusions).

Gabel et al. took a comprehensive look at rating reforms across the 50 states from 1990 to 1997 and concluded that, although states have adopted policies limiting the use of rating factors to offset possible abusive rating practices, the overall effect is questionable. Their findings were inconclusive as to the impact on administrative cost and overall cost of coverage for small employers. They argue that healthy groups may opt to drop coverage or decide to self-insure in response to increases in premiums resulting from the elimination of rating practices (1997).

Between 1996 and 1997, there was a decline of 7% in the proportion of small businesses offering health insurance, and between 1993 and 1996 small businesses experienced a decline of 31% (Morrisey et al. 1994). Morrisey reported 51% of small employers offering health insurance to their employees in 1993. The high cost of health insurance appears to be the over-riding factor inhibiting coverage. Dun and Bradstreet report, based on their annual survey of small businesses, that the average cost increase for insurance premiums was 13% in 1997 (De Mont 1998). Faced with rising costs, only 24% assumed the extra costs, while the remainder had exercised other options such as shopping for a new carrier (39%), reducing the number of providers (27%), establishing medical savings accounts (34%), or adding a co-pay plan (22%). In the Dun and Bradstreet survey, 47% of small business owners cited the high cost of health care insurance as one of their two top problems. Along similar lines, Morrisey et al. (1994), found that two thirds of small businesses that dropped health insurance coverage, blamed their action on substantially increased premiums.

Other major issues in the small business health insurance market also revolve around cost. These issues include:

1. balancing the impact on profits versus the fear of losing qualified employees due to a reduction in benefits;
2. maintaining level premiums at the expense of smaller benefit packages;
3. weighing the cost of health insurance versus eliminating coverage for employees with pre-existing medical conditions;
4. being penalized for high promotional and handling costs compared with large employers;
5. facing experience rating and medical underwriting costs as compared to larger employers;
6. balancing the different insurance needs of different employees based on wages, age, and income; and
7. having reluctance to get into administrative problems associated with managing health insurance benefits (Cooper et al. 1997; Morrisey et al. 1994; Gable et al. 1997; Cantor et al. 1995).

In-depth surveys of employers tend to confirm the primacy of the cost issue and the related issue of value for price in purchasing decisions by small employers. According to Morrisey et al., a leading reason for small firms not offering health insurance coverage, was their inability to qualify for an insurance contract at employer rates comparable to large employers (1994). Thirty-nine percent of employers who did not offer health insurance reported this as the major reason. Another 15% reported this as part of the reason for not offering health insurance coverage. Further investigation of this factor led to inconclusive findings. Only 18% of small employers said they did not qualify due to pre-existing health conditions of one or more

employees, and only 14% said it was due to being in an industry which makes them ineligible. Nine percent of employers reported being dropped by the insurer, while 66% reported dropping coverage because of cost. Morrisey also noted that small firms offered similar breadth of coverage (range of services) as the large ones, but less depth of service than the large firms (1994).

Additional research has shown that small businesses are less likely to offer health insurance, especially if they have a high proportion of low-wage earners (Gable et al. 1999). Small businesses are also less likely to pay 100% of health insurance premiums or offer coverage to dependents (Gable et al. 1999). Lastly, as premiums become a larger portion of income, eligible workers are more likely to decline coverage (Gable et al. 1999). In sum, the issue of cost appears to be the driving factor from both the employer and employee perspective in the small group market.

A frequently used solution to overcome the problem of cost has been to offer managed care plans. Notwithstanding the many issues associated with the transition from traditional indemnity insurance to managed care, it has remained the most enduring strategy to address the problem of cost escalation in health care. In the small business sector, however, managed care appears to have been less effective in achieving enough cost control to positively impact coverage. The offering of managed care plans increases with firm size, while many small employers still predominantly offer traditional health insurance plans. With increasing penetration of managed care in health care markets, the market shares of managed care plans in the small employers market has increased from 58% in 1993 to 74% in 1996 (Jensen et al. 1997). However, the proportion of small employers offering health insurance declined by 31% during

this same period. It appears that managed care plans have been attractive enough to those who offer health insurance to their employees to result in a shift from traditional insurance to managed care. But for those who have not traditionally offered health insurance coverage, managed care has not been attractive enough to entice those employers to add a health insurance benefit. Helms et al., McLaughlin et al., and Feldman et al. studied the results of demonstration projects offering subsidized HMO plans and other tailored strategies in eight states, to promote coverage in the small business sector (1992; 1992; 1993). They concluded that the practical implementation of promising strategies is ridden with operational complexities, given complex small business market scenarios.

Purchasing cooperatives were hailed as a potential solution to address insurance market failures for small groups. Morrisey reported that 59% of small employers who provided health insurance said that they had investigated the option of purchasing health insurance through a local employer coalition or trade group, but only 17% indicated that their current plan was part of such an organization (1994). Other studies have examined the lack of demand for health insurance by workers. Cooper et al. (1997) studied the take-up rate of insurance when employers offered insurance to their employees and found the many employees opt not to take the health insurance benefit. Chernew et al. (1997) studied the price elasticity of demand for health insurance using the subsidy model of inducing demand among low income workers.

An issue closely related to costs and affordability, is the health maintenance mission/vision expected of HMOs, which implies an emphasis on disease prevention and health promotion to reduce costs of health care which leads to affordability, and therefore access. Chapman et al. (1997) reported the relatively restricted range of preventive and health promotion

services provided by a sample of HMOs in the western United States. However, Schauffler et al (1998) reported considerable emphasis on a comprehensive range of preventive and health promotion services in advanced managed care markets such as those found in California.

In summary, considerable, though dated, information is available from small employers and employees of small firms. No national level data are available regarding health plans= offerings and perspectives. A study focusing on managed care insurers, particularly HMO's, and Preferred Provider Organizations (PPO), is needed in view of the continuing importance of managed care in the U.S. health care system. This study (1) addresses the impact of federal and state health insurance legislation on the use of managed care by the small business market, (2) identifies how HMO's are responding to the small businesses market. and (3) provides the small business perspective on health care insurance benefit issues.

DOCUMENTS REVIEW

A comprehensive review of Federal and State legislation as related to the small business health insurance market was conducted. The provisions of statutes and regulations are presented for 48 states and the District of Columbia. Michigan and Pennsylvania were not available. Statutes were reviewed with a major focus on ratings practices, guaranteed renewal, guaranteed issue, pre-existing conditions, reinsurance, mandated benefits, and minimum loss ratios. Appendix A provides a complete review of state regulations/legislation. A summary is included at the end of this section in Table 1.

Rating Practices. Rating practices fall into three basic categories, community rating, rating bands, and National Association of Insurance Commissioners (NAIC) rating bands. Fifteen out of 48 states and the District of Columbia have some form of community rating requiring insurers to price a given benefit plan the same for all small groups in the community, allowing differences for geography and family composition only. States more often restrict the use of health status than age for setting premium rates for small groups. Those states with the tightest rating bands were most likely to limit the use of experience rating, health status, age, gender, industry size, and type. Four of the states had regulations for tight rating bands, that are defined as setting small employer premiums in the ratio of 1.5 to 1.0, meaning that small employers could not be charged more than 150% of those premiums offered to large employers. Loose rating bands, are those that allowed premiums for small employers to be set at greater that 150% of those offered to large employers (Curtis et al. 1999). See Figure 1

RATINGS PRACTICES

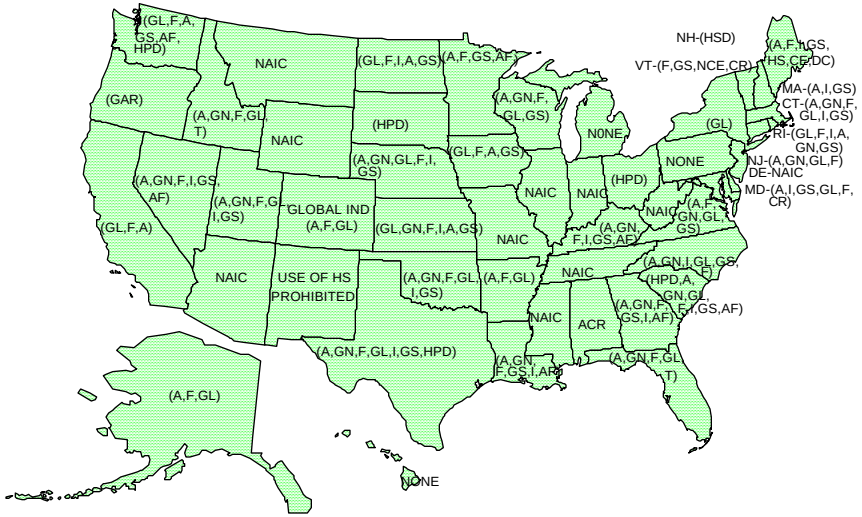

Figure 1. Ratings Practices by States

Guaranteed Renewal. Guaranteed renewal legislation, that allows businesses to renew their health insurance year-to-year regardless of the insurance company's desire to do so, was present in all states as established under the Health Insurance Portability and Accountability Act (HIPAA) and which supersedes earlier regulations in 43 states. There are only a few exceptions to guaranteed renewal that have occurred. These include: 1) health plans electing to withdraw product offerings from both the small and the large group markets; 2) groups are allowed to purchase any other insurance product; 3) health insurance plans may elect not to offer an insurance product to any small employer, effectively withdrawing from the small group market altogether; and 4) allowing an insurance company not to renew a policy to a small employer if very strict guidelines are followed, that might include documented heavy losses.

Guaranteed Issue. Guaranteed issue laws require that health insurance plans offer some insurance product to small businesses regardless of health status or claims experience. Only two states (IL, IN) have no guaranteed issue laws. Guaranteed issue regulations vary tremendously from state to state. Some states have specific basic plans that must be offered, while other states have no provisions for a standard or basic plan. As result, insurance plans in states without a stipulated basic plan, will offer plans with substantially reduced benefits to offset the guaranteed issue regulations. The effect of guaranteed issue has been shown to significantly increase coverage in the small business group market, but without regard to types and numbers of insurance benefits (Nichols et al. 1998). See Figure 2

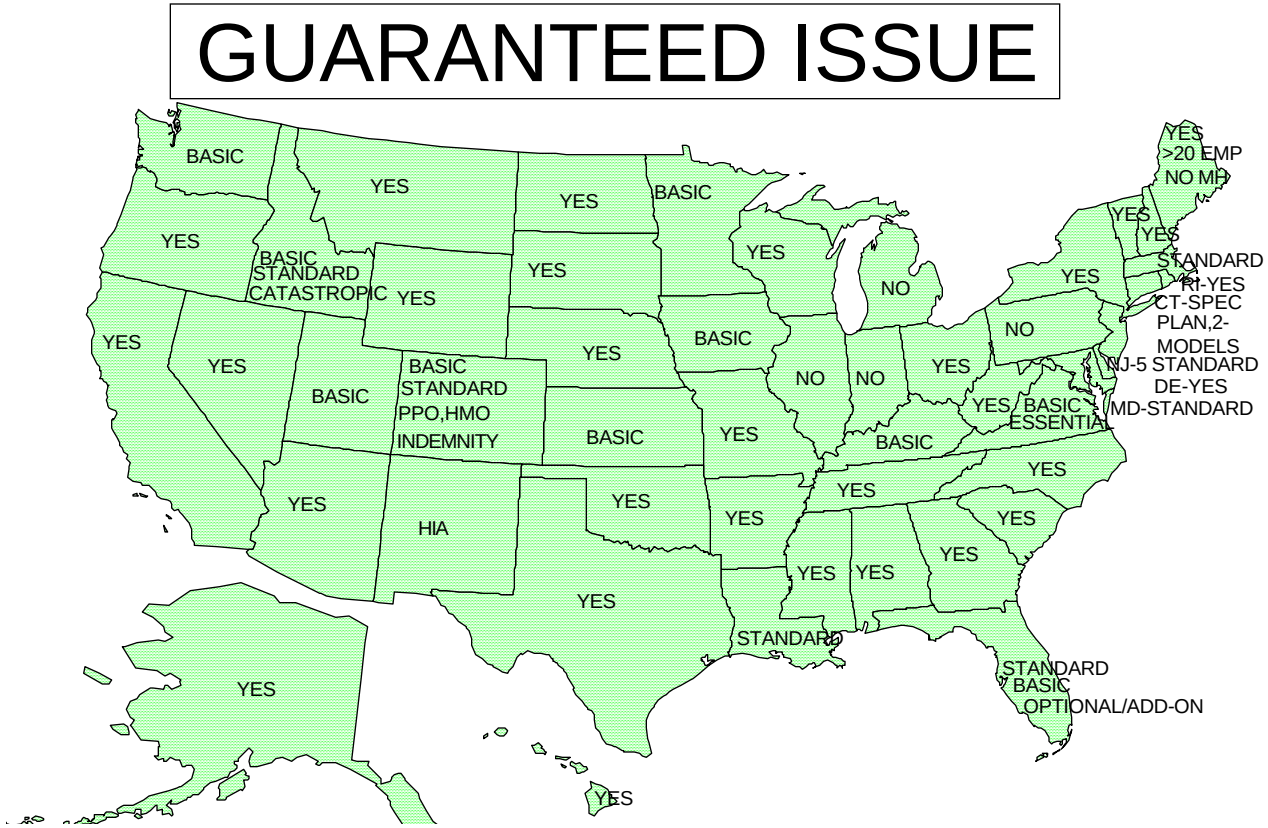

Figure 2. Guaranteed Issue Regulations by States

Pre-existing Conditions. Pre-existing conditions legislation limits pre-existing exclusions in policies. All states having small business health insurance regulations have some form of limitation on exclusions of pre-existing conditions. The effect of limiting pre-existing condition exclusions has not been demonstrated to be effective in the literature (Nichols et al. 1998; McCall et al. 1998). This study did not find an association between pre-existing condition legislation and the trend in the number of uninsured. See Figure 3

Reinsurance Laws. Reinsurance laws refer to regulations that allow health plans to insure themselves against extensive loss. In some states there exists a statutory, non-profit entity that is established under the auspices of the State Insurance Commission to reinsure small employee groups or health plans offering insurance to small employers. In some states, reinsurance laws allow some insurers to perform this function (for-profit), but if they do so, they cannot offer primary insurance to the small businesses themselves. The effect of reinsurance laws is to spread risk over a number of health insurance plans and companies, and by doing so, enables insurers to take greater risks in their offerings to small businesses, resulting in lower premiums. This study indicates, for each state, whether the state required (mandatory) reinsurance, or whether it is voluntary. See Figure 4. There are no Federal regulations on reinsurance.

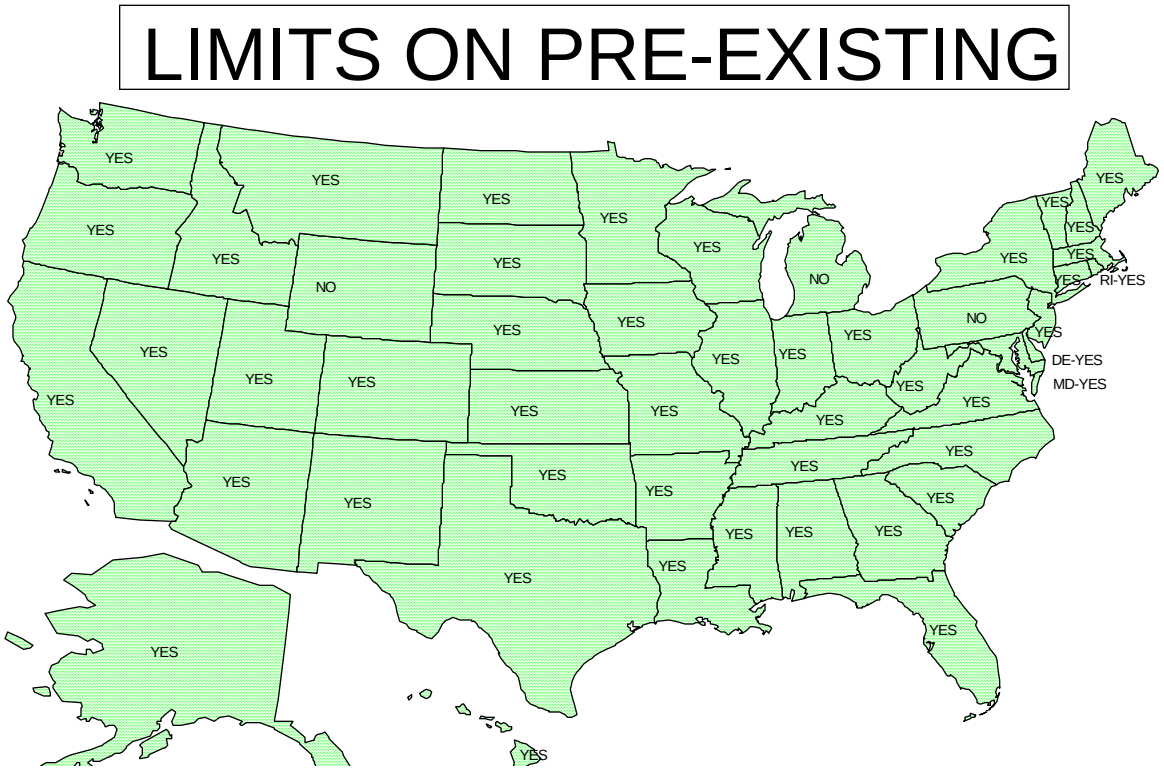

Figure 3. Limits on Pre-Existing Conditions

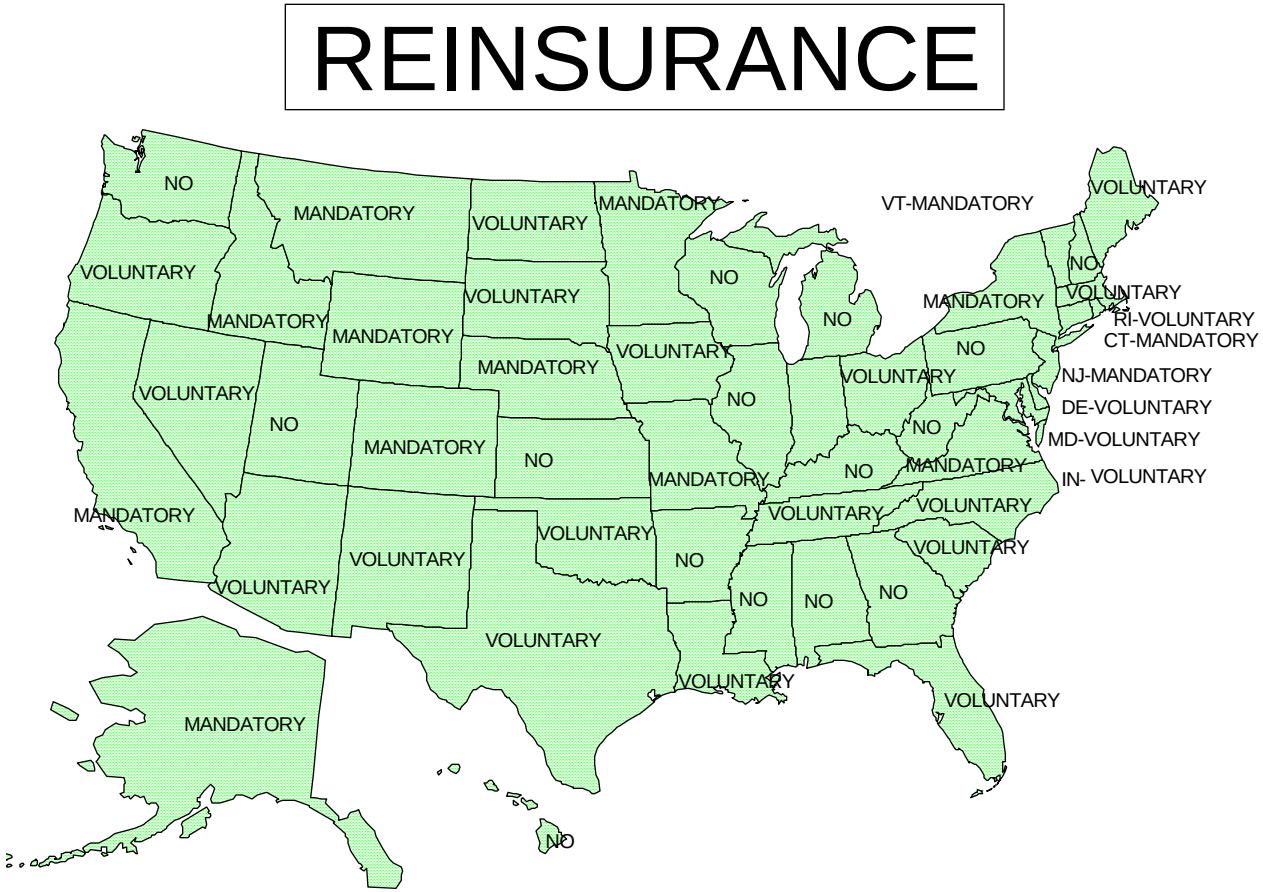

Figure 4. Reinsurance Laws by States

Mandated Benefits. Mandated benefits are those benefits that are required to be offered in each health plan written for small businesses. States vary widely on mandated benefits. See Figure 5. Jensen and Morrisey (1999) estimate that 20 to 25% of the uninsured lack coverage because of mandated benefits. Jensen and Morrisey (1998) found that workers report that mandated benefits impact their paychecks through decreased wages, fewer benefits, and higher premiums. Dental services have been shown to result in the highest percentage increase in premiums (15%), followed by visits to psychologists (12%), psychiatric hospital stays (13%), and chemical dependency (9%) (Jensen and Morrisey, 1998).

The most common mandates observed across the states in this study were mammography screening, chemical dependency/alcohol treatment, maternity benefits, immunizations, and mental health. Among mental health mandates, states have tremendous latitude in what services and how often they cover certain services, such as numbers of visits (generally a minimum of ten per year) to a psychologist or psychiatrist, numbers of inpatient treatment days (generally a minimum of 30 days), and caps on total expenditures per year. South Dakota provides for biologically-based mental illnesses, such as schizophrenia, bipolar disorder, and any other diagnosis that causes serious impairment to functioning, to be paid as other physical illnesses. Texas, on the other hand, does not require reimbursement of substance abuse treatment when the substance was obtained and consumed in violation of the law.

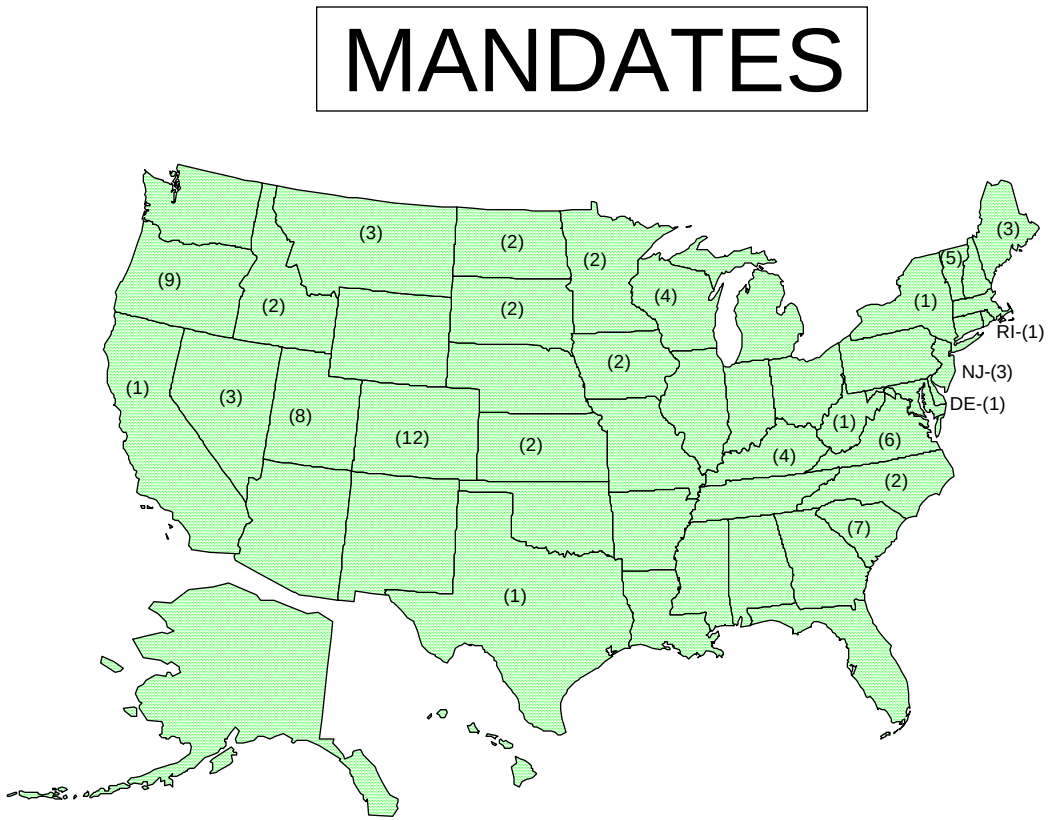

Figure 5. Number of Mandated Benefits by State

Minimum Loss Ratio. Minimum loss ratio refers to the proportion of premiums collected that should be paid out in claims. Eight out of the 48 states and the District of Columbia had either prescribed minimum loss ratios or prescribed guidelines for arriving at minimum loss ratios. These ratios ranged from 50% in Minnesota to 80% in Washington. There are two states (NY, NJ) that stipulate that if a carrier paid out less than 75% in the prior year, they must pay out the balance as dividends or credits against subsequent premiums to employers. There is no Federal legislation directed toward minimum loss ratios. See Figure 6. for a sample of states which stipulate minimum loss ratios.

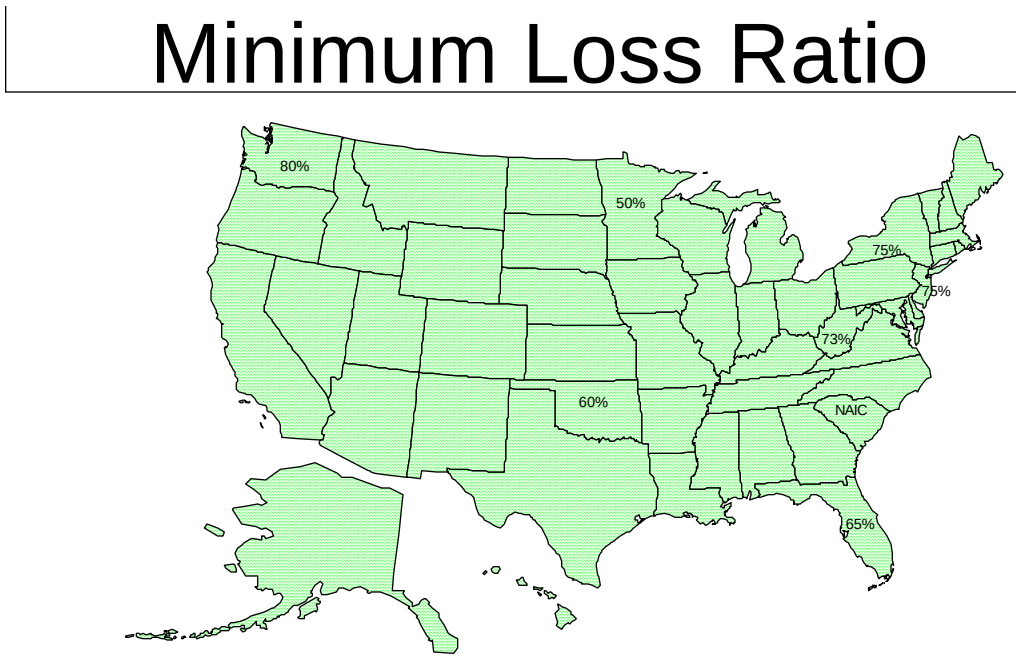

Figure 6. Minimum Loss Ratio by States

In the course of reviewing these dimensions of state regulations/legislation, it was found that although Federal regulation is silent on continuation of coverage of employees after termination of employment or loss of eligibility, some states have made provision for continued coverage through such mechanisms as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), maintenance of coverage at the same premium level, or a premium that cannot exceed some percentage of the group rate. The Health Insurance Portability and Accountability Act (HIPAA) provided for portability, which is defined as the ability to go from one insurance plan to another without having to go through medical examinations or having to meet new waiting periods for existing conditions. To date, only 35 states have specifically adopted the HIPAA regulation as a state law.

Summary. The comprehensive review of health insurance regulations across the states did not uncover any significant patterns that could be associated with the number of uninsured in each state. The mixed results suggest a different approach to determine the impact of legislation on access to health insurance for small employers. There are a number of major factors that confound the findings in this state document review, such as individual state policies and laws concerning Medicaid coverage and eligibility, Children's Health Insurance Plan (CHIP) regulations, and welfare to work programs. In addition, each state has a unique economy, many of which are booming at this time (low unemployment, lack of qualified employees in many sectors, stable tax base), resulting in employers= willingness to provide more extensive employee benefits. As seen in the Robert Wood Johnson Foundation's, Community Snapshots Project through the Center for Studying Health System Change, communities vary tremendously in their health care markets. And the health care markets have a complex and intertwining relationship with both the small and large members

of the business community. Each community, or state, has unique catalysts that impact the dynamics of the health insurance industry and other industries. These markets also operate in the context of widely varying social and political environments. These complexities mask any discernable relationships between the numbers of uninsured and state regulations.

One approach to standardizing the various health insurance markets across states, is to have more and stronger Federal legislation as related to the small business insurance market. Of particular interest are those areas where states have tremendous latitude in setting their own regulations, such as establishing a national reinsurance guidelines for small groups, and establishing purchasing pools at a state level and providing support of the administration of those pools.

Table 1. Summary of Regulations/Legislation By State

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
AL	Inc/dcr/inc	Adjusted Community Rating	Yes	Yes			Yes		
AK	Inc	Age, Family, Geographical Location	Yes	Yes		Yes	Yes		
AZ	Inc	NAIC(d)	Yes	Yes	Yes		Yes		
AR	Inc	Geographical Location, Age, Family	Yes	Yes					
CA	Inc/dcr/inc	Geographical Location, Family, Age	Yes	Yes		Yes	Yes		Basic Health Care
CO	Dcr	Global Index, Age, Geographical Location, Family	Yes	Basic Standard PPO Indemnity HMO		Yes	Yes		Inpatient, Mammogram, Maternity Immunizations, Family Planning, Smoking Cessation, Child Care, Adopted Children, Outpatient, Emergency out of area, Handicapped, Prostate Screening
CT	Inc	Age, Gender, Family Geographical Location, Industry, Group Size	Yes	Special Plan 2-Models		Yes	Yes		
DE	Dcr	NAIC	Yes	Yes	Yes		Yes		Mental Health
FL	Inc	Age, Gender, Family, Geographical Location, Tobacco		Standard, Basic, Optional, Add-on	Yes		Yes	65%	
GA	Dcr	Age, Gender, Family, Group Size, Industry, Avocational Factors	Yes	No mention of Basic, Standard, or Special Plans			Yes		
HI	Dcr		Yes	Yes			Yes		
ID	Inc	Age, Gender, Family, Geographical Location, Tobacco	Yes	Basic, Standard, Catastrophic		Yes	Yes		Maternity, Immunization
IL	Inc	NAIC	Yes	No			Yes		
IN	Inc/dcr/inc	NAIC	Yes	No	Yes		Yes		
IA	Inc	Geographical Location, Family, Age, Group Size	Yes	Basic	Yes		Yes		Maternity, Immunization
KS	Inc/dcr/inc	Geographical Location, Gender, Family, Industry, Age, Group Size	Yes	Basic	Yes		Yes		Medically Uninsurable, Mental Health

Table 1. Summary of Regulations/Legislation By State - Continued

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
KY	Dcr/inc/dcr	Age, Gender, Family, Industry, Group Size, Avocational Factors	Yes	Basic		Yes	Yes		Medically Uninsurable, Maternity, Immunizations, Alcohol
LA	Dcr	Age, Gender, Family, Group Size, Industry, Avocational Factors	Yes	Standard Plan	Yes		Yes		
ME	Inc/dcr/inc	Age, Family, Industry, Group Size, Health Status, Claims Experience, Duration of Coverage		Yes; >20 Employees-No Mental Health	Yes		Yes		Maternity, Immunizations, Mental health
MD	Inc/dcr/inc	Age, Industry, Group Size, Geographical Location, Family, Community Rating	Yes	Standard Plan	Yes		Yes		Maternity, Immunizations, Mental health
MA	Inc	Age, Industry, Group Size	Yes	Standard Plan	Yes		Yes		
MI(e)	Inc/dcr/inc		Yes						
MN	Dcr	Age, Family, Group Size, Avocational Factors, Use of Gender Prohibited	Yes	Basic Plan Only		Yes	Yes	50%	Maternity, Immunizations
MS	Inc/dcr/inc	NAIC	Yes	Basic Plan Only			Yes		
MO	Dcr	NAIC	Yes	Yes		Yes	Yes		
MT	Inc	NAIC	Yes	Yes		Yes	Yes		Maternity, Immunizations, Mental Health
NE	Dcr/inc/dcr	Age, Gender, Geographical Location, Family, Industry, Group Size	Yes	Yes		Yes	Yes		
NV	Inc/dcr/inc	Age, Gender, Family Industry, Group Size, Avocational Factors	Yes	Yes	Yes		Yes		Basic Health Care, Maternity, Immunizations
NH	Inc/dcr/inc	Health Status Discount	Yes	Yes			Yes		
NJ	Inc/dcr/inc	Age, Gender, Geo, Family	Yes	5 Standard Plans	Yes	Yes	Yes	75%	Maternity, Immunizations, Alcohol
NM	Dcr	Use of Health Status Prohibited	Yes	HIA Plan (f)	Yes		Yes		
NY	Inc	Geographical Location	Yes	Yes		Yes	Yes	75%	Risk Pool
NC	Dcr/inc/dcr	Age, Gender, Industry, Geographical Location, Group Size, Family	Yes	Yes	Yes		Yes		Maternity, Immunizations

Table 1. Summary of Regulations/Legislation By State – Continued

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
ND	Inc	Geographical Location, Family, Industry, Age, Group Size (With Prior Approval)	Yes	Yes	Yes		Yes		Pre-natal Care, Immunizations
OH	Der	Health Promotion Discount	Yes	Yes	Yes		Yes		
OK	Inc/der/inc	Age, Gender, Family, Geographical Location, Industry, Group Size	Yes	Yes	Yes		Yes	60%	
OR	Der/inc/der	Geographic Average Rate	Yes	Indemnity HMO Basic Plan	Yes		Yes		Medically Uninsurable, Family Planning, Women & Children, Maternity, Immunizations, Alcohol, Prevention, Chemical Dependency
PA(g)	Inc/der/inc		Yes						
RI	Inc/der/inc	Geographical Location, Family, Industry, Age, Gender, Group Size	Yes	Yes	Yes		Yes		Mental Health
SC	Der/inc/der	Health Promotion Discount, Age, Gender, Geographical Location, Family, Industry, Group Size, Avocational Factors	Yes	Yes	Yes		Yes	NAIC	Prevention, Women and Children, Prostate Screening, Maternity, Immunizations, Mental Health
SD	Inc	Health Promotion Discount	Yes	Yes	Yes		Yes		Maternity > 15 Employees, Mental Health
TN	Der/inc,der	NAIC	Yes	Indemnity, HMO, Basic Plan, Standard Plan	Yes		Yes		
TX	Inc/der/inc	Age, Gender, Family, Geographical Location, Industry, Group Size, Health Promotion Discount	Yes	Basic Plan Catastrophic	Yes		Yes		Mental Health
UT	Inc	Age, Gender, Family, Geographical Location, Industry, Group Size	Yes	Basic Plan			Yes		Family Planning, Alcohol, Chemical Dependency, Prevention, Women and Children, Maternity > 15 Employees, Mental Health
VT	Der	Family, Group Size, No Claims Experience Community Rating	Yes	Yes		Yes	Yes		Family Planning, Prevention, Women and Children, Mental Health

Table 1. Summary of Regulations/Legislation By State - Continued

State	Trend Uninsured 97/96/95(a)	Ratings Practices	Guaranteed Renewal	Guaranteed Issue	Reinsurance Vol(b)	Reinsurance Man(c)	Limit Pre-existing Exclusions	Minimum Loss Ratio	Mandates
VA	Inc/dcr/inc	Age, Gender, Family, Geographical Location, Group Size	Yes	Essential Plan, Standard Plan		Yes	Yes		Family Planning, Prevention, Women and Children, Maternity, Immunizations
WA	Dcr/inc/dcr	Geographical Location, Family, Age, Group Size, Avocational Factors, Health Promotion discount, Use of Gender Prohibited	Yes	Basic Plan			Yes	Yes	
WV	Inc/dcr/inc	NAIC	Yes	Yes			Yes	73%	Immunizations
WI	Dcr/inc/dcr	NAIC	Yes	Yes			Yes		Maternity, Immunizations, Mental Health, Risk Pool
WY	Inc/dcr/inc	Age, Gender, Family, Geographical Location, Group Size	Yes	Yes		Yes			

Notes:

(a) Trends in Uninsured Rates for 1995, 1996, 1997 From Census Data

(b) Voluntary Reinsurance Regulations

(c) Mandatory Reinsurance Regulations

(d) National Association of Insurance Commissioners

(e) Michigan's Statutes Did Not Specifically Address the Small Employer Market

(f) Health Insurance Alliance

(g) Pennsylvania Statutes Did Not Specifically Address the Small Employer Market

(h) Inc : Increasing, Dcr : Decreasing

HMO SURVEY DATA

Sample

A survey of HMO's in ten selected states was conducted. The states were selected based on the degree to which they had regulations or legislation in place to address the small employer market across six dimensions (ratings practices, guaranteed issue, reinsurance, limits on pre-existing exclusions, minimum loss ratios, and benefit mandates). Some states have not adopted any small business health insurance regulations (MI and PA), while others have adopted all six types of legislation, such as New Jersey and South Carolina. The other states include GA and IL (3 of 6), MO and TN (4 of 6), and CA and TX (5of 6). These states are also geographically distributed and represent states with different economic bases.

Source of HMO Listing:

The "Executive Managed Care Directory – 1999, A Comprehensive Reference to Managed Care Suppliers and Plans", served as the source of information on HMOs to be contacted. All 439 HMOs listed were contacted to complete the survey. The list of HMOs along with the names of the respective contact persons to whom the survey was faxed/from whom information was received is included in Appendix A.

Survey Methodology:

Marketing vice-presidents or directors of three HMOs in Columbia, South Carolina, were personally interviewed to pilot test and refine the draft survey instrument. The final format of the survey used is included in Appendix B.

Three interviewers were trained to administer the survey. Marketing representatives from the respective organizations were identified as the appropriate contact person to provide the requested data. In most organizations, the Vice President of Marketing or the Director of Marketing received the survey. Following an introductory call, the survey was faxed to the

respondent. Follow-up calls were made at two-week intervals over a three month period requesting that the survey be completed and returned.

All 436 organizations listed in the Directory's HMO list, excluding the three in South Carolina, were contacted by phone. A total 69 HMOs (16%) responded and 22 surveys were completed for a completion rate of thirty-two percent (32%). Three surveys were completed over the telephone, one was received by email, and the remaining 15 were received by fax.

Distribution of HMOs

The distribution of HMO plans by state is presented in Table 2. Of the total 439 organizations contacted, the number of organizations from which a completed survey could potentially be expected was 158 as reflected in the table. Sixty-nine HMOs responded to the initial contact, but only 22 HMOs were operational in the small employer market and completed and returned the survey in its entirety.

TABLE 2
Distribution of HMOs listed in the Directory by State

Status on contacting the organization	CA	GA	IL	MI	MO	NJ	PA	SC	TN	TX	Total
Total HMOs listed in the directory	130	22	40	41	30	24	39	11	28	74	439
Corporate office at another location in the state (multiple regional office listings in other cities of the same state)	21	0	7	16	4	5	7	1	8	29	98
Phone disconnected. Unable to trace organization through telephone directories and assistance.	8	2	2	2	1	2	1	2	0	6	26
No response/automated voice mail with no option for reaching operator/message left	16	3	1	1	0	0	1	0	0	2	24
Operator declined to provide fax numbers, and no response to repeated messages on voice mail	0	0	0	1	0	0	0	0	0	1	2
Declined to participate	7	1	2	2	3	1	8	0	1	3	28
Merged/acquired by another HMO/insurance company	7	2	4	2	4	2	3	0	3	5	32
Out of business	2	0	0	0	0	3	1	0	0	0	6
HMO business in the small business sector being phased out	0	0	0	0	1	0	0	0	0	0	1
Phasing out managed care business	0	0	1	0	0	0	0	2	1	1	5
Not an HMO, only indemnity insurance/PPO/POS/IPA	18	0	2	2	1	1	0	0	2	2	28
Not an HMO, only third party administrator/marketing agent	1	0	1	0	1	0	0	0	0	1	4
Not an HMO, a behavioral care/mental health managed care organization	0	0	0	1	0	0	1	0	0	0	2
Not an HMO, only life insurance/dental insurance/supplemental health insurance	1	2	0	0	0	0	0	0	0	0	3
Not an HMO, offers insurance to HMOs (reinsurance)	1	0	0	0	0	0	0	0	0	0	1
No commercial HMO plans, only self-insured plans	1	0	0	0	0	2	0	0	0	0	3
No commercial HMO, Medicaid/Medicare HMO only	1	0	0	1	0	1	1	0	0	0	4
Not an HMO, a hospital system	0	0	0	1	0	0	0	0	2	0	3
No small business plans, only for large businesses	2	0	1	0	1	0	0	1	0	4	9
No HMO plan in this state	0	0	1	0	0	0	0	0	0	0	1
Survey faxed/emailed, response awaited	38	11	17	10	10	7	13	2	10	18	136
Completed survey	6	1	1	2	4	0	3	3	1	1	22

HMO Survey Findings

General characteristics

Of the 69 respondents 37 were no longer in, or were in the process of phasing out, of the HMO business. Twenty two companies returned detailed surveys. Of these, 50% were for-profit and 50% were private not-for-profit. Of the18 HMOs that answered the question pertaining to the types of managed care products offered, 16 offered a HMO product, 14 offered a Point-of-service (POS) product, and 10 offered a Preferred Provider Organization (PPO). Sixteen offered at least two products.

The mean number of base plans offered by HMOs to all sizes of businesses is 9.73. The mean number of base plans offered to the small business sector is only 3.52. (See Figure 7) Thirteen (13) out of 20 HMOs required at least 75% employee participation to enroll a small business in a health plan, and 13 out of 20 required a minimum employer contribution of 50% to the employee premium. Most did not mandate minimum employer contribution for dependent premiums.

Of the 21 respondents to this questions, 15 had plans specially designed for small businesses. To encourage small businesses to enroll in their health plans, a majority (13 out of 20) offered a low cost(basic)plan, 11 out of 20 provided administrative support for claims administration and clarifications, 13 provided drug formularies, and 19 provided maternity benefits.

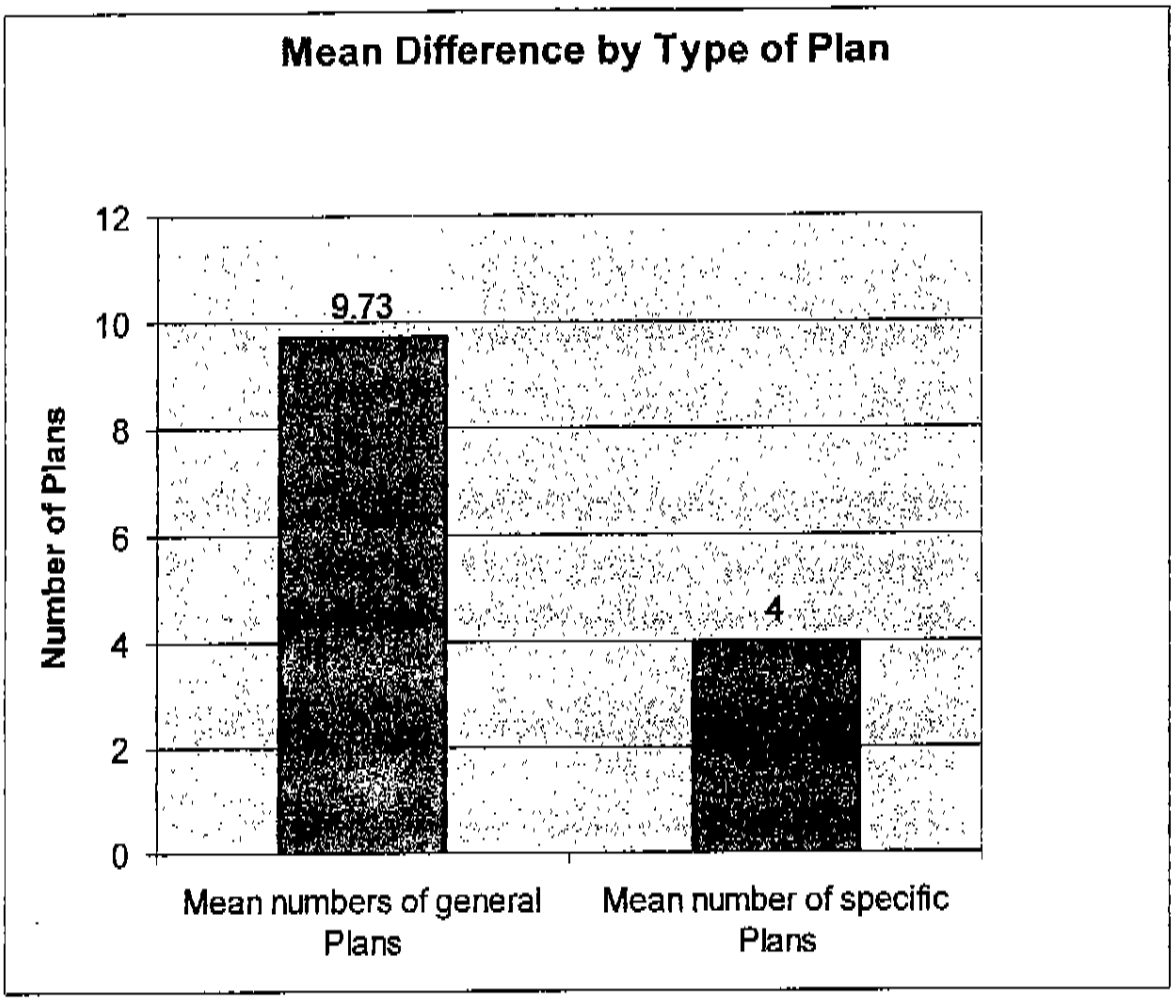

Figure 7. Mean Difference by Type of Plan

Plan Features and Benefits

HMOs were asked about specific features and options of their three most popular plans in the small business sector. Of the 22 companies responding, one had moved out of the small business sector, two had only one managed care plan for small businesses, and 18 reported two plans were offered to small businesses.

Of the most popular HMO plans in the small business sector, 68% (34 out of 50 plans) had specifically assigned primary care physicians for members, 78% (39) had their primary care physicians function as gatekeepers to control service utilization, 44% (22) paid

their physicians/practices on a capitated basis, and 72% of the plans (36) paid physicians/practices on a contracted (discounted fee-for- service) basis, although most of these were specialists. See Table 3 and Figure 8.

Table 3. HMO Payment Mechanisms for Physicians

	Yes (%)	No (%)	Total plans(%)
Primary Care Physician or Practice	34 (68.0)	16 (32.0)	50 (100.0)
Primary Physician As Gatekeeper	39 (78.0)	11 (22.0)	50 (100.0)
Capitation Payment for Physician/Practice	22 (46.8)	25 (53.2)	47 (100.0)
Contact Based Payment for Physician/Practice	36 (73.5)	13 (26.5)	49 (100.0)

Ninety four percent (47) of the plans required a co-pay for office visits, 66% (33 plans) imposed a penalty on the patient for using an emergency room for primary care, 90% (45 of 50 plans) had a drug benefit, and almost all (49 of 50) required patients to use specific pharmacies. Most of the plans had drug formularies (44 out of 50), required a co-pay per prescription (48 out of 50), and had a provision for generic prescriptions (46 out of 49 responses). See Table 4. and Figure 9.

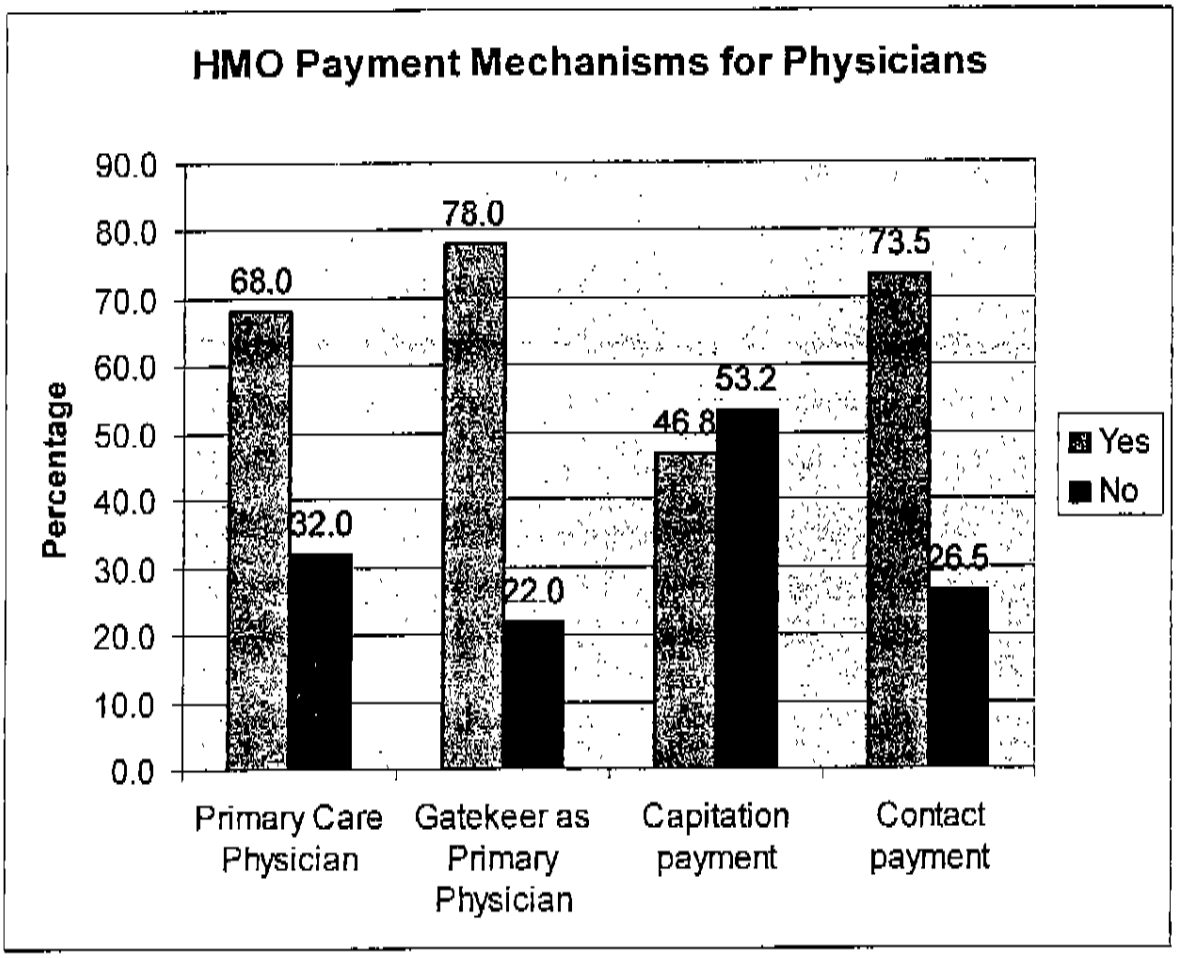

Figure 8. HMO Payment Mechanisms for Physicians

Table 4. HMO Cost Control Features

	Yes (%)	No (%)	Total plans (%)
Co-payment for a Office Visit	47 (95.9)	2 (4.1)	49 (100.0)
Penalty for Using an ER for Primary Care	36 (80.0)	9 (20.0)	45 (100.0)
Have a Drug Benefit	45 (95.7)	2 (4.3)	47 (100.0)
Patient Required to Use a Specific Pharmacy	49 (100.0)	0 (0.0)	49 (100.0)
Drug Formulary	44 (89.8)	5 (10.2)	49 (100.0)
Co-Payment per Prescription	48 (98.0)	1 (2.0)	49 (100.0)
Generic Prescription	46 (93.9)	3 (6.1)	49 (100.0)

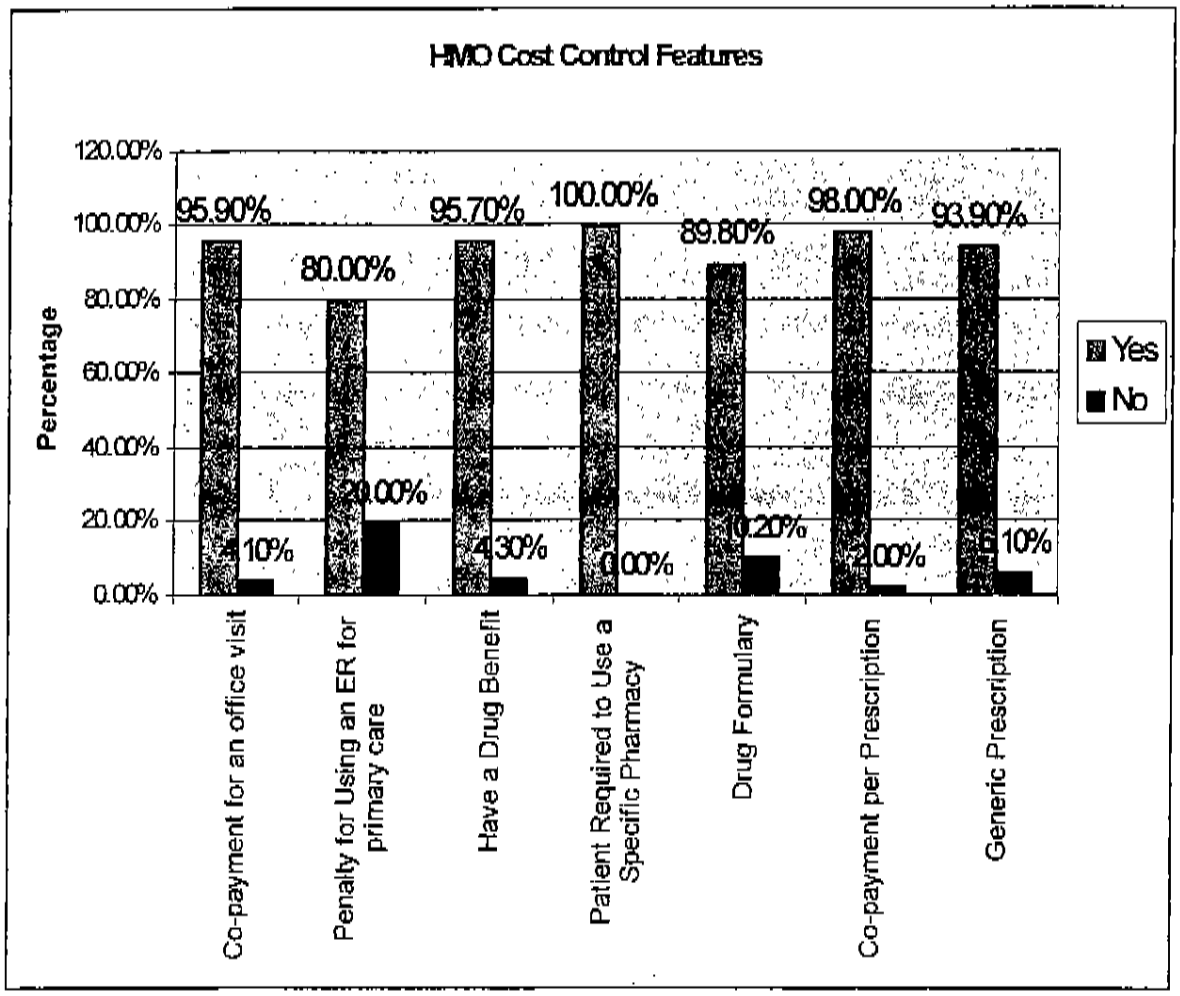

Figure 9. Cost Sharing by Enrollees and Cost Control Features

When asked specifically about preventive services, 92% (46 out of 50) of the plans required a minimum or no co-pay for immunizations, 86% (43 out of 50) offered free or nominal co-pay mammography services, 48% (24) had free or nominal co-pay mammography services, 69% (31) offered free or nominal co-pay prenatal care services, and 60% (30) offered free or nominal co-pay childhood immunizations. Ninety-four percent of the plans (47 out of 50) offered disease prevention or health promotion activities to enrollees, and an equal percentage actively attempted to educate enrollees on how best to use the plan benefits. See Table 5 and Figure 10.

Table 5. Preventive Services Offered in the Plans

	Yes (%)	No (%)	Total (%)
Immunizations free/nominal co-payment	46 (92.0)	4 (8.0)	50 (100.0)
Mammography free/nominal co-payment	43 (86.0)	7 (14.0)	50 (100.0)
Prenatal Care	31 (69.0)	14 (31.0)	45 (100.0)
Childhood Immunization	30 (60.0)	15 (40.0)	45 (100.0)
Disease prevention or Health promotion activity	47 (94.0)	3 (6.0)	50 (100.0)

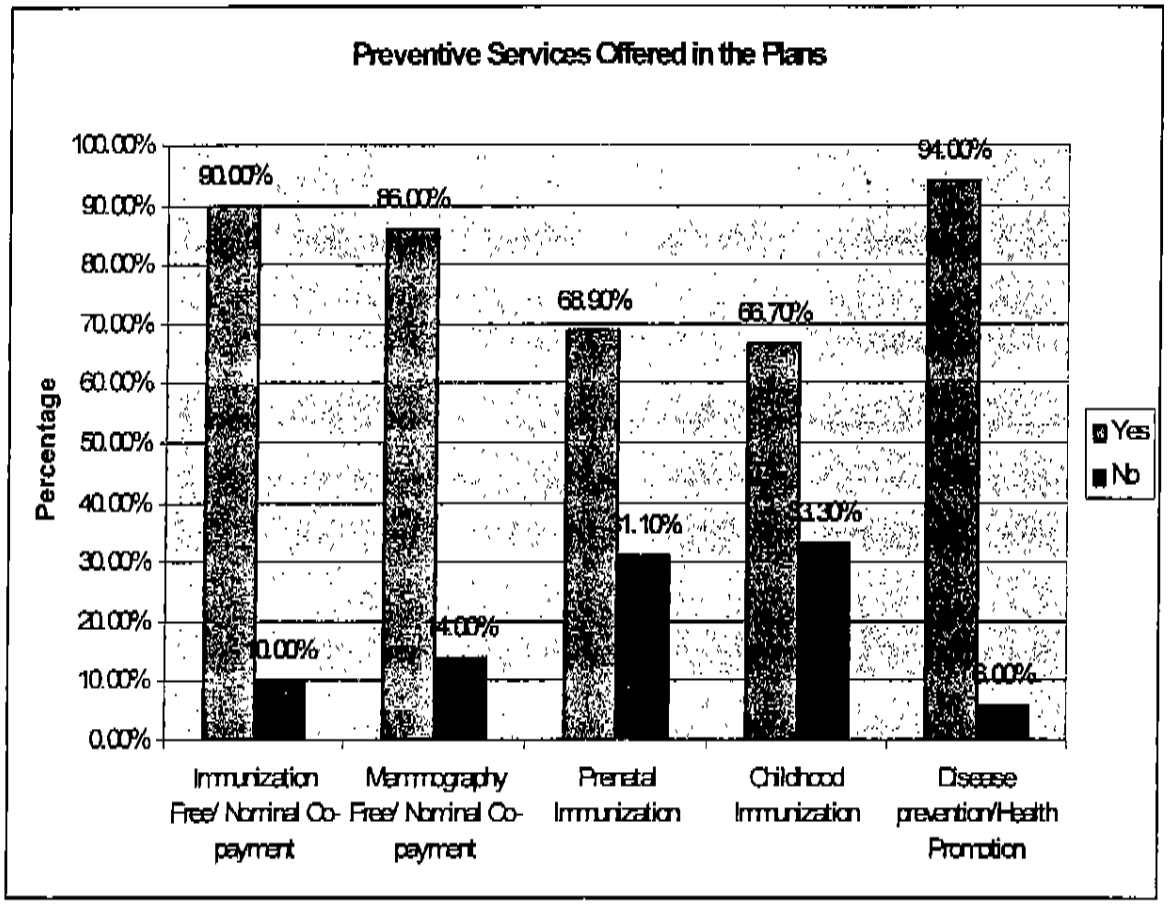

Figure 10. Preventive Services Offered in the Plans

In responding to the question on other services, ninety-four percent (47 out of 50) offered maternity benefits. Only 48% (24 out of 50) of the plans offered dental benefits. All plans reported offering mental health benefits, with 24% (12) treating it as a carve-out, 78% (39) limited the number of visits per year, and 34% (17) imposed a dollar limit per year. All plans offered physical therapy benefits, mostly limited in number and scope, and 96% offered speech therapy. See Table 6 and Figure 11.

Table 6. Other Benefits

	Yes (%)	No (%)	Total plans (%)
Maternity Benefit	47 (94.0)	3 (6.0)	50 (100.0)
Dental Benefit	24 (48.0)	26 (52.0)	50 (100.0)
Mental Health Benefit	50 (100.0)	0 (0.0)	50 (100.0)
- Treated as a carve-out	12 (24.5)	37 (75.5)	49 (100.0)
- Limited number of visits per year	39 (79.6)	10 (20.4)	49 (100.0)
Physical Therapy	50 (100.0)	0 (0.0)	50 (100.0)
- Limited number and scope	45 (90.0)	5 (10.0)	50 (100.0)
Speech Therapy	49 (98.0)	1 (2.0)	50 (100.0)

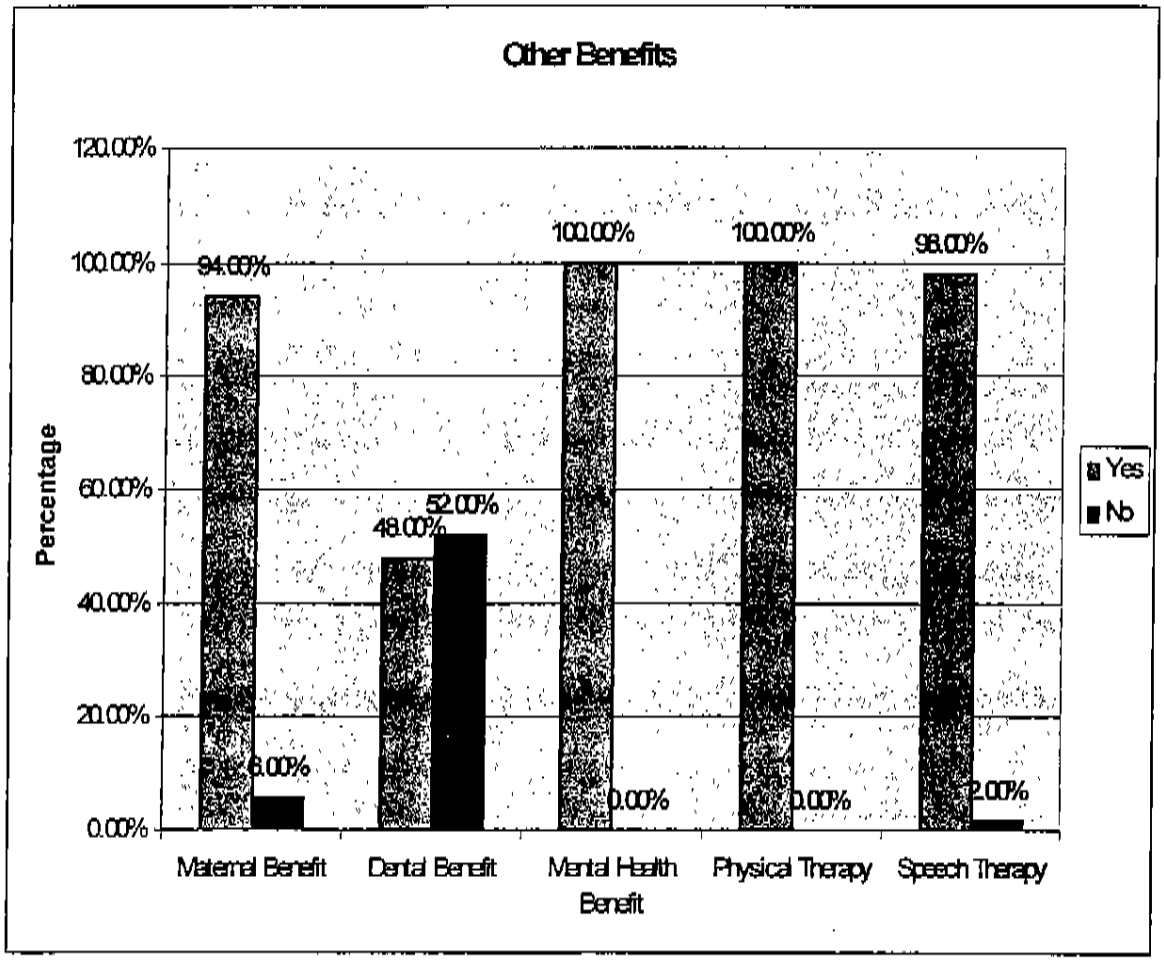

Figure 11. Other Benefits

Although 22 plans reported having capitated payment arrangements, only 4 plans provided information regarding capitation payments from physicians. These four did not withhold capitation payments based on physician performance. Only 48% (24) of the plans required pre-certification for outpatient procedures, compared to 78% (39) requiring pre-certification for hospitalization. Eighty eight percent (44 of the 50 plans) of the plans had provisions for concurrent management of hospitalization. See Table 7.

Table 7. Capitated Payment Arrangements

	Yes (%)	No (%)	Total Plans (%)
Pre-Certification for Out-Patient	24 (51.1)	23 (48.9)	47 (100.0)
Pre-Certification for Hospitalization	39 (78.0)	11 (22.0)	50 (100.0)
Hospitalization Managed by the HMO	44 (88.0)	6 (12.0)	50 (100.0)
Educate enrollees on use of benefits	45 (93.8)	3 (6.2)	48 (100.0)

The respondents were also asked a series of questions on their perspective of the issues concerning small employers and the small employer insurance market.

The 22 respondents offered the following reasons why they believed small employers provide health insurance benefits to their employees: 1) need to attract and retain employees (21); 2) respond to employee demands for coverage (17); 3) the tight labor market (10); and 4) to get coverage for only the owner and family(14). Of these reasons, attracting and retaining employees was indicated as the single most important reason. See Tables 8 and 9.

Table 8. Reasons Small Businesses Provide Health Insurance

	Yes (%)	No (%)	Total Plans (%)
Attract & Retain current employees	21 (95.5)	1 (4.5)	22 (100)
Tight labor market	10 (45.5)	12 (54.5)	22 (100)
Respond to employee demands for coverage	17 (77.3)	5 (22.7)	22 (100)
Coverage for owner & family	14 (63.6)	8 (36.4)	22 (100)

Table 9. Priority of Reasons Small Employers Provide Health Insurance

Reasons	Number of companies	Percentage
Attract & Retain current employees	9	45%
Respond to employee demands for coverage	3	15%
Other similar firms offer health insurance	2	10%
Coverage for owner & family	1	5%
Other	5	25%
Total	20	100%

Of the 22 respondents, almost all (20) indicated that cost was the major reason for employers not offering health insurance coverage. Most felt there are adequate choices for plans in the market, and also believe small employers are being provided adequate information about plans and options. See Tables 10 and 11.

Table 10. Reasons Small Business Don't Provide Health Insurance

Reasons	Yes (%)	No (%)	Total plans (%)
Not affordable	20 (90.5)	2 (9.5)	22 (100)
High employee turnover	12 (57.1)	9 (40.9)	21 (100)

Table 11. Priority of Reasons Small Employers Do Not Provide Health Insurance

Reasons	Number of Companies	Percentage
Not Affordable	14	87.5%
Lack of information about options	1	6.25%
Any others	1	6.25%
Total	16	100%

Respondents were asked to provide what percent of their small business voluntarily elected not to renew. Of the total 12 respondents that answered this question, 9 reported that 10% or more of small employers voluntarily terminated their health insurance coverage with their plan and six reported 20% or more voluntary terminations in the previous year. See

Table 12. Respondents were also asked to provide the percentage of small business plans they terminated for reasons other than non-payment of premium. The nine respondents on this question reported 22 or fewer policies were terminated in the previous year at the HMO's initiative.

Table 12. HMO's Non-renewal Rate of Small Businesses

Non-renewal Rate	Number of Companies	Percentage
less than 9 %	3	25%
10% or higher	9	75%
Total	12	100%

Ten of 18 respondents reported that their state had expanded Medicaid coverage to include the working poor. In response to the perceived effect of such state legislation on the small employer market, eight out of 16 believed that flexibility had decreased and adversely impacted their market share. All respondents indicated increased costs, decreased affordability, and decreased real access associated with recent state and federal legislation. See Table 13.

Table 13. Perceived Impact of State and Federal Legislation on Small Business Insurance

Reasons	Number of Companies	Percentage
Decreased	2	18.2%
Increased	1	9.1%
Stayed	8	72.7%
Total	11	100%

Survey respondents were asked about "pooled purchasing" in their respective state and the degree to which they felt it was an effective mechanism for improving access to health insurance for the small employer. Nine respondents indicated the presence of pooled

purchasing mechanisms for small businesses in their state, and six thought it had been helpful for small businesses in accessing health insurance for their employees.

Lastly, respondents were asked a series of questions related to specific prevention and health promotion programs offered in their plans available to small employers. Of the total respondents, 13 had a smoking cessation program, seven had a physical activity promotion program, nine had a stress management program, eight had both a healthy nutrition promotion program and a weight reduction program, three had an asthma management program, and only one had an alcohol abuse program. A variety of program strategies were reported for the health promotion services provided by the plans to include, individual personal counseling for smoking cessation and stress management (2), phone counseling for physical activity (1), smoking cessation, nutrition, weight management, and stress management (1); educational videotapes for smoking cessation (2), and referrals to community services for all five programs listed above (2). The only major physical activity promotion program consisted of a fitness facility membership discount that was offered by seven HMOs. Thirteen out of 22 respondents offered incentives to members to participate in health promotion programs: free gifts (3), free educational materials (3), gift certificates (1), reduced premiums (1), and a one time cash gift (1). Twelve of the 17 plans with a health promotion program evaluated the program through participation rates (9), cost effectiveness (6), member satisfaction (11), change in health care costs (4), and change in health behaviors (7). When asked whether their HMO informed primary care providers about members' participation in health promotion activities, seven of the 16 plans responding to the question reported in the affirmative. Of the 17 respondents, five subsidized work site health promotion programs, mostly a fully subsidized educational program. Nine of the 16 who answered this question, indicated they had a line item on the corporate budget for health

promotion programs, and ten indicated having full time health promotion staff. See Tables 14-16.

Table 14. Specific Prevention/Health Promotion Services

Health Behaviors	Yes (%)	No (%)	Total plans (%)
Physical activity	7 (38.9)	11 (61.1)	18 (100)
Proper nutrition	8 (44.4)	10 (55.6)	18 (100)
Weight Mgt	8 (44.4)	10 (55.6)	18 (100)
Smoking cessation	13 (72.2)	5 (27.8)	18 (100)
Stress Mgt	9 (50.0)	9 (50.0)	18 (100)

Table 15. Health Promotion Program Strategies

	Health Behavior				
Programs	Physical activity	Proper nutrition	Weight Mgt	Smoking cessation	Stress Mgt
Individual counseling in person				2	2
Individual counseling via phone	1	2	2	2	1
Health advice line	6	8	7	8	8
Free Classes	1			1	
Subsidized classes	4	4	5	3	3
Member newsletter	9	10	9	12	11
Printed self-help matericals	3	5	3	5	5
Educational videotapes				2	
Referral to Community Services	2	3	2	4	3

Table 16. Health Promotion Program Evaluation

Indicators	Yes (%)	No (%)	Total plans (%)
Participation rates	9 (69.2)	4 (30.8)	13 (100)
Cost-effectiveness	6 (46.2)	7 (53.8)	13 (100)
Member Satisfaction	11 (84.6)	2 (15.4)	13 (100)
Changes in health behavior	7 (53.8)	6 (46.2)	13 (100)

FOCUS GROUP DATA

Methodology

The focus groups were held for small business employers located in South Carolina, between July and October 1999. Key informant interviews were conducted via telephone with small business employers who were unable to attend the focus groups. The focus groups and key informant interviews were conducted to achieve the following objectives:

1) to assist the researchers in interpreting the results of other research related to small businesses' access to health insurance;

2) to gauge the prevalence of low take-up rates among small businesses;

3) to determine the availability of HMO coverage for participating small businesses;

4) to obtain opinions and recommendations regarding innovations and improvements in the small business insurance market that would benefit small businesses; and

5) to use the findings to develop a research agenda focusing on the issues of importance in the small employer health insurance market.

Community Setting/Environment

Businesses were located in the Midlands of South Carolina which is comprised of Richland, Lexington, Fairfield and Newberry Counties, and has an estimated population of 545,000 persons, residing in urban, suburban and rural areas. Major employer categories include state and federal government, educational institutions, health care providers, construction, manufacturing, retail trade and service industries. The unemployment rate (as a percentage of the labor force) has been decreasing over the past several years and has reached approximately 2% in Richland and Lexington Counties in 1999.

A fourth focus group was conducted in Sumter, SC. This county's population is 108,720, residing in urban, suburban, and rural areas. Major employer categories included

military, health care providers, educational institutions, construction, wholesale and retail trade and service. The unemployment rate (as a percentage of the labor force) in Sumter County has been decreasing over the past year, and in June 1999 the rate was 4.9%.

Participants and Respondents

There were a total of sixty-seven (67) small business representatives who participated in focus groups or key informant interviews for this portion of the study. Participants for three of the focus groups were selected with the assistance of the Greater Columbia Chamber of Commerce and the Greater Sumter Chamber of Commerce. Participants for the small business focus groups, with less than 50 employees and between 50 and 100 employees, were selected from the membership list of the Greater Columbia Chamber of Commerce. With the assistance of the Chamber staff, invitation letters were mailed to approximately 25 potential attendees for each focus group. Participants for the Sumter focus group were selected from the membership list of the Greater Sumter Chamber of Commerce. With the assistance of the chamber staff, 20 small business employers were invited to attend.

The invitees to the fourth focus groups were selected from a list of small businesses which were known to have uninsured employees. The researchers received the listing of employers from a community health center and hospital, which provided health care services to employees of these businesses on a free or sliding scale basis. Fourteen (14) small businesses were invited.

The fifth focus group was conducted at the South Carolina Chamber of Commerce's Health Care Summit. The researchers took advantage of a captive audience of small business owners attending the summit who agreed to participate in the focus group discussion on health care access. Thirty-three (33) business owners or representatives participated in the process.

Key informant interviews were conducted to follow up with those small businesses, which were unable to participate in the focus groups. Twenty-three (23) interviews were conducted in mid-September.

The industry types for the sixty-seven (67) small businesses were: service (27), wholesale trade (4), financial/real estate/insurance (8), retail trade (1), health care providers (4), and manufacturing (23). There was a mix of company size, as measured by the number of employees. Of those which offered health insurance, the majority (26) of the small businesses had between 3 and 25 employees. Thirteen (13) small businesses had between 25 and 50 employees, and twelve (12) had between 50 and 100 employees. See Table 17. One small business had multiple locations within South Carolina and two were multi-state with a home office in another state.

Table 17. Focus Group Participants by Number of Employees Whose Firms Offer Health Insurance

Employee Number Categories	Number of Companies (%)
< 25 Employees	26 (42.4)
25-49	13 (30.3)
50-100	12 (27.3)
Total	51 (100.0)

Health Insurance Status

Fifty-one (51) of the small businesses offered health insurance to their employees, and sixteen (16) were not currently offering health insurance. Of those companies that offered health insurance, eleven (11) offered indemnity, sixteen (16) offered Preferred Provider Organization (PPO) coverage, and twenty-four (24) offered Health Maintenance Organization

(HMO) coverage. Of the sixteen small businesses, that were not currently offering health insurance, eight were actively seeking health insurance coverage. One small business was attempting to join an existing group in order to make the premiums affordable. Focus participants responded to a series of questions to include: 1) Who pays the health insurance premiums and at what percentage? 2) Why they offered health insurance benefits? 3) Did they have adequate access to health insurance coverage, particularly HMO coverage? 4) What was the take-up rate in their respective businesses? and 5) What recommendations would they make to improve the small business insurance market?

Who Pays the Premiums?

The proportion of the premium, that was being paid by the employer, for employee only coverage varied from 100% to 50%. Thirty-five (35) employers paid 100% of the employee only premium. The other companies paid 90%, 80%, 75%, 60% or 50% of the premium. In most small businesses (39), the employee paid for dependent coverage. One small business paid 50% of the premium for dependent coverage, one paid 75% of the premium for dependent coverage, and another small business paid 100% of the premium for dependent coverage.

Why Offer Health Insurance?

When asked why do you offer health insurance, all participants agreed that health insurance was a necessary benefit for recruitment and retention in today's employment market. One respondent said, "It (having health insurance) helps to keep good employees. It increases employee loyalty and decreases turnover." Another employer indicated that his business was not able to hire a qualified applicant because she chose another employer, that offered health insurance. Other respondents indicated that offering health insurance was "the

right thing to do/everyone needs health insurance" and that "employees want and expect it". And, one participant said that health insurance would help keep employees healthy, especially older employees who have greater health care needs.

Do You Have Adequate Access To Health Insurance and HMO Coverage?

No participant expressed a concern that their small business lacked access to health insurance or HMO coverage. Several respondents indicated that their companies had a choice of insurance products from which to choose. The primary concern expressed by respondents related to the affordability of health insurance premiums for their companies and their employees. A second concern related to the potential bias that health insurance brokers and sales persons have against smaller accounts because of the lower sales commission and higher costs associated with servicing a small business.

What Is the Take-Up Rate Within Your Company?

No participant indicated that employees did not accept "employee only" coverage in those small businesses that paid 100% of the premium. In those small businesses where the employees contributed to the cost of the premium for employee only coverage and also had to pay 100% of dependent coverage, employees were less likely to enroll. Those employees choosing not to enroll tended to have other forms of health insurance coverage, such as Medicare, through parents, a spouse, or a retirement plan. Employees who opted for no coverage and were not covered elsewhere, were more likely to have low wage jobs and affordability was a major issue in their election decision. One participant also indicated that two employees were not able to enroll in the company's health insurance plan due to their pre-existing health conditions. Another employer said that younger employees often did not feel that they needed health insurance and therefore would not pay their portion of the premium. The following are some of the quotes, which were received in response to this question:

- "These people have never had coverage before. They use the ER and pay as they go."
- "They think, 'Why should I pay for it now?'"
- "Even with insurance, they must pay a co-payment when they go to the doctor."
- "My employees are able to get free care if they say that they do not have health insurance when they go to the doctor."
- "As long as we (the nation) provide free care, why do we need health insurance?"
- "They (young people) do not enroll because they think they do not need it."

In each of the focus groups, researchers asked employers about their low-income employees whose children might be eligible for the state's Child Health Insurance Plan (CHIP). Many participants indicated that there may be potentially eligible employees in their company, but no one had knowledge of the program. These comments were especially interesting in light of the CHIP program's successful enrollment of over 100,000 children in South Carolina. There is a tremendous opportunity to provide information and education about the CHIP to small business employers in South Carolina, and perhaps nationwide if these results are indicative of problem occurring in other states as well.

What Innovations Would You Recommend for The Small Business Insurance Market?

With the exception of the first recommendation, the following recommendations are not presented in any specific priority order. The method of data gathering, i.e. multiple focus groups and key informant interviews, did not allow for a ranking process.

- Overwhelmingly, employers expressed a concern about the future cost of health insurance premiums for small businesses and their employees. Additionally, many respondents felt that an increasing number of low-wage earners would choose not to have health insurance because of increasing premiums and deductibles and co-payments.
- Small businesses want to continue to have choices. Competition among health insurance carriers helps to keep costs down and helps employers to maintain/enhance benefits. They also want to have flexibility to adjust benefits, co-payments, and deductibles.
- Employees of small businesses need education (from the health insurance company/HMO) regarding their benefits, how to use them, and their responsibility to be wise purchasers of health care services.
- Small businesses need more information about federal and state health insurance laws and regulations.
- Small businesses often do not receive the level of customer service from the insurer/HMO that larger employers receive.
- Reduce government intervention between the employer and the employee. One participant indicated that his company traditionally assisted employees in interpreting health care bills and filing health insurance claims. New federal

health insurance legislation regarding patient confidentiality prevents the insurer from sharing claims information with the employer, even when the employee asks for assistance from the employer.

- Small employers want more health promotion and wellness programs for their employees.

SUMMARY AND RECOMMENDATIONS

Definition of "small business"

Congruence between the state legislation definition of a "small business" for the purpose of health insurance, and HMOs' definition was reviewed. Significant differences between the states' definition and HMOs' definition were found. See Table 18 and Figure 12. In Missouri, out of 4 responding HMOs, 3 defined a small business as "an employer with 1-50 employees", and one HMO defined a small business as "2-99 employees", while the state of Missouri defined it as "3-25 employees". The state of California, from which six HMOs responded, had all of them defining a small business as one with less than 50 employees, although the state regulation defined it as 3-25 employees.

Table 18. Company Definition of Small business by State (n=22)

	CA	GA	IL	MI	MO	PA	SC	TN	TX	NJ
1-50					1	1				
≥2		1		1						
2-49/50	5				2	1	3	1		
2-99					1					
≤ 50	1			1		1			1	
≤ 100			1							
Total	6	1	1	2	4	3	3	1	1	0

* Federal Government defines small employer as 3 through 25 as same as CA and MO.
GA, SC, TN, and TX defines small employer as 2 through 50.
IL defines small employer as up to 25
NJ defines small employer as 1-49.
PA, and MI don't have any small employer legislation.

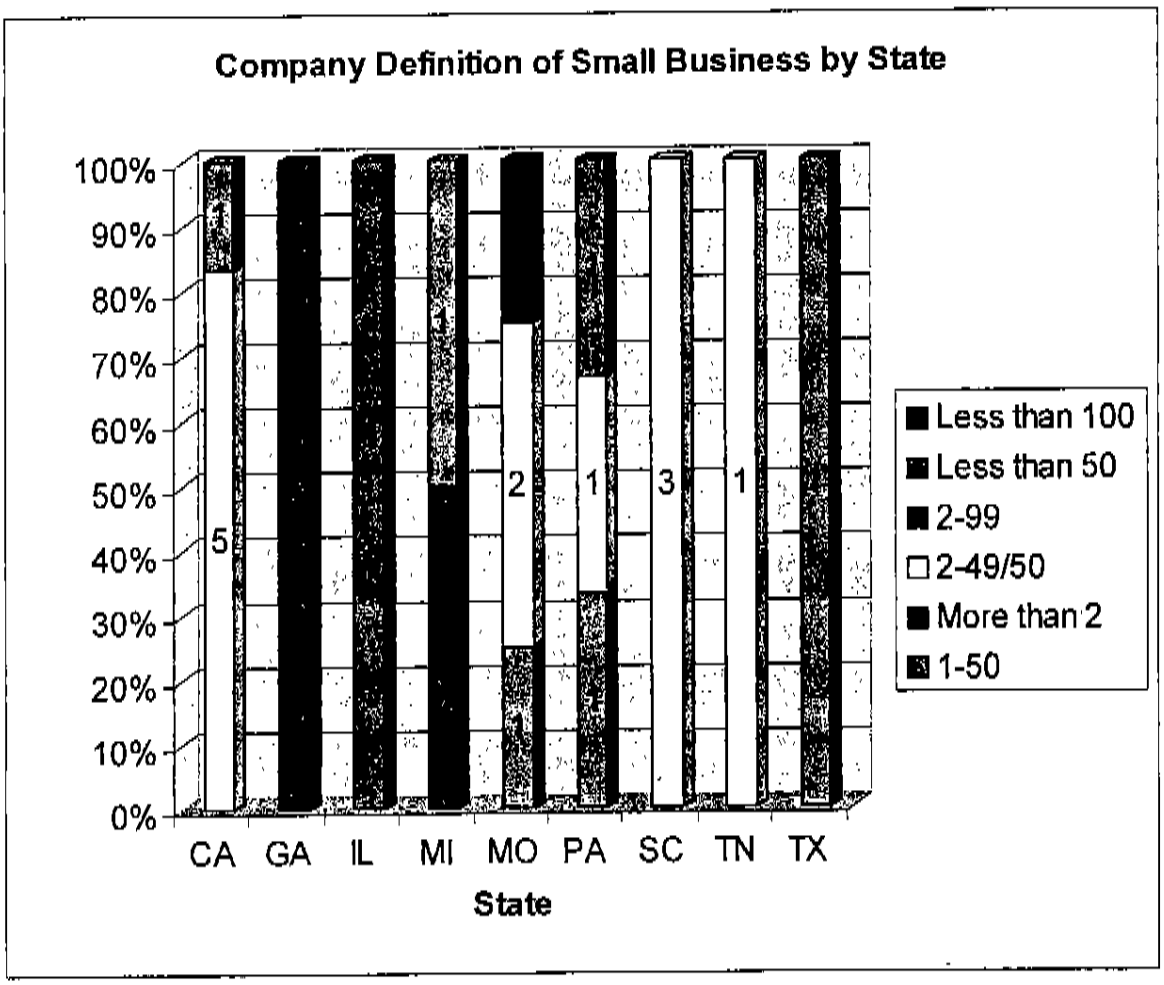

Figure 12. Company Definition of Small Business by State

The discrepancy in itself is surprising considering that small business regulations are binding upon insurance companies. This raises important questions regarding the role of regulation in bringing about desired socio-economic change. Apart from larger issues of compliance, the curious nature of the discrepancy raises the issue of the state's rationale in defining a small business, and how do HMOs benefit from a policy of including larger employers in the small business sector, contravening the prevailing regulation.

Effect of Mandates

HMOs appear to be complying with mandates related to maternity and mental health benefits, as reported by all HMO plans that responded to the survey.

Guaranteed renewal provisions

The survey indicated that the non-renewal rate at the initiative of the HMO, (apart from reasons of non-payment of premium) was negligible, ranging from 1-22 policies in the last year for the ten states surveyed. The guaranteed renewal provisions appear to be effective in limiting involuntary terminations of small business health insurance.

Issues of real access and cost of HMO plans

Access. All states (except Michigan and Pennsylvania whose statutes were not available for review) require small employer carriers, as a condition of doing business in the state, to "actively market each of its health benefit plans to all small employers in the state with full information on each plan,"... "shall market the basic and standard plans with the same resources and methods as other health plans", and, that a small employer carrier may not vicariously violate any of the adverse selection practices through commercial arrangements with insurance producers or agents to selectively enroll small employers for commercial advantage. Yet, the small employer focus group participants indicated that often the marketing agents do not disclose information about low cost plans due to monetary considerations (commissions being paid as a percentage of volume of business generated). This raises an important issue of how far regulation can really ensure the fair marketing of low cost plans by insurance agents, which is the key to improving small business access to insurance. This issue was also raised in the focus groups. Very small employers (groups with less than 25 employees) reported they faced problems of access in South Carolina.

Cost. Recent published research findings and the results of this study draw an emerging picture of small businesses finding it increasingly difficult to obtain affordable health insurance for their workers. This is especially so for those small businesses that have less than 25 employees and have a disproportionate share of low-wage earning employees. This is occurring in spite of ongoing state and federal efforts to address this problem through legislation. Gable, et al (1997) found similar results even though states have been consistent in adopting regulations that limit ratings practice use. These state and federal efforts to address the problem are occurring even as the number of uninsured Americans continues to increase, with increasing numbers of the working poor being added to the rolls. These may be full-time workers in small or medium size businesses, part-time workers, or temporary workers without benefits. At the same time, findings indicate that low-wage earners are less likely to be eligible for health benefits and less likely to take them up (take-up rate). When they do take up health benefits, they are more likely to pay a greater share of the premium for single and family coverage and have a benefit package that requires a greater sharing of expenses in the form of higher deductibles and co-payments, as well as restricted benefits.

This project was devoted to examining the "supply" side of the health benefit equation. Each state's laws have been reviewed in depth to determine the different approaches of state regulation to aid small businesses in acquiring health insurance for their employees. Federal model legislation provided a template or framework for structuring legislation at the state level. It is clear from the review that each state is unique in its structuring of health insurance legislation for the small employer market.

No previous literature has reported any similar study on the health insurance industry and its response to the small business market. General statistics are available from insurance companies (HMO's) regarding the number and types of small businesses that they sell a product to, the types of plans that small businesses opt to purchase or offer, including some

limited information regarding employee cost-sharing. The HMO survey attempts to explore the small business health insurance market by attempting to understand marketing issue. The survey was used to examine different types of services available to small businesses including disease prevention and health promotion activities, special product designs for the small business market, and small business market issues as perceived by the health insurance provider. One of the problems of ascertaining information from HMOs is the poor response rate, even after repeated contact. Colleagues from other institutions report similar problems.

Survey findings covering the 50 most popular plans offered by these HMOs are presented in this report. An integrated review of these findings in conjunction with the focus group findings and document review, suggests that regulation at best, has been only partly successful in achieving its goal, which is consistent with earlier studies (Nichols et. al, 1998). This study has shown that discrepancies between explicit legal provisions and practice do exist, such as in the definition of a small business. This also suggests the need to research in depth the extent to which regulation is actually being implemented.

Mandated benefits appears to be implemented by the HMOs which is illustrated by universal offering of maternity and mental health benefits in line with state regulations. Other regulations such as mandates for fair marketing of low cost plans, are being implicitly breached. Built-in adverse marketing incentives mitigate against fair marketing of low cost plans, revealing an inadequacy of current forms of legislation. Further study is required to better understand this newly identified problem.

Additional research is needed to better understand the "demand" side of the equation. Specifically, a detailed exploration into the reasons small businesses do or do not provide a health insurance plan, specifically an HMO option. In addition, several questions from the employer perspective need to be addressed: 1) What are the barriers to offering a plan to all

employees, as opposed to only high-wage, full-time employees? 2) Have the laws in the different states had an impact on a small business's ability to provide a health plan to employees? 3) What do small businesses actually know about state insurance regulation? 4) What is the impact of expanding Medicaid and CHIP programs to their employees?

A review of the current literature indicates that those employees in companies with many low-wage earners, especially found in small businesses, have a significant number of employees that do not take up insurance even when it is offered to them. The "take-up" rate (employee demand) and the attending issues have not been examined from the employee perspective, although an occasional article proposes an explanation.

Additional research is needed focusing on those employees that do not accept the health plan offered by their employers. Specific questions that need to be addressed are: 1) What are the reasons (barriers) for not taking up the health insurance benefit? 2) What changes are needed to enable the employee to use the health insurance benefits offered? 3) What benefit options are most desired? 4) How do employees view HMO products and services? 5) Are employees aware of expanded Medicaid and CHIP programs in their states and do they view them as a possible alternative to employer-sponsored health insurance?

REFERENCES

1. Gabel, J., Hurst, K., Whitmore, H., Hoffman, C. Class and work benefits at the workplace. Health Affairs, 18(3), May/June, 1999.

2. Cooper, P.F., Schone, B.S. More offers, fewer takers for employment-based health insurance: 1987 and 1996, Health Affairs, 16(6), 142-149, Nov-Dec, 1997.

3. Morrisey, M.A., Jensen, G.A., Morlock, R.J. Small employers and the health insurance market, Health Affairs, 13(4), 149-161, Winter 1994.

4. Gabel JR, Ginsburg PB, Hunt KA: Small employers and their health benefits, 1988-1996: An awkward adolescence, Health Affairs, 16(5), 103-149, Sep.-Oct. !997.

5. Helms WD, Gauthier AK, Campion DM: Mending the flaws in the small-group market, Health Affairs, 11(2), 6-27, Summer 1992, 144-150.

6. Nochols, L.M., Marsteller, J., Rajan, S., Zuckerman, S. The effects of state policies on insurance coverage: health insurance reforms and selective contracting restrictions. Abstr. Book Assoc Health Ser. Res. 1998, 15, 75-6, The Urban Institute, Washington DC.

7. McCall, N.T., Lee, A.J., Liu, C.F., Kirsch, L., Freitas, R. Evaluation of small group and individual health insurance reform in New Hampshire. Abstr. Book Assoc Health Ser. Res. 1998, 15, 74-5, Center for Health Economics Research, Inc., Washington DC.

8. Percy, A. Community rating and small group reform in health insurance markets. Abstr. Book Assoc Health Ser. Res. 1998, 86-7, Health Care Systems Department, The Wharton School, University of Pennsylvania, Philadelphia.

9. De Mont, T: Dun and Bradstreet=s Small Business Hot Topics Research, First Quarter 1998 Report on Employee Issues, Personal communication.

10. Cantor, J.C., Long, S.H., Marquis, S.M: Private employment-based health insurance in the United States, Health Affairs, 14(2), 199-211, Summer 1995.

11. Jensen, G.A., Morrissey, M.A., Gafney, S., Liston, D.K. The new dominance of managed care: Insurance trends in the 1990s. Health Affairs, 16(1), Jan/Feb 1997, 125-136

12. McLaughlin, C.G., Zellers, W.K. The shortcomings of voluntarism in the small group market, Health Affairs, 11(2), 28-40, Summer 1992.

13. Feldman, R., Dowd, B., Gifford, G. The effect of HMOs on employment based premiums, Health Services Research, 27(6), 779-811, Feb 1993.

14. Chernew, M., Frick, K., McLaughlin, C.G. The demand for health insurance coverage by low income workers: Can reduced premiums achieve full coverage? HSR: Health Services Research, 32(4), 453-470, October 1997.

15. Curtis, R., Lewis, S., Haugh, K., Forland, R. Health insurance reform in the small group market. Health Affairs, 18(3), May/Jun 1999, 151-160.

16. Jensen, G.A., Morrissey, M.A. Managed care and the small group market, in Morrisey, M.A. (ed.), Managed care and changing health care markets, Washington DC: AEI Press, 1998.

17. Schauffler, H.H., Chapman, M.S. Health promotion and managed care: surveys of California=s health plans and population. American Journal of Preventive Medicine, 14(3), 161-167, 1998.

18. Chapman, L.S., Nelson, L., Sloan, B., Plankenhorn, R. Primary, secondary and tertiary prevention capabilities of selected HMOs: findings of an employer survey. American Journal of Health Promotion, 12(2), 102-109, 1997.

Appendix - A
List of HMOs contacted in the 10 states

(*Source of HMO listings*: State-wise HMO list in the "Executive Managed Care Directory – 1999, Eighth Edition, Published by Managed Care Interface, Bronxville, NY)

	Listing	*City*	*Contact person/ Comments*	*Phone #*
	CALIFORNIA			
1.	Care 1st Health Plan	Alhambra	Sergio Gonzales, Director, Mktg.	626-299-4299
2.	Pacific IPA	Alhambra	Michael Tran, Marketing	626-281-3400
3.	Talbert Medical Group	Anaheim	Penelope Nordeman, Marketing	714-436-4834
4.	Mullikin Medical Center	Artesia	Phone operator declined to provide name of mktg. Person	562-860-6611
5.	Bakersfield Memorial IPA	Bakersfield	Not an HMO	661-324-8156
6.	Kern Family Health Care	Bakersfield	Janice Sanders, Marketing	661-391-4000
8.	Kaiser Foundation	Berkeley	Ref. To Corporate office at Oakland	510-559-5470
9.	Blue Shield of California	Brea	Ref. To Corporate office at San Francisco	415-229-5000
10.	Maxicare Northern California	Burlingame	Phone disconnected, No such listing	650-652-6300
11.	Well point Health Networks	Calabasas Hills	Phone disconnected, No such listing	818-878-2600
12.	DCHC	Chatsworth	Phone operator declined to provide name of mktg. Person	818-701-7556
13.	Community Health Group	Chula Vista	Joseph Garcia, Director, Mktg.	619-422-0422
14.	Sharp Rees Stealy Clinic	Chula Vista	Cathy Hutchins, Mktg.	858-499-2777
15.	Pacific Care	Concord	Call not going through on repeated trials	510-246-1300
16.	American Health Guard Corp.	Costa Mesa	Phone disconnected, No such listing	949-574-8874
17.	Health Net	Costa Mesa	Automated answering system for members only, no option for operator	949-253-6100
18.	Talbert Medical Management Corporation	Costa Mesa	Ref. To Corporate office, Anaheim	714-436-4834
19.	Affiliated Physicians Medical Group IPA	Covina	Automated answering system for members only	626-331-3886
20.	Pacificare of California	Cypress	Judy Richards, Marketing	714-952-1121
21.	Human Affairs International	El Segundo	Moreno Grady, Sales	800-424-1565

			& Mktg.	
22.	East Bay Medical Network	Emeryville	Lawana, Admin. Asst	510-5
23.	Blue Shield of California	Folsom	Chris Bettner, Dir. Mktg.	415-2
24.	Kaiser Permanente Fontana Medical Center	Fontana	Ref. To Corporate office	909-4
25.	Priority Health Service	Fresno	Carole Lewis, Admin. Director	559-4
26.	Cigna Health Plan of California	Glendale	Christy Harrison, Dir. Sales & Mktg.	818-5
27.	UHP Health Care	Hawthorne	Frank S Vo, Mktg. & Sales	800-5
28.	Kaiser Permanente Medical Center	Hayward	Dean Kemp, Dir. Small Business	626-5
29.	California Benefits	Huntington Beach	Phone disconnected, No such listing	714-8
30.	WellPoint Health Networks	Huntington Beach	Ref. To Corporate office	818-3
31.	United Health Plan	Inglewood	Peter Tamayo, VP Mktg. & Sales	310-6
32.	Cornerstone Physicians Corporation	Irvine	Not an HMO, per operator	949-8
33.	Universal Care (formerly Health Max America)	Irvine	Amanda Gross, Asst to Mktg. Dir.	800-6
34.	FHP HMO	Long Beach	Phone disconnected, No such listing	562-5
35.	Lakewood Health Plan	Long Beach	Caesar Abutin, Controller	562-6
36.	Long Beach Memorial Health Service	Long Beach	Phone ringing, no response, tried several times	562-9
37.	Molina Medical Center	Long Beach	Seidric Tapscott, Regional Sales Mgr.	562-4
38.	PacifiCare	Long Beach	April Ingall, Mktg.	714-9
39.	Saint Mary Medical Center	Long Beach	Automated message system, no option to talk to operator	562-4
40.	Scan Health Plan	Long Beach	Sim Hussein, Mktg.	800-5
41.	Scan & Smartcare Health Plan	Long Beach	Ref. To corporate office above.	800-7
42.	United Health Care of California	Long Beach	Michael Kin, Small Groups Sales	562-9
43.	Aetna US Health Care	Loma Linda	Automated response	800-3
44.	Aetna US Health Care of Southern California	Los Angeles	Phone disconnected, No number given by inquiry	310-5
45.	Blue Shield of California	Los Angeles	Jim English, Mktg.	310-5
46.	BPS HMO	Los Angeles	Jack Tillman, Sr. VP	800-6
46.	Community Health Plan	Los Angeles	Phone disconnected	800-8
47.	FHP Inc.	Los Angeles	Phone gives busy note, tried several times	323-7
48.	Kaiser Permanente Health Plan	Los Angeles	Ref. To corporate office	323-8

49.	Kaiser Permanente LA Medical Center	Los Angeles	Ref. To corporate office	213-783-4011
50.	Managed Health Care Network	Los Angeles	Automated response	310-354-2755
51.	Maxicare California	Los Angeles	Sonya Ortiz, Small Groups	213-765-2000
52.	Watts Health Foundation	Los Angeles	Frank Vo, Mktg.	323-564-4331
53.	Access Medical Group	Marina Del Ray	Angel Dalis, Mktg.	310-306-6966
54.	Contra Costa Health Plan	Martinez	Nancy McCauley, Dir. Mktg.	925-957-7222
55.	Lifeguard HMO	Milipitas	Automated message system	800-995-0380
56.	National Health Plan	Modesto	Declined participation	209-527-3350
57.	Cigna Health Care of Northern California	Oakland	No service to small business, per operator	510-273-8400
58.	Health Net	Oakland	Karen Lau, Mktg.	510-465-9600
59.	Kaiser Permanente of Northern California	Oakland	Ref. To Corporate office	510-873-5073
60.	QualMed Plans for Health & Foundation Health	Oakland	Acquired by Health Net	510-226-3651
62.	Orange County Foundation Medical Care	Orange	Not an HMO, (Joann Stewart, phone operator)	714-978-5048
63.	UCI Health Net	Orange	Automated answering system, no option for operator	714-456-6206
64.	Los Angeles Foundation Medical Care	Oxnard	Richard Michael, Mktg.	800-232-9043
65.	Kaiser Permanente	Panorama City	Ref. To corporate office	800-790-4061
66.	Affiliated Health Funds	Pasadena	Not an HMO, per operator	626-356-1090
67.	Community Care Network	Pasadena	Diane Thomas, Sales & Mktg.	800-247-2898
68.	Foundation Health Services	Pasadena	Automated answering system for members only, no option for operator	626-683-6300
69.	Kaiser Permanente	Pasadena	Ref. To corporate office	818-405-5000
70.	Inter Valley Health Plan	Pomona	Chuck Nickel, Mktg.	909-623-6333
71.	Managed Care USA	Rancho Cordova	Automated message system	916-635-5808
72.	Greater Pacific HMO	Rancho Cucamonga	Phone no longer in service but same number given by inquiry	909-483-9595
73.	FHP Life	Rancho Palos Verdes	Phone gives busy note, tried several times	714-513-6161
74.	Foundation Health Services	Riverside	Phone gives busy note, tried several times	909-320-6400

75.	Kaiser Permanente Riverside Medical Center	Riverside	Ref. To corporate office	909-35
76.	Landmark Health Care	Sacramento	Lynette Lasell, Mktg.	916-64
77.	Metlife	Sacramento	Barbara Carpenter, Mktg.	914-28
78.	Omni Health Care	Sacramento	Out of Business	209-47
79.	Prudential Health Care	Sacramento	Automated answering system, no option for operator	916-85
80.	Coastal Health Care Administration	Salinas	Pepa Larose, Dir. Mktg	831-45
81.	Aetna US Health Care	San Bernardino	Phone no longer in service, same # given by inquiry	909-79
82.	Inland Empire Health Plan	San Bernardino	Dave Tamayo, Mktg.	909-89
83.	Aetna US Health Care	San Bruno	Lisa Curley, Sup, Estab. Businesses	650-95
84.	Aetna Health Plan of California	San Diego	Susan Ghirardi, Mktg.	619-49
85.	Cigna Health Plan of California	San Diego	Automated answering system, no option for operator	858-45
85.	Great American Health Plan	San Diego	Phone disconnected, No such listing	619-29
86.	Greensprings Health Plan	San Diego	Ron Sharpshair, Mktg.	800-33
87.	Kaiser Permanente	San Diego	Ref. To corporate office	619-52
88.	Mercy Physicians Medical Group	San Diego	Arnie Garcia, Provider Relations	619-54
89.	Pacific Foundation for Medical Care	San Diego	Kevin Connolly, Mktg.	619-66
90.	PacifiCare	San Diego	Ref to corporate office	714-95
91.	Palomar Pomerado Health Network	San Diego	Not an HMO, Camile Drew, Mktg.	858-67
92.	Premier	San Diego	Not an HMO, Sandy Hooper, Human Resources	858-48
93.	Primary Provider Management Company	San Diego	Operator declined to provide name of mktg. person	909-77
94.	Prudential Health Care	San Diego	Belinda Whitler, Sales & Mktg.	619-45
95.	Sharp Health Plan	San Diego	Jeff Lazenby, Mktg.	619-63
96.	Aetna US Health Care	San Francisco	Ref to corporate office	415-64
97.	Blue Shield of California	San Francisco	Ref to corporate office	415-44
98.	Chinese Community Health Plan	San Francisco	Yolanda Lee, Mktg.	415-83
99.	Kaiser Permananete Medical Center	San Francisco	Ref. To Corporate office	415-20

100.	On Lok Senior Health Services	San Francisco	Carole Smith, Director, Mktg.	415-689-2578
101.	Pacific Mutual Group	San Francisco	Not an HMO, per phone operator	415-421-8972
102.	San Francisco Health Plan	San Francisco	Janie Tyre, Dir. Mktg.	415-547-7800
103.	United Healthcare of San Francisco	San Francisco	Linh Huynh, Mktg. Services	415-546-3439
104.	LifeGuard HMO	San Jose	Tom Carter, VP, Mktg.	408- 432-3699
105.	Medical Dimensions Inc.	San Jose	Leslye Maninang, Mktg.	408-377-9877
106.	Meridian Medical Group	San Jose	Dr. Gomez, Hospital Admin	408-729-5800
107.	One Health Plan of California	San Jose	Brad Steiner, Member Services	408-437-0272
108.	Valley Health Plan	San Jose	Susan Brauss, Mktg.	408-885-4760
109.	Health Plan of San Mateo	San Mateo	Phone ringing, no response, tried several times	650-573-9710
110.	San Rafael Medical Group	San Rafael	Not an HMO, per phone operator	415-454-9100
111.	Admar Corporation	Santa Ana	Steve Ashley, Mktg. & Sales	800-955-9600
112.	Aetna US Health Care	Santa Ana	Mike Giar, Mktg.	888-788-0387 714-972-3407
113.	Talbert Medical Group	Santa Ana	Ref. To Corporate office	714-835-8501
114.	Monarch Health System	Santa Barbara	Not an HMO, per phone operator	805-963-0566
115.	Baycare Health Plan	Santa Clara	Pauline Lugo, Supervisor, Member Services	408-441-9340
116.	Health Plan of the Redwoods	Santa Rosa	Bob Dickes, Director, Mktg.	707-544-2273
117.	Universal Care	Signal Hill (moved to Long Beach)	Allan Rahn, Mktg.	800-635-6668
118.	Health Plan of San Joaquin	Stockton	David Hirsh, Dir. Mktg.	209-939-3500
119.	Omni Health Care	Stockton	Carrie Sanchez (Out of business)	209-474-6664
120.	Aetna US Health Care	Thousand Oaks	Phone no longer in service same # given by inquiry	805-446-3800
121.	California Care	Van Nuys	Ref. To Blue Cross corporate office	800-825-1030
122.	Health Net	Ventura	Michelle Carriolo, Mktg.	805-658-5000
123.	First Health Medical Cost Management	West Sacramento	Karen Galcik, Secretary	916-374-4600
124.	Aetna Health Plans California	Walnut Creek	Phone disconnected, directory assistance gives same number.	925-941-3000
125.	California Care	Woodland Hills	Alan Katz, Small Group Sales	805-480-7006

126.	Care America Health Plan	Woodland Hills	Acquired by Blue Shield of California	818-598-8
127.	Foundation Health Systems	Woodland Hills	David Green, Manager, Small Business Dept	818-676-6
128.	Kaiser Permanente	Woodland Hills	Ref. To corporate office	818-719-2
129.	Prucare of California	Woodland Hills	Brad Burr. Mktg.	818-610-6
130.	Well Point Health Networks	Woodland Hills	Lisa Mee. Sr. Corp. Comm Consultant	818-703-2
	GEORGIA			
131.	Aetna US Health Care	Alpharetta	Rachel Larue, Director, Marketing	770-346-4
132.	Athens Area Health Plan Select	Athens	Rachel Bianco, Mktg.	706-549-0 Ext. 4835
133.	Blue Cross Blue Shield	Atlanta	Ref. To 888-404-3152, in turn to 404-842-8000, and in turn back to 888. Unable to get to a responsible person to respond.	404-842-8
134.	Cigna Health Plan of Georgia	Atlanta	Jeffrey Zaputio, Mktg	404-681-7
135.	HCP Health Plan	Atlanta	Phone disconnected, No such listing	404-815-7
136.	Health Source Georgia	Atlanta	Acquired by Cigna	800-762-1
137.	Humana Health Plan	Atlanta	Joan Thorson, Director. Mktg. Compliance	770-399-5
138.	Kaiser Permanente	Atlanta	Greg Mercer, Director, Mktg.	404-364-7
139.	Managed Health Care Concepts	Atlanta	Company policy: Names not given to strangers	404-473-4
140.	One Health Plan of Georgia	Atlanta	Sharon Andrews, Mktg.	770-391-9
141.	Principal Health Care of Georgia(now Coventry Health care)	Atlanta	Sagina Hlubi, Mktg.	678-202-2
142	Promina Health Plan	Atlanta	Jane Pruett, Sales & Mktg.	770-956-6
143.	Prudential Health Care	Atlanta	Acquired by Aetna	770-955-8
144.	Scottish Rite Pediatric Health Alliance	Atlanta	Bonnie Block, Director Mktg.	404-25027
145.	United Health Care of Georgia	Atlanta	Chris Wilson, Mktg.	404-982-8
146.	John Deere Health Care	Augusta	Russel Thornberry, Mktg	800-330-9
147.	AFLAC	Columbus	No HMO Plan only supplemental health insurance	706-323-3
148.	Blue Cross Blue Shield	Columbus	Bob Matz, Marketing	706-571-5 Ext. 35205

149.	Family Plus Health Plan	Decatur	Automated answering system only for members, no other number from inquiry	404-235-1010
150.	American Medical Plans of Georgia	Duluth	Phone gives busy note, tried several times	678-380-6600
151.	Oncare Inc.	Roswell	Julie Summers, Mktg	770-752-5570
152.	Complete Health Plan of Georgia	Smyrna	Teresa Handy, Director. Mktg.	770-432-6158
	ILLINOIS			
153.	Rush Prudential	Calumet City	Ref. To corporate office	312-665-7600
154.	Personal Care	Champaign	Skip Pickering, Mktg.	217-366-1348
155.	Community Health Plan	Charleston	Being phased out of managed care business	217-348-7866
156.	Aetna Health Plan	Chicago	Amy Scavo, Regional Marketing Manager	312-441-300 Ext. 3404
157.	Americaid Illinois	Chicago	Paul Hardwick, VP Mktg.	312-214 0400
158.	Blue Cross Blue Shield Of Illinois	Chicago	Anthony Richardson, Small Group Proposals	312-653-6000
159.	Cigna	Chicago	Terry Kolbus, Mktg.	312-648-2460
160.	Community Health Plan	Chicago	Operator declined to give names of marketing persons	773-296-7014
161.	First Commonwealth	Chicago	Mark Lindberg, Mktg	312-644-1800 Ext. 8638
162.	HMO Illinois	Chicago	Belongs to Blue Cross Blue Shield	312-938-6000
163.	Humana Health Care	Chicago	Thomas Clemans, Mktg.	312-441-9111
164.	Illinois Masonic Community Health Plan	Chicago	Pat Cruz, Director, Managed Care	773-975-1600
165.	Maxicare Health Plans of Illinois	Chicago	Phone disconnected, no such listing	312-616-4700
166.	Rush Prudential HMO	Chicago	Keith Stein, Sales Executuve	312-234-7000
167.	Union Health Service Inc.	Chicago	Jill Rock, Mktg. Director	312-829-4224
168.	United Health Care	Chicago	John Gialamas, Sr Director, Sales	312-424-4565
169.	Unity HMO of Illinois Inc	Chicago	Belongs to United Health Care Professionals	312-251-0955
170.	University of Illinois HMO	Chicago	Automated answering system, no provision for operator assistance	312-996-3553

171.	Humana Health Direct	Des Plaines	Paul McGowan Mktg. Manager	847-391-9
172.	Wellborn HMO	Evansville	Part of Humana	812-425-3
173.	Unicare Inc	Hoffman Estates	Angie Hanson, Mktg. Asst.	800-949-9
174.	Highland Managed Care Group	Lombard	Brian Cottone, Mktg.	630-916-3
175.	American Health Care Providers Inc	Matteson	Bob Brodel, Mktg.	708-503-9
176.	John Deere Health Care Inc	Joliet	Susie Snyder Bush, Corporate Mktg.	309-765-1
177.	United Healthcare Professionals	Naperville	Phone disconnected, operator gave the same number	708-637-4
178.	NYL Health care of the Midwest Inc	Oakbrook	Acquired by Aetna	800-286-0
179.	Principal Health Care	Oakbrook Terrace	Phone disconnected, no such listing	630-916-6
180.	Health Plus Inc	Peoria	Professional group	309-676-4
181.	OSF Health Plans	Peoria	Melody Berry, Mktg.	309-677-8
182.	Benchmark Health Insurance Co.	Rockford	Sandy Spataro, Mktg.	815-391-7
183.	Blackhawk IPA & Midland Mgmt Co.	Rockford	Third party administrators	815-963-9
184.	John Deere Health Care/Heritage	Rockford	Ref. To corporate office	815-391-8
185.	Rockford Health Plan	Rockford	Chris Anderson, Mktg. Director	815-654-3
186.	One Health Plan of Illinois	Rosemont	Sue Novick, VP Operations	847-518-0
187.	Oxford Health Plans/Illinois	Rosemont	Phone disconnected, inquiry gave same number	800-892-2
188.	Health Alliance Medical Plans	Urbana	Peter Reudi, Mktg	217-337-8
189.	Accord Health Network	Westchester	Sean Prizeman, Mktg	708-531-1
190.	Accord Health Plan	Westmont	Same as above	630-887-4
191.	Preferred Health Network	Wilmette	Acquired by Health Net & Foundation Health	847-853-6
	MICHIGAN			
192.	M Care	Ann Arbor	Tim George, Mktg	734-747-8
193.	Mercy Health Plan	Ann Arbor	No HMO plan	734-677-3
194.	Comprehensive Behavioral Care (formerly Healthcare Management Services)	Bloomfield Hills	Behavioral managed care only	800-688-6
195.	Midwest Health Plan	Dearborn	Judy Call, Mktg	888-654-2
196.	Blue Cross & Blue Shield of Michigan	Detroit	Juanita Woods, Mktg.	248-448-6
197.	Bluecare Network Southeast Michigan	Detroit	Francine Pegues, Regional Director	877-257-9
198.	Health Alliance Plan	Detroit	Chris Fanning, Mktg.	313-872-8
199..	Henry Ford Health System	Detroit	Hospital system, not HMO	313-876-8
200.	Omnicare Health Care	Detroit	Operator declined to give marketing	313-259-4

			person's name	
201.	Total Health Care Inc	Detroit	Sandra Speers, Director, Mktg.	313-871-2000
202.	Ultimed HMO of Michigan	Detroit	Phone disconnected, no such listing	734-961-1717
203.	Weliness Plan Comprehensive Health	Detroit	Cheryl Forte, Director, MKtg.	313-875-4200
204.	Care Choices HMO	Farmington Hills	Colleen Schulte, Mktg. & Sales	800-261-3452
205.	Health Plus	Flint	Nancy Jenkins, Director, Mktg.	810-230-2000
206.	Blue Care Network	Grand Rapids	Paula Brawdy, Director Marketing	800-635-6439
207.	Grand Valley Health Plan	Grand Rapids	Pam Silva, Director Mktg.	616-949-2410
208.	Priority Health	Grand Rapids	Rob Pocock, Director, Mktg.	616-942-0954
209.	Priority Health	Holland	Ref. To corporate office	616-392-6401
210.	Physicians Health Plan	Jackson	John Rogus, Director. Mktg.	517-782-7154
211.	Physicians Health Plan	Kalamazoo	Erin Stiglitz, Director Mktg	616-349-6692
212.	Care Choice Health Plan	Kentwood	Ref. To corporate office	616-285-3801
213.	Bluecare Network	Lansing	No response to voicemail requesting fax number	800-428-7631
214.	Ingham Regional Medical Center	Lansing	Cheryl Smith, Mktg.	517-336-9750
215.	Physicians Health Plan	Lansing	Larry Baneck. Mktg.	517-349-2101
216.	Family Health Plan of Michigan	Monroe	Phone out of order, tried several times	734-457-8370
217.	Paramount Care of Michigan	Munroe	Mark Moser, VP Mktg.	419-887-2500
218.	Care choices HMO	Muskegon	Ref. To corporate office	231-285-3801
219.	PHP-United Health Care	Muskegon	Ken Rauschert, Mktg	231-728-3900
220.	Wellness Plan	Muskegon	Ref. To corporate office	231-725-6000
221.	Blue Care Network-Great Lakes	Muskegon Heights	Refer to corporate office	800-972-9797
222.	Blue Shield	Novi	Refer to corporate office	800-258-8000
223.	Care Choices HMO	Okemos	Refer to corporate office	517-349-2111
224.	Community Choice Michigan	Okemos	Nora Crawford, Mktg.	517-349-9922
225.	Blue Cross Blue Shield	Portage	Refer to corporate office	616-285-7910
226.	Grand Valley Health Plan	Rochford	Refer to corporate office	616-866-9568
227.	Health Plus	Saginaw	Debbie Beyer, Mktg. Director	517-799-6451
228.	Blue Care Network of South East Michigan	Southfield	Refer to corporate office	248-354-7550

229.	Care America Health Plan	South field	Phone service only for members	888-698-3
230.	Blue Care Network	Traverse City	Refer to corporate office	248-354-7
231.	Priority Health (formerly North Med HMO)	Traverse City	Dixie Steven, MKtg	231-935-0
232.	Walker Health Center	Walker	Acquired by Grand Valley Health Plan	616-784-4
	MISSOURI			
233.	Missouri Advantage	Bolivar	Ref. To corporate office	417-777-6
234.	United Health Care of Missouri	Chesterfield	Ref. To corporate office	314-592-7
235.	Health Partners of the Midwest	Clayton	Linda Huber, Mktg.	314-505-5
236.	Prudential Health Care St. Louis	Creve Coeur	Mike Dooley, Director Mktg.	314-542-4
237.	Missouri Advantage	Jefferson City	Mercy Wood, Mktg.	573-659-5
238.	Blue Cross Blue Shield/Blue Advantage	Kansas City	Torre Nigro, VP Marketing	816-395-2
239.	First Guard Health Plan	Kansas City	Dennis Kasselman, Director, Mktg.	816-922-7
240.	Health Net	Kansas City	Carolyn Adair, Mktg.	816-221-8
241.	Humana	Kansas City	Mike Williams, Director Mktg.	816-941-8
242.	MedPlan	Kansas City	Annette Jackson, Mktg.	816-941-8
243.	Coventry Health Care (formerly Principal Health Care)	Kansas City	Vernon Avant, Director, Mktg.	816-941-3
244.	Prudential Health Care	Kansas City	Peggy Smith Mktg.	816-756-5
245.	Total Health Care	Kansas City	Acquired by Blue Cross Blue Shield	816-395-3
246.	United Health Care of the Midwest	Maryland Heights	David Chaga, Director Mktg.	314-592-7
247.	Humana Prime Health	Prairie Village	Phone disconnected, no such listing	816-333-0
248.	Community Health Plan	St. Joseph	Kelley Stuck, Director Mktg.	816-271-1
249.	Blue Choice Alliance BCBS	St Louis	Katie Slade, Director, Mktg.	314-923-4
250.	Cigna Health Care	St Louis	Rue Santi, Mktg	314-726-7
251.	Community Care Plus	St Louis	Deborah Cooper, Business Devpt. Director	314-454-0
252.	First Commonwealth of Missouri	St Louis	Michael Calhoun, Mktg.	314-436-0
253.	General American Life Insurance	St Louis	John Peterson, Regional VP	314-523-9
254.	Group Health Plan	St Louis	Ref. To corporate office	314-436-2
255.	Healthcare USC of Missouri	St Louis	Camilla Allen, Mktg.	314-241-5
256.	Health Link HMO Inc.	St Louis	Christine Brodeur-Berger, Mktg.	314-989-6
257.	Labor Health Institute/St Louis	St Louis	Only union contracting. no	314-658-5

			commercial HMO	
258.	Mercy Health Plan of Missouri	St Louis	Bill Bennet, VP Marketing	314-214-8100
259.	Physicians Health Plan	St Louis	Physicians' office	636-970-1234
260.	Group Health Plan	St Louis	Kathy Gamblin, Mktg.	314-434-6990
261.	United Healthcare of the Midwest	St Louis	Ref. To corporate office	314-592-7000
262.	Cox-Freeman Health Plans	Springfield	VP, Mktg.	417-269-2925
263.	**NEW JERSEY** Mastercare Inc.	Clark	Patricia Bacloss, VP Mktg.	908-931-1010
264.	Americaid New Jersey Inc.	Edison	Natalie Cummins, Asst. VP, Mktg. & Govt. Relations	732-452-6000
265.	Oxford Health Plans	Edison	Automated voice mail for members only	800-632-9494
266.	United Health Care of New Jersey	Fairfield	Kimberley Anderson, Corporate Mktg. & Communications (NY office)	212-216-6400
267.	NYL Health Plans	Fort Lee	Acquired by Aetna	800-640-6400
268.	Prudential Health Care	Iselin	Ted Chomko, Small Group Insurance	973-716-2081
269.	Physician Health Care of New Jersey	Lawrenceville	Phone disconnected, operator giving the same number	609-896-1233
270.	HIP Pinnacle Medical Group	Medford	Out of business	800-240-7524
271.	Horizon Blue Cross Blue Shield Health Center	Newark	Ellen DeRoza, Corporate Mktg.	609-633-1882
272.	Prudential Insurance Company	Millville	Ref. To corporate office	856-507-2800
273.	Aetna Health Plans of New Jersey	Mount Laurel	Frank McCouley, Corporate Mktg.	610-251-6367
274.	Amerihealth	Mount Laurel	Frank White, Mktg. Manager	732-726-6803
275.	First Option Health Plan of New Jersey	Neptune	Acquired by PHS Health Plan	732-643-7400
276.	HIP Health Plan of New Jersey	New Brunswick	Ref. To Corporate office	732-249-5700
277.	HIP Rutgers Health Plan	New Brunswick	Ref. To corporate office	732-937-9600
278.	HMO Blue	Newark	Phone disconnected, no such listing	732-466-8100
279.	Managed Health Care systems of New Jersey	Newark	Dorothy Worth, Corporate Mktg. (at NY office)	212-509-5999
280.	University Health Plans Inc.	Newark	Frank Alkin, Mktg.	973-623-8700 Ext.613
281.	Physicians Health Services of New Jersey & PHP Health Plan	Paramus	Jennifer Heinklein, Mktg.	732-643-7400
282.	Cigna Health Plan	Rockaway	Virginia Fowler,	201-533-7712

			Mktg.	
283.	Prudential Health Care	Roseland	Ref. To Corporate office	973-716-8
284.	Vista Health Systems	Summit	Nancy Meyerowitz, Mktg.	908-598-9
285.	Garden State Health Plan	Trenton	Joe Cicatiello, Mktg.	609-588-3
286.	HMO Blue	Trenton	Ref. To Corporate office	609-396-4
287.	**PENNSYLVANIA** Aetna US Health Care	Allentown	Ref. To corporate office	610-336-1
288.	Keystone Health Plan East	Berwyn	Dennis Stodd. Mktg.	215-241-2
289.	Aetna Us Health Care	Blue Bell	Kathy Thomas, Regional HQ Mktg.	800-547-2
290.	Keystone Health Plan Central	Camp Hill	Brett Johnson, Mktg.	800-547-2
291.	Highmark Blue Cross Blue Shield	Camp Hill	Janet Bretti, Mktg.	717-763-3
292.	Alleghany Integrated Health Group	Cheltenham	Phone disconnected, no such listing	215-663-5
293.	Penn State Geisinger Health Plan	Danville	Susan Studenski, Regional Manager	570-387-1
294..	Alliance Health Network	Erie	Shirley Green. Mktg.	814-878-1
295.	Aetna US Health Care	Harrisburg	Ref. To Corporate office	717-561-7
296.	Capital Blue Cross	Harrisburg	Nancy Zeider, Mktg. Small Business groups	717-541-7
297.	Health America-Central Pennsylvania	Harrisburg	Operator declined to provide name of marketing person	717-540-4
298.	Health Central	Harrisburg	Fina Wert. Mktg.	800-968-7
299.	Prucare	Horsham	Phone disconnected, could not trace new number	215-433-3
300.	Health Guard of Lancaster	Lancaster	Don Palmer, Mktg.	717-560-9
301.	Three Rivers Health Plan	Monroeville	Jennifer Adams, Mktg.	412-858-4
302.	Health Access (formerly Provident American Corp.)	Norristown	Michelle Mc Guire	610-279-2
303.	Cigna Health Plans	Philadelphia	Brice Rekant, Mktg.	215-761-1
304.	Health Partners of Philadelphia	Philadelphia	Medicaid/ Medicare only	215-849-9
305.	Healthcare Management Alternatives/Americhoice	Philadelphia	Cheryl Mc Daniel, Secretary to VP, Mktg	215-832-4
306.	HMA Health Plan	Philadelphia	Belongs to theabove company	215-832-4
307.	Keystone Health Plan East	Philadelphia	David Rockwell, Mktg.	800-227-3
308.	Keystone Mercy Health Plan	Philadelphia	Mary Jefferson, Mktg.	215-937-8
309.	Medigroup HMO of Pennsylvania	Philadelphia	Acquired by Blue Cross Blue Shield	973-466-4 (Newark Corporate
310.	Oxford Health Plan of Pennsylvania	Philadelphia	Acquired by Oaktree	215-814-4

			Health Plans	
311.	Qual Med Plans for Health of PA Inc	Philadelphia	Eric Bresnaham, Mktg.	215-209-6300
312.	Advantage Health / Qual Med	Pittsburgh	Cathy Mormon, Commercial Sales Manager	412-391-9300
313.	Aetna US Health Care	Pittsburgh	Ref. To Corporate office	412-788-0500
314.	Health America	Pittsburgh	Jay Moorhead	412-553-7300
315.	Highmark BCBS	Pittsburgh	Don Cockbrenner, Mktg. & Communications	412-544-2307
316.	Intercare Mental Health	Pittsburgh	Only Mental Health managed care	800-400-7400
317.	Keystone Health Plan West	Pittsburgh	Acquired by BCBS	800-547-9378
318.	Options UR Comp. Network (now National Health Care Resources)	Pittsburgh	Mark Laffey, Mktg.	412-323-8500
319.	Qual Med Plans for Health/Advantage	Pittsburgh	Ref. To corporate office	412-391-9300
320.	HIP Health Plan of Pennsylvania	Trevose	Ref. To corporate office	717-787-7823
321.	Aetna US Health Care	Wayne	Ref. To corporate office	800-822-0505
322.	Independence Health Plan	Wayne	Jennifer Forster, Mktg.	610-225-9898
323.	Health America	Wexford	Ref. Corporate office	724-935-6975
324.	BCBS of Northeastern Pennsylvania & Priority Health	Wilkes-Barre	Evelyn Conahan, Mktg.	570-829-6011
325.	First Priority Health	Wilkes-Barre	Same as above	570-829-6926
	SOUTH CAROLINA			
326.	Aetna US Health Care	Charleston	Doris Harvey, Mktg.	843-402-7300
327.	Health Source of South Carolina	Charleston	Janice Beatson, Mktg.	843-723-5520
328.	Blue Cross Blue Shield of SC/HMO Blue	Columbia	Jim Deyling, VP Mktg.	843-788-3860
329.	Companion Health Care	Columbia	Charles Campbell, VP Mktg.	843-883-3860
330.	Physicians Health Plan of SC	Columbia	Carson Meehan, VP Mktg.	843-705-7400
331.	Cigna Health Care	Greenville	Ref. To Health Source corporate office (Taken over Healthsource)	864-234-7790
332.	Health First	Greenville	Phone disconnected, no such listing	800-832-7713
333.	Maxicare Health Plan	Greenville	Out of business	864-233-7437
334.	Kanawha Health care	Lancaster	Dale Vaughn, Mktg	803-283-5300
335.	Select Health of SC	North Charleston	No small business sector	843-569-1759
336.	Health Source	Wando	Ref. To corporate office	843-884-4063
	TENNESSEE			
337.	Health Source Tennessee	Brentwood	Shelley Thill, Mktg.	615-221-6779

338.	Blue Cross Blue Shield	Chattanooga	Roy Steele, Regional Manager	423-755-5
339	Cariten Health Plans	Chattanooga	Bill Galloway, Senior Executive Sales	423-778-7
340.	CIGNA	Chattanooga	Todd Harrison, Mktg.	423-755-1
341.	Tennessee Health care Network	Chattanooga	Acquired by Blue Cross/Blue Shield	423-755-5
342.	Cigna Health Care of Tennessee Inc.	Franklin	Ref. To corporate office	615-595-3
343.	John Deere Health Care	Kingsport	Rhonda Carmack, Account Rep.	423-378-5
344.	Cariten Health Plans	Knoxville	Mike Williams, Mktg.	423-470-7
345.	Health Source Tennessee	Knoxville	Brent Wick, New Business Manager	423-546-2
346.	John Deere Health Care	Knoxville	Chris Julian, Mktg.	423-690-5
347.	Tennessee Health Partnership	Knoxville	General Voice Mail	423-531-5
348.	University of Tennessee Health Plan	Knoxville	Jim Adcock, Director of Sales and Mktg.	423-670-6
349.	American Medical Security	Memphis	Ernie McKinnis, Mktg.	901-523-1
350.	The Apple Plan	Memphis	Rob Elsea, Mktg.	901-544-2
351.	Blue Cross Blue Shield	Memphis	Ref. To corporate office	901-544-2
352.	CIGNA Health Care	Memphis	Ref. To corporate office	901-755-7
353.	Mid South Health Plan	Memphis	Ref. To corporate office	901-766-7
354.	Omnicare Health Plan	Memphis	Martin Ikle, Director of Marketing	901-346-0
355.	Prucare of Memphis	Memphis	Virgie Lewis, Officer Manager	901-541-9
356.	OLTC Family Health Care Plan	Memphis	Ana Brooks, Marketing Coordinator	901-725-7
357.	Aetna Health Plan of Tennessee	Nashville	Audrey, Office Administrator	615-322-1
358.	Health 1-2-3	Nashville	Kim White, Mktg.	615-343-2
359.	HealthNet	Nashville	Baker Goodman, Account Manager	615-291-7
360.	Phoenix Health Care Corporation	Nashville	Jim Hutchinson, Senior Account Executive	615-298-3
361.	Prucare of Nashville	Nashville	Ref. To corporate office	615-248-7
362.	Tennessee Managed Care Network	Nashville	Ray Stewart, Mktg.	615-329-2
363.	United Health Care	Nashville	Eddie Lightsey, Mktg.	614-297-9
364.	VHP Community Care	Nashville	Ref. To corporate office	615-782-7

	TEXAS			
365.	HMO Blue	Abilene	Ref. To corporate office	915-738-3518
366.	First Care	Amrillo	Greg Cook, Director of Regional Sales	806-356-5151
367.	Accountable Health Plans of Texas	Arlington	Conny Smith, Mktg.	817-633-8335
368.	Harris Methodist Health Care (now Specific Health Care)	Arlington	Parrant County Sales	817-878-5800
369.	Co Vantage Inc	Austin	Nancy Burkman, Office Manager	800-677-7344
370.	First care	Austin	Penny, Mktg.	512-257-6000
371.	Prucare	Austin	Lisa, Mktg.	512-465-6661
372.	Foundation Health Plan	Austin	Gretchen Stevenson, Director of Sales Dept.	800-585-7290
373.	Health Source Texas	Austin	Phone disconnected, operator gave the same number	512-494-1090
374.	HMO Blue	Austin	Ref. To corporate office	512-345-0089
375.	Humana PCA	Austin	Ref. To corporate office	512-338-6100
376.	Seton Health Plan	Austin	Amber, Mktg.	512-323-1953
377.	United Health care	Austin	Lisa, Mktg.	512-347-2600
378.	Vista Health Plan	Austin	Fran Prudhomme, Director of Marketing	512-433-1000
379.	HMO Blue Roi Grande/BCBS of Texas	Corpus Christi	Ref. To corporate office	512-878-1626
380.	Humana Health Care Plans	Corpus Christi	Janey Stewart, Mktg.	512-866-2200
381.	Principal Health care of Texas	Corpus Christi	Leo Barrer, Manager of Marketing	512- 887-0101
382.	Prudential Health Care	Corpus Christi	Ref. To corporate office	512-992-6363
383.	Aetna Health Plans	Dallas	Ref. To corporate office	214-470-7910
384.	Aetna US Health Care	Dallas	Ref. To corporate office	800-992-7947
385.	Anthem Health (now Amerihealth)	Dallas	Marketing department	972-732-2000
386.	Blue Cross Blue Shield of Texas	Dallas	Helen Hand, Director of Marketing	972-766-6900
387.	Exclusive Health Care Inc.	Dallas	Phone gives busy signal, tried several times	972-450-4500
388.	Humana Health Plans	Dallas	Marketing department	972-868-0101
389.	Kaiser Foundation (now Texas Health Choice)	Dallas	Karen Mack, Mktg.	972-458-5000
390.	One Health Plan of Texas	Dallas	Kyle Moss, Regional Manager	214-363-1281
391.	Parkland Community Health Plan	Dallas	Randy Jones, Mktg.	214-590-2800
392.	Pacificare	Dallas	Ref. To corporate office	214-361-5312

393.	Prucare of North Texas	Dallas	Ref. To corporate office	214-991-0
394.	United Health Care	Dallas	Pam Deason, Mktg.	972-866-6
395.	Foundation Health Care	El Paso	Phone number disconnected	915-532-1
396.	HMO Blue	El Paso	Ref. To corporate office	512-349-4
397.	Prucare of El Paso	El Paso	Ref. To corporate office	915-532-0
398.	All Saints Health System	Ft. Worth	Amy Henderson, Mktg.	817-922-2
399.	Americaid Texas	Ft. Worth	Brandy Johnson, Manager of Marketing and Outreach	817-870-1
400.	Kaiser Permanente Health Plan	Ft. Worth	Ref. To corporate office	817-336-1
401.	Provider Network of America Inc.	Ft. Worth	Jennifer, Mktg.	817-735-8
402.	Access UTMB Health Care Systems	Galveston	Phone number not listed	404-797-8
403.	Aetna Health Plans	Houston	Ref. To corporate office	713-683-5
404.	Amerihealth HMO Texas	Houston	Phone gives busy signal, tried several times	713-888-1
405.	Centra Health care	Houston	Phone disconnected, No such listing	713-785-0
406.	Community Health Choice	Houston	Mack Hamilton, Marketing Manager	713-746-6
407.	HMO Blue-South East Texas	Houston	Ref. To Corporate office	713-663-1
408.	HMO Texas	Houston	Albert Chalker, Sales	713-952-6
409.	Humana Health Plans of Texas Inc.	Houston	Ref. To corporate office	713-622-6
410.	Methodist Care	Houston	Tonya Morris, Marketing Coordinator	713-793-7
411.	NYL Care	Houston	Ref. To corporate office	713-624-5
412.	Pacificare of Texas	Houston	Ref. To corporate office	713-993-3
413.	PCA Health Plans of Texas, Inc.	Houston	Phone number disconnected, no other listing	713-329-5
414.	Prudential Health Care/Houston	Houston	Ref. To corporate office	281-494-3
415.	Texas Children's Health Plan	Houston	Janae Hebert, Sales and Marketing	713-770-1
416.	Unicare Texas Health Plan Inc.	Houston	Not an insurance company	713-782-4
417.	United Health Care	Houston	Not in small business market	713-961-4
418.	CIGNA Health Care	Houston	Not in small business market	713-552-7
419.	Cigna Health Plan of Texas	Irving	Not in small business	972-401-5

			market	
420.	Foundation Health Plan	Irving	Acquired by Amcare	972-756-5000
421.	Kaiser Permanante	Irving	Ref. To corporate office	972-570-6019
423.	NYL Care	Irving	Ref. To corporate office	972-650-5500
424.	First Care South West Health Alliance	Lubbock	Cannon Allen, Mktg.	800-264-4111
425.	HMO Blue	Lubbock	Ref. To corporate office	806-798-6367
426.	Cenus Health Care	McAllen	Recently became Wellcare, no marketing dept.	956-630-1956
428.	HMO Blue	Richardson	Ref. To corporate office	972-766-5121
429.	Aetna US Health Care	San Antonio	Ref. To corporate office	210-530-1830
430.	Community First Health Plans	San Antonio	Vince, Mktg.	210-227-2347
431.	Humana Health Care Plans	San Antonio	Ref. To corporate office	210-617-1000
432.	Pacificare of Texas	San Antonio	Declined to participate	210-524-9800
433.	Prudential Health Care	San Antonio	Ref. To corporate office	210-266-8686
434.	United Health Care	San Antonio	Lori Rice, Sales and Marketing	210-617-6850
435.	Well Choice Comprehensive Health Services of Texas, Inc.	San Antonio	Phone number disconnected, no other listing	210-321-4050
436.	Prudential Health Care	Sugar Land	Ref. To corporate office	281-494-3000
437.	Scott & White Health Plan	Temple	Patricia Ryc, Mktg.	817-742-3000
438.	Health First	Tyler	Kelly Sackett, Mktg.	800-303-5155
439.	Health Plan of Texas Inc.	Tyler	Sandy Bailey, Mktg.	903-531-8441

Appendix B
University of South Carolina, Department of Health Administration's Managed Care Survey about Small Business Health Insurance

Please fax the completed questionnaire (12 pages), to (803) 777 2772,

(**For any clarification**, or if you do not receive all 12 pages, please contact by email or by **phone at (803) 777-2772 or 777-5043, or email sxirasagar@hotmail.com** (Will Cord or Sudha Xirasagar, will answer telephonic inquiries) . Thank you very much.

Organization Name:_____Location: _____
Fax #: _____
Respondent's name & Title:_____
Date:

Introduction

Please refer to our discussion/voice mail message on your telephone. As indicated, we are studying the managed care options and features offered to small business. The survey is being done for the US Senate Sub-committee on Small Businesses.

Please complete to the extent possible and fax/email to us by March 30.

All information is confidential and will not be revealed to anyone. Aggregated information will be used for analysis.

We will be happy to send you the aggregated information after completing the survey. We sincerely appreciate your participation and time.

Background Information

1. Which of the following best describes your HMO?

_____	Staff model	_____	Group model
_____	IPA model	_____	Network model

2. Is your company [for-profit; private not-for-profit]? Circle one

3. How many years has your HMO been in existence? _____ years

4. a. What are the managed care products you offer?

_____, _____, _____.

4. b. How many different *base plans(total for all sizes of business)* do you offer? _____
(please exclude customized variations)

5. a. Do you currently offer health insurance to small businesses? Yes / No
(If yes, skip to 5. d.)

5. b. Did you offer small business health insurance previously? Yes / No
(If no, skip to Question 23)

5. c. (If yes to 5.b), why did you drop the small business sector?
(After answering this question, skip to Question 23)

5. d. By number of employees, how do you define a "small business"? _____

6. What is the mandatory employer contribution to qualify for small group insurance?
___ % for single coverage?
___% for dependent coverage?

7. What is the minimum participation requirement to qualify for small group coverage
(except for very small businesses with fewer than four employees?) ___%

8. In your opinion, what % do most small employers contribute to single cost? ___%

9. What % do they contribute to dependent cost? ___%

10. Are any of your plans specifically designed for small businesses? Yes / No

11. How many base plans are specifically designed for small businesses? _____

12. What incentives do you offer small businesses to accept your plans?
(check all that apply)

_____ low cost basic plan
_____ catastrophic coverage only (high deductible)
_____drug formularies
_____administrative support
_____ customized products
_____ preventive and maternity benefits
_____Others: (Specify)

Characteristics of HMO plans

13. In this section, the questions will deal with **your three most popular plans in the small business sector.**

Plan #1 _____ (name)

Plan #2 _____ (name)

Plan #3 _____ (name)

Please describe characteristics of each plan:	Plan #1	Plan2	Plan3
2a. Does enrollee have a deductible?	____	____	
Amount per person($ per year)	____	____	
Amount per family($ per year)	____	____	
2b. The co-insurance for this plan is (%)	____	____	
2c *Regarding primary care*			
Does patient have specifically assigned primary care physician or practice?	____	____	
Does the primary care physician act as a gatekeeper for specialty care?	____	____	
Is the physician/practice paid on a per capita basis?	____	____	
Is the physician/practice paid on a contracted fee-for-service basis?	____	____	
Does patient pay co-pay for a office visit?	____	____	
Does patient pay a penalty for using an ER for primary care?	____	____	
2d. *Regarding specialty care*			
Can patient see a specialist without a referral from primary care?	____	____	
Do patients pay a co-pay when visiting a specialist?	____	____	
If a patient self-refers to a specialist, does the patient pay a higher co-pay?	____	____	

		Plan #1	Plan 2	Plan3
2e.	*Regarding prescription drug benefits*			
	Does this plan have a drug benefit?			
	Does the patient need to use specific pharmacies?			
	Is there is a drug formulary?			
	Does the patient pay a co-pay per prescription?			
	Is there provision for generic prescriptions?			
2f.	*Regarding preventive services*			
	Are immunizations free/have a nominal co-pay?			
	Is mammography free/small co-pay?			
	Are patients notified or tracked for			
	annual pap smears?			
	mammography?			
	prenatal care ?			
	childhood immunizations?			
2g.	*Regarding other services*			
	Does this plan have maternity benefits?			
	Does this plan have dental benefits?			
	Does this plan have mental health benefits?			
	If yes.....			
	Are they treated as a carve-out?			
	Is it paid for similar to other benefits?			
	Are they limited in number of visits/year?			
	Is there a dollar limit per year?			
	Does this plan have physical therapy benefits?			
	If yes....			
	Are they limited in number and scope?			
	Does this plan provide for speech therapy?			

3. *Regarding cost-containment efforts*

What percent of capitation payment is withheld from the physician?	____	____	____
Is pre-certification required for outpatient procedures?	____	____	____
Is pre-certification required for hospitalization?	____	____	____
Is hospitalization concurrently managed by the HMO?	____	____	____

4. Does this plan offer any disease prevention or health promotion activities to enrollees? ____ ____ ____

5. Does this plan *actively* attempt to educate enrollees on how best to use plan benefits? ____ ____ ____

6. *Any other comments about these plans:*

Plan # 1: _____

Plan # 2: _____

Plan # 3: _____

14. In your opinion, why do small businesses provide your plan? (check all that apply)

_____ Attract & retain current employees
_____ Compulsions of the tight labor market
_____ Desire to have healthy employees
_____ Increase productivity
_____ Respond to employee demands for coverage
_____ Other similar firms offer health insurance
_____ To get coverage for owner & family
_____ Other: _____

15. Which one is the most important of all? _____

16. Why don't some businesses offer health insurance? (check all that apply)

_____ not affordable
_____ many employees are insured elsewhere
_____ employees can be hired without insurance
_____ high employee turnover
_____ employees prefer wages
_____ cannot find an acceptable plan
_____ lack of information about options
_____ Any other (specify)

_____ employees do not see a need for it

17. Which one is the most important? _____

18. Since 1997, has the total number of enrollees from small business increased, decreased, or stayed the same?

18a. In the past year, what was the percent non-renewal rate in the small business sector (voluntarily terminated their plan)? _____(% non renewals)

18b. How many small businesses did you terminate in the last year? _____
(apart from those who did not pay premium)

19. Has your state expanded Medicaid coverage in the last few years for the working poor
Yes / No

19 a. If yes, do you believe this has caused the number of enrollees from small businesses to [increase, decrease, or stay the same] since 1997?

20. How has state legislation affected your HMO's small business products?
_____ allows for more flexibility in plans
_____ decreases flexibility in plans
_____ has increased your market share
_____ other:_____
(Specify)

21. Has there been "pooled" purchasing in your state? Yes No

21a. If yes, has this helped small businesses get health insurance for their employees?

[very helpful somewhat helpful not helpful definitely not helpful No idea]

22. How has HIPA and mandated benefits affected access to insurance and affordability?

The last few questions are about disease prevention activities

23. Which health behaviors are specifically targeted by your HMO? (check all that apply)

_____ None
_____Physical activity
_____Proper nutrition
_____Weight management
_____Smoking cessation
_____Stress management
_____Other (specify)_____

24. What methods do you use to address each health behavior:

Method	Physical Activity	Proper nutrition	Weight Mgt	Smoking Cessation	Stress Mgt
Individual Counseling in person					
Individual Counseling via phone					
Health Advice line					
Free classes					
Subsidized classes					
Member newsletter					
Printed self-help materials					
Educational videotapes					
Referrals to community services					

Other comments:

25. Which of the above health promotion programs are offered in your small business sector too?

_____

Regarding Your Fitness Program

26. Does your HMO provide..... (check all that apply)

____fitness facility membership discounts/reimbursements? ____personal exercise coaching?
____Walking program? ____physical fitness assessment?
____Reimbursement/subsidy for home exercise equipment?
____other(specify):_____

27. Do you offer incentives to members to participate in health promotion programs? Yes / No

27 a. If yes, which of the following incentives are used?

___free gifts ____free educational materials
___gift certificates ____reduced or no co-payment
___reduced deductibles ____reduced premium
___Cash payment for _____ (example: for quitting smoking)
____Other: (specify)_____

28. Does your HMO evaluate its health promotion programs? Yes / No

28 a. If yes, which of the following indicators are used for evaluation? (check all that apply)

____participation rates ____employer satisfaction
____change in health status ____cost-effectiveness
____member satisfaction ____changes in health behaviors
____-changes in medical care costs ____other:_____

29. Does your HMO inform primary care providers about members' participation in health promotion activities? Yes / No

30. Do you subsidize work site health promotion programs for insured companies? Yes / No

31. If yes, which programs are subsidized?

Program	Wholly subsidized	Partly subsidized
Educational programs		
Preventive screening		
Program	**Wholly subsidized**	**Partly subsidized**
Health risk appraisals		
Exercise facilities		
Other:		

32. Do you require a minimum group size for work site health promotion programs? Yes / No

32 a. If yes, what is the required minimum number of enrollees? _____

33. Is there a line item on your corporate budget for health promotion programs? Yes / No

34. Does your HMO have full-time health promotion staff? Yes / No

35. a. If yes, how many full-time health promotion staff members do you have ?_____

b. For how many total enrollees? _____

36. To which corporate division or department does the health promotion program(s) belong? (e.g. marketing, member services, etc.) _____

37. Of the businesses that contract with your HMO, please fill in the table,
A. How many are the ones with 1-19 employees? B) How many total enrollees are from these sized companies? And so on for **each size of business.**

Size of business	(A) Number of businesses offering your plan	(B) Number of enrollees in this business category
1-19 employees		
20-49		
50-99		
100-500		
>500		
Total		100%

38. This question has to do with the **type of businesses you contract with**, Please fill in the table below.

Type of business	# of businesses insured (<100 employees)	# of businesses insured (100 plus employees)
Manufacturing		
Mining		
Wholesale		
Agricultural/Forestry/Fishing		
Transportation/Communication/Utility		
Financial/Insurance/Real Estate		
Service		
Construction		
Retail		
Total Insured		

39. What is the typical **monthly premium for the most popular plan,** in each size of business?

Size of business: Number of employees	Premium ($) for employee only	Premium ($) for employee and spouse	Premium ($) for employee and family
1-19 employees			
20-49			
50-99			
100-500			
>500			

40. Of the businesses that you contract with, how many offer only employee coverage? How many offer employee plus spouse coverage? How many offer employee plus family coverage? (Fill in the table below)

Size of business:	# of businesses covering the employee only	# of businesses covering employee and spouse	# of businesses covering employee and family
1-19 employees			
20-49			
50-99			
100-500			
>500			

41. Of the plans specifically designed for small businesses, please give the following details for the four plans with highest number of small businesses contracted.

Plan name	Number of enrollees in the plan	Number of businesses enrolled in the plan
1.		
2.		
3.		
4.		

42. **Among the HMO plans marketed to all sizes of businesses including small businesses**, please fill in your enrollee information, for the four plans with highest enrollment)

Plan name	Total number of enrollees	Number of enrollees working in businesses with less than 100 employees
1.		
2.		
3.		
4.		