THE HOUSE TRI-COMMITTEE HEALTH REFORM DRAFT
The Small Employer Perspective

Comments on the Draft
Provided by NFIB

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The small business community is all too familiar with the impact of high healthcare costs. For more than two decades, NFIB research has reinforced what small business owners across the country tell us every day – the most significant obstacle to gaining access to health insurance is the prohibitive cost of coverage.

The goals of reform are clear: to lower costs for small businesses, provide an easier way to shop for insurance and expand the number of choices when buying insurance plans. Fundamental insurance market reform must be implemented; only then can small businesses have greater access to a competitive marketplace where private, quality healthcare is affordable and available.

We appreciate the Tri-Committee's interest in solving the healthcare affordability crisis. Healthcare reform is NFIB's number one priority, and we are committed to working with Congress to develop solutions that decrease healthcare costs and increase access to quality healthcare – for America's job creators and all Americans.

Health Benefit Requirements

Health insurance products are as varied as those individuals and employers purchasing insurance plans themselves. The challenge in designing a benefit package for a reformed marketplace is to balance the unique and diverse needs of the population against the goal of ensuring that a high quality product is both affordable to the consumer and sustainable for the future. This is a significant challenge in the small employer setting because although data is available to suggest what is being spent, little information is available to know what is in the various plans that they are purchasing with those dollars.

Essential Benefits and the Health Benefits Advisory Committee

The Tri-Comm draft creates a Health Benefits Advisory Committee charged with establishing benefit standards for "essential health benefits." Those benefits include, but are not limited to: preventive services with no cost-sharing, mental health services, dental and vision for children, and caps the amount of money a person or family spends on covered services in a year.

NFIB is deeply disturbed by the composition, responsibilities and powers vested to the Health Benefits Advisory Committee. While the draft legislation provides that the committee reflect a variety of constituencies including employers, it does not specify a small employer role. Absence of a small employer perspective is analogous to leaving the largest sector of job creators without representation. In addition to the lack of representation on the committee, the parameters that the Health Benefits Advisory Committee uses to determine recommendations does not specify that the cost of the benefit standards must be taken into account when reviewing the essential benefits included in the standard benefit package. For NFIB members who have long cited the cost of healthcare as the single greatest challenge they face, it is critical that a concerted effort be made to address both the package of services considered as qualified coverage, and how the cost of that package will affect the ability of business owners to purchase a plan.

As drafted, this package will serve as the "basic" benefit package for coverage in the exchange and over time will become the minimum quality standard for employer plans. In order for small employers to be able to offer health insurance to their employees, it's critical that the minimum coverage that is established by the Health Benefits Advisory Committee be less expensive than the insurance options that are currently available in the small group market today. If the minimum coverage option is more expensive than current insurance options, more small employers will simply not be able to afford to provide insurance for their employees. As drafted, it is highly likely that the "essential benefits" will be more expensive than what small employers are currently purchasing today.

The Intersection between Cost and Coverage

As small employers transition to a reformed system, it is critical to remember that reform must address their greatest concern – costs. Designing a package of benefit options requires a determination about where to start. Wherever you set that "base" or

"minimum" threshold, will be where you start, and there will be a specific price tag attached to such a plan. While seeking to expand coverage for small employers, it is critical to understand both what those small employers spend and the value of those services that are purchased. Available data suggests that:

- Small businesses, on average, pay about 18 percent more for health insurance than their larger counterparts for the same group of services.[1] Such data suggests that small employers either pay more for the same services or receive less (in terms of services) for their health insurance.
- The figure cited above confirms that there is a difference between the price of a plan and the value of a plan. This is particularly true in small firms where it is found that such firms have "received slightly less generous health insurance benefits, according to calculations of actuarial value."[2]
- Actuarial costs vary according to size of firm. Actuarial value ranged from 78 percent of expected costs for firms with one to nine employees to 83 percent of expected costs for firms with 1,000 or more employees.[3]

To illustrate the intersection between cost and the value of coverage, consider the Blue Cross Blue Shield (BCBS) PPO plan offered through the Federal Employee Health Benefits Program (FEHBP). There is an annual premium cost of approximately $5,387 for individual coverage and $12,335 for a family. The plan as reported in Consumer Reports includes but is not limited to: no annual lifetime limits for major services, deductibles of $300 per person and $600 per family, prescription drugs, maternity care, inpatient and outpatient hospital care, preventative care and organ and tissue transplants.[4]

In contrast, Medical Expenditure Panel Survey (MEPS) data indicates that annual premium cost in the small group market is $4,260 for individual coverage and $11,100 for a family. However, the MEPS data is an average of all plans available, and there is no indication that there is a plan that includes the services, benefit options and price sharing that are found in the FEHBP BCBS plan.

Although the FEHBP plan and the MEPS data are not substantially different in cost, the price tag alone is not an indicator of the value of the plan. **Rather, the value of the plan is a combination of both the cost and the services provided in that insurance plan**. To understand the significance of that difference requires the ability to do an apples-to-apples comparison of plans.

While such data is readily available for the FEHBP plan, no such data is publicly available for small group plans sold today. It is well-established that small employers

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1 Commonwealth Fund, Benefits and Premiums in Job-Based Insurance, May 2006.

2 Chu, Rose C. and Gordon R. Trapnell, "Study of the Administrative Costs and Actuarial Values of Small Health Plans," Actuarial Research Corporation under contract no. SBAHQ-01-M-0811, January 2003.

3 Hazardous health plans. *Consumer Reports*, p. 24-29. May 2009.

4 For example, the Family Medical Leave Act exempts businesses with fewer than 50 workers and cash accounting may be used by corporations with a three-year average annual gross receipts of $5 million or less.

receive fewer services in their plans than larger employers that pay roughly the same amount per employee. Without transparency from insurance carriers, it is impossible to know where to begin when designing plan options for small employers. NFIB strongly encourages that such data be made available by insurers prior to finalizing a plan design that serves as the foundation by which all coverage will be measured and deemed "adequate."

"Keep What You Have"

As drafted, the Tri-Comm legislation specifies that only individual policies can be treated as "acceptable coverage" for an indeterminate period of time (e.g., "grandfathered"). Conversely, group health plans cannot be treated as "acceptable coverage" after the "grace period," a period of time to be determined by the Commissioner. The grace period cannot extend more than five years.

To be "grandfathered," individual policies need only satisfy a handful of statutory requirements. By contrast, the legislation lacks clarity as it applies to employer plans and could be interpreted to imply that the Commissioner can prescribe regulatory standards for a group health plan's treatment as "acceptable coverage" during the grace period. Clarification regarding this provision is necessary.

Health Insurance Market Reforms

Insurance market reforms are a key component to increasing access to and availability of quality, affordable healthcare. These reforms are especially critical to the individual and small group marketplaces because they have historically experienced the greatest lack of choice, the most significant premium volatility and the most abusive rating practices.

Small employers have long sought a competitive and simplified marketplace for all to purchase affordable health insurance. The insurance rating reform outlined in the draft specifies comprehensive insurance market regulations for the group and individual market. The draft also creates a new Health Choices Administration and Health Choices Commissioner.

Insurance Rating Reform

Under the proposal, premiums can vary based only on age (no more than 2:1), geography and family size. In addition, insurers can no longer exclude coverage of treatments for pre-existing health conditions or prohibit lifetime and annual limits on benefits.

Rating reform is critical to increasing affordability and access to health insurance, but achieving that is a challenge. While we must guarantee that rating reforms ensure affordability for those with health-related problems, rating reforms should not discourage the purchase of insurance. As constructed, the rating reforms for age suggested in the Tri-Comm draft are so tight (no more than 2:1), that those who are younger and healthier will have a difficult time finding an affordable product. Some actuaries would also agree that a 2:1 rating practice discourages certain individual's from obtaining coverage – the opposite of the goal that policymakers have – to increase coverage. If the goal is to

increase the size of the pool, there must be a greater variation for rating based on age. Likewise, other rating factors must also be taken into consideration including rating on behavioral conditions such as smoking.

A Politically Powerful Insurance Commissioner
As outlined in the draft, a new Health Choices Commissioner will have unprecedented authority to institute rules and regulations that greatly affect small employers, including the ability to define who is and is not a full-time employee. The commissioner will also have the ability to enact a complex formula to determine and require coverage of part-time workers.

NFIB is concerned that empowering a commissioner with such vast authority means small business owners will be in constant fear of ever-changing thresholds that could impact compliance requirements. These decisions are too important to small employers to have delegated to a commissioner who is a: not politically accountable to the American people and b: whose qualifications do not require having any experience running a business or providing the very coverage they are responsible for enforcing.

Health Insurance Exchange

Small business desperately needs a more efficient marketplace in which to purchase health insurance. The Exchange concept or some variation on this proposal might be an appropriate answer to these needs.

Transition times to enter the exchange for employers (by size)
It is critical that all small employers have the ability to purchase health insurance through the exchange. However, the draft legislation only specifically addresses entry for a portion of the small-group marketplace. As drafted, individuals without access to employer-based coverage and small businesses may obtain coverage through the exchange. In the first year, small businesses with less than 10 employees are allowed to participate in the exchange and those with less than 20 employees are allowed the second year. While the draft leaves the commissioner with the authority to extend coverage to larger businesses after three years of operation, it does not provide specific instructions for the transition of the remaining small-group market.

NFIB understands phase-in periods are necessary for the size of employers entering into the exchange. However, we are concerned this market could be split between non-group (1), micro group (2-10), and small groups (2-50 in most cases), effectively creating smaller pools and greater segmentation. As constructed, this provision effectively limits entry into the exchange to only the smallest of small businesses while leaving the overall small group market with fewer, rather than more options to shop for and obtain health insurance. Congress must specify a timeframe for the entire fully insured small-group market to be permitted entry into the exchange.

Exchange Requirements Should be a Ceiling, Not a Floor
The draft provides that the Exchange will offer health plans that comply with the minimum requirements established under the bill. The draft also provides that if state

law licensing requirements mandate a richer benefit than the mandatory benefit options described in the bill, those requirements will apply to the Exchange-participating health plan only if the State reimburses the Exchange for any increase in premiums as a result of the State law requirement. The draft permits states to add on top of the requirements defined by the federal authorities.

The current structure of 50 states with 50 different sets of rules necessitates establishing national rules that provide a more organized, competitive and simplified marketplace for the purchase of insurance. This is an essential component of reform, but only if the rules serve as the "ceiling" rather than a "floor." Allowing states to add additional requirements would leave small employers vulnerable to the same regulatory incongruity they suffer from today and would stifle the competition among carriers that the small group market so desperately needs.

A Government-Run Healthcare Option

The draft establishes a new public health insurance option. The plan would be available through the newly established Exchange and would:

- ✓ Have the authority to set rates that can be charged by health care providers, with limited rights to judicial review;
- ✓ Receive funding from the Treasury (through general revenues) to cover start-up costs for establishing the public option plan; and
- ✓ Will incentivize providers to participate in the public option plan at payment rates 5 percent above Medicare.

NFIB opposes the public plan option. Insurance markets need reform, as they are not currently adequately competitive. However, we do not believe that a public plan would fill that void, and we are deeply concerned that a public plan would further compromise the viability of private insurance, which would limit rather than expand choice. NFIB believes a truly competitive private insurance market would best provide businesses and their employees with more affordable coverage and a sustainable choice of plans.

Employer Roles and Responsibilities

Small business and NFIB have consistently opposed the employer mandate. We have two principal reasons for opposition, though there are others. The first is that employees ultimately bear the cost of their health insurance through lower employment, depressed wages, depressed productivity, and loss of economic opportunities. This position is well-understood by economists of all philosophical stripes. As Ezekiel Emanuel and Victor Fuchs wrote in JAMA regarding the issue, "Shared responsibility is a myth. … Employers' contribution to the healthcare premium is really workers' compensation in another form."

The second reason NFIB has consistently opposed the employer mandate is that the initial costs –costs before they can be transferred to employees – are borne by the most vulnerable employers. In effect, employers must "front" or initially lend the money for

employees to purchase their health insurance, but where they would obtain the money to make the initial outlay is an interesting question. A common perception is that employers have plenty of money, or at least have access to it. Complicating matters is the direct relationship between what owners take from their businesses, the wages they pay and the rate they offer health insurance. Those taking the least from their businesses are also the ones least likely to provide health insurance to their employees and will have to "front" the money for their employees to purchase insurance under an employer mandate. In other words, those most impacted by a mandate are those least capable of making the initial required outlays.

Recent rumblings suggest small employers may have changed their traditional opposition to employer health insurance mandates.[5] Small employers have not changed their collective views on the issue. A telephone survey of 1,000 small employers conducted for the NFIB Research Foundation by Mason-Dixon in December and January show 80 percent opposition. To determine whether NFIB member employers vary from the broader small employer population, the survey polled 500 NFIB members and 500 non-NFIB member small employers. As the attached graphs show, there is no statistical difference between the two. Both groups overwhelmingly oppose a mandate.

Pay-or-Play

As presented, the draft legislation requires employers to provide and contribute to health insurance coverage (72.5 percent of the premium for single coverage and 65 percent of the premium for family coverage for the lowest cost plan that covers essential health benefits) to their workers or pay a new tax equal to 8 percent of payroll (e.g. "pay-or-play" mandate). The 8 percent tax would be applied to the employer's entire payroll, including wages paid to owner-employees and others who may be covered under the employer's group health plan.

The approach of levying a tax based on payroll is especially egregious for employers, as employers pay the tax regardless of whether or not they actually are profitable. The employer requirements raise additional concerns. For example, the draft infers that even those employers who offer care but whose employees decline coverage will still be required to pay the 8 percent payroll tax. This is an exceptionally punitive approach for those employers who are attempting to provide coverage, because regardless of that effort they can be punished for a decision that is beyond their control.

Experiments aimed at achieving universal coverage provide a concrete example of the ineffectiveness of employer mandates. A recent report by the Federal Reserve Board of San Francisco examining the impact of the employer mandate in Hawaii, illustrates the

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5 For example, the Robert Wood Johnson Foundation conducted a survey of small business owners (released December, 2008) that suggested small business owners are split on the issue. Unfortunately, the survey sampled only those with insurance, worded the question so those with insurance received a tax credit, and got a bare majority. In other words, half of small employers were omitted from the sampling frame, the ones most likely to oppose the mandate; the question included provision of a tax credit which meant everyone sampled would gain and no one would lose; and, it applied only to those with 10 employees or more. A similar pay of play proposal came in dead last as an idea to that would their help smaller firm most.

failure of an employer mandate such as pay-or-play to increase the offering of health insurance coverage in an employer setting. Citing its findings, the Board finds that an "employers' primary response to the mandate was increased reliance on the exempt class of workers who are employed for fewer than 20 hours per week...In addition to such labor market distortions, the results of our research imply that an employer mandate is not an effective means for achieving universal coverage."

Exemptions for Small Business

An exemption for an employer mandate seems an attractive "band-aid" but it fails to address the core challenge facing small business – affordability. An exemption fails to increase affordability of quality healthcare and tends to harm the very population that tends to be uninsured while doing nothing to increase access to the affordable healthcare they would like to obtain.

Small Business Tax Credit

Cost is the main concern facing small businesses currently offering or planning to offer health insurance. In general, providing a tax credit to small businesses offering health insurance could be a valuable incentive to reduce cost, keep coverage, or incentivize a small business to take-up coverage.

As drafted, the credit limitations could impact the availability of the credit and could have some adverse consequences on employee wages. The tax credit in the draft legislation is available to qualifying small businesses to help cover up to 50 percent of qualifying health care costs. The full credit is available to businesses with 10 or fewer employees with an average annual employee payroll of less than $20,000. The credit phases out at $40,000 in average annual payroll and for businesses with 25 employees.

These narrow limitations could greatly limit the impact of the credit and could have some adverse consequences on employee wages. Measuring an average wage within a small business means looking at a very small pool of employees and a slight divergence between wages could restrict the use of the credit. This is the case in other areas of the law where nondiscrimination is a factor in determining benefits. For example, contributions to 401k plans are measured by comparing highly compensated earners versus other workers. In such a case, the benefits to small businesses can be quickly limited because the pool of total workers is much smaller, meaning that a very small number of employees earning a disproportionately higher wage can impact the average of the rest of the employees.

This seems to be what could happen in limiting a credit based on employee wages. If the owner and a senior employee's wages are included in the average, it is almost certain that the value of the credit will be drastically reduced. Looking at U.S. census data from 2007, the average wage of full-time employees at businesses with fewer than 10 employees is over $30,000 meaning that in many cases the value of the credit is already cut in half.

This could also mean that a small business owner must make trade-offs when compensating workers. Increasing wages would have to be measured against the amount of the lost credit, which could lead to workers – especially lower-wage workers – seeing stagnant wages for a longer period of time. In addition, the ability to attract skilled workers may also be limited since the addition of such a worker is going to require a higher wage and may mean losing the credit.

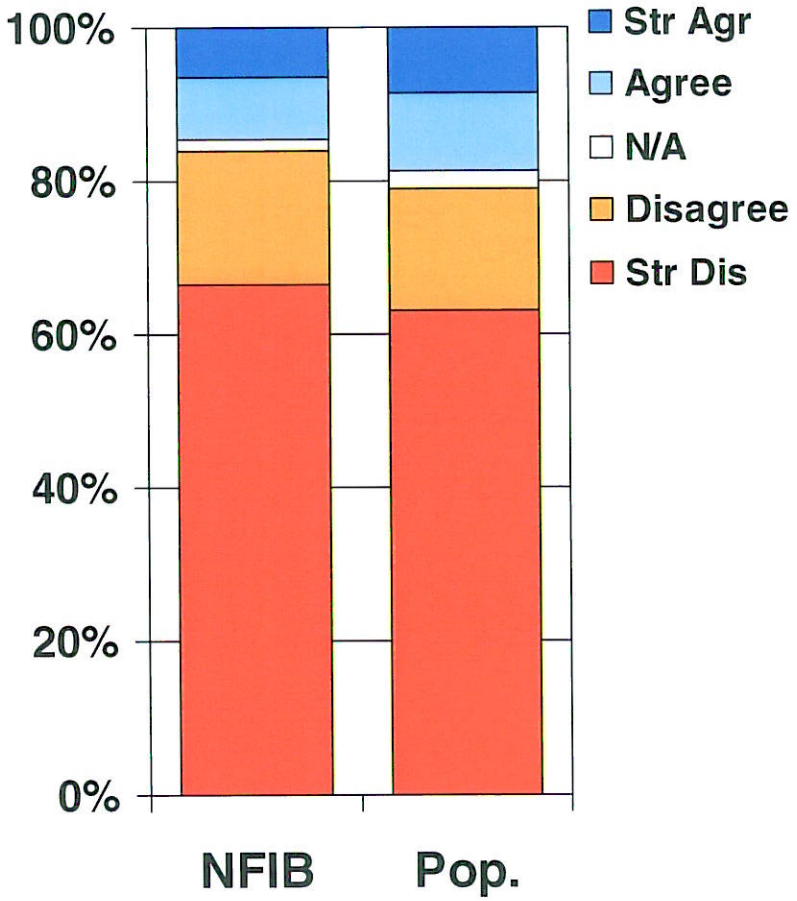
A credit to help small businesses cover the cost of health insurance is in general a good idea. While the credit needs to be limited to help the businesses that need it most, if the credit is tied to factors that severely restrict the credit's applicability then the value of the credit is essentially nullified.

Conclusion

As the U.S. House works to refine the Tri-Committee legislation, one thing is clear – small business owners remain committed to developing and adopting meaningful reforms that increases access to quality, affordable healthcare for all Americans. Our nation's job creators are watching reform closely because as both payers and customers in our healthcare system, they are keenly aware that they will either be helped or harmed by healthcare reform.

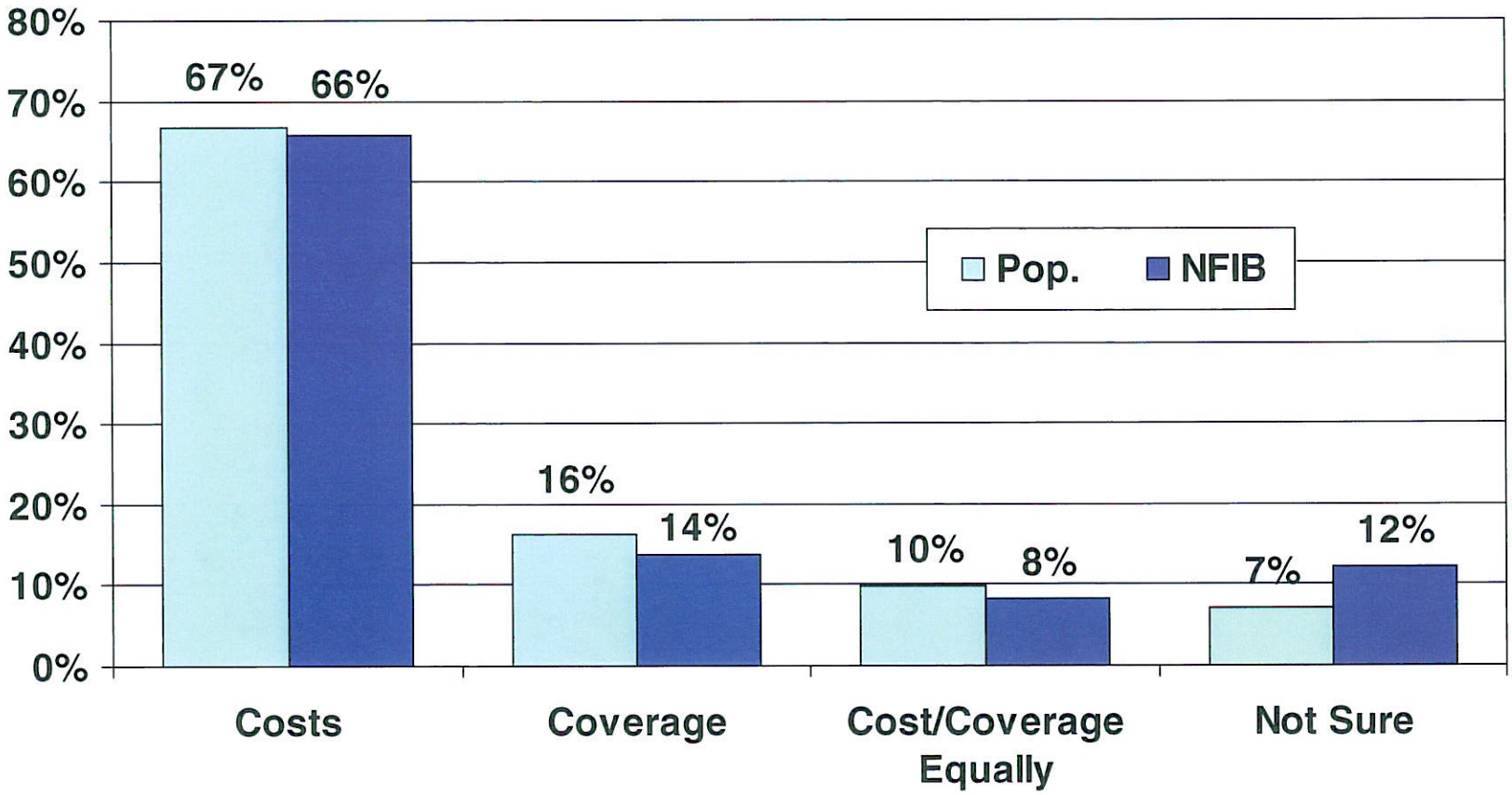
NFIB remains committed to supporting policies and proposals that will lower costs, increase competition and provide real choice so that small businesses can get the coverage they need – at a price they can afford.

Q. All employers should be required to offer health insurance to all their full-time employees and pay 60 percent of the premium.



- Summary
  - NFIB mean score = 3.45
  - Pop. mean score = 3.35
  - Difference = 0.10
- No statistical difference
- About 80% of both groups oppose

Q. In addressing the country's health care problems, which of the following do you feel Washington should make the top priority?



MEPS Annual Health Insurance Premium Cost Per Employee for Single Coverage				AHIP Annual Health Insurance Premium Costs for Single Coverage	
State	**All Employers**	**Less than 50 employees**		**State**	**Small Group Market**
Alaska	4,539	5,123		Alaska	6,048
New York	4,605	5,010		Massachusetts	5,496
Rhode Island	4,595	4,955		Rhode Island	5,184
Delaware	4,712	4,949		New Hampshire	5,040
Massachusetts	4,448	4,945		Maryland	4,968
New Jersey	4,471	4,879		Wyoming	4,944
New Hampshire	4,622	4,806		West Virginia	4,944
West Virginia	4,349	4,672		NewYork	4,884
Illinois	4,245	4,657		New Jersey	4,812
Connecticut	4,402	4,616		Utah	4,764
Wyoming	4,605	4,588		Illinois	4,716
Maine	4,663	4,528		Wisconsin	4,656
New Mexico	4,037	4,464		Connecticut	4,656
Texas	4,133	4,463		Florida	4,596
Vermont	4,322	4,405		New Mexico	4,560
Montana	4,144	4,394		Texas	4,428
Michigan	4,446	4,370		Colorado	4,416
District of Columbia	4,540	4,368		District of Columbia	4,392
Wisconsin	4,241	4,343		Nebraska	4,380
North Carolina	4,027	4,277		Oklahoma	4,368
Florida	3,936	4,274		Maine	4,320
Oklahoma	3,967	4,266		North Carolina	4,260
Pennsylvania	4,277	4,262		Minnesota	4,236
United States	4,118	4,260		California	4,188
Virginia	4,091	4,217		Louisiana	4,188
Louisiana	3,938	4,212		United States	4,152
Maryland	3,930	4,208		Montana	4,080
Colorado	4,024	4,152		Nevada	4,068
California	4,036	4,117		Pennsylvania	4,044
South Carolina	4,013	4,096		Indiana	3,996
Ohio	4,054	3,997		Georgia	3,960
Kansas	3,833	3,991		Mississippi	3,888
Hawaii	3,549	3,972		Ohio	3,840
Alabama	3,943	3,971		South Carolina	3,828
Minnesota	3,981	3,937		Kansas	3,816
Nebraska	3,890	3,908		Iowa	3,804
Oregon	4,122	3,889		Missouri	3,756
North Dakota	3,787	3,859		Virginia	3,756
Indiana	3,989	3,855		Arizona	3,660
Georgia	3,873	3,848		Kentucky	3,612
Tennessee	3,747	3,842		South Dakota	3,576
Iowa	3,916	3,824		Alabama	3,552
Nevada	3,583	3,819		Arkansas	3,396
South Dakota	3,938	3,804		Michigan	3,360
Washington	4,056	3,804		Oregon	3,300
Arizona	4,280	3,777		Tennessee	3,288
Missouri	3,958	3,754		North Dakota	3,000
Kentucky	3,791	3,678		Washington	2,376
Arkansas	3,567	3,642			
Utah	3,849	3,569			
Mississippi	3,704	3,534			
Idaho	3,573	3,351			

Health Insurance Fact Sheet for Small Firms

HOW MANY SMALL FIRMS OFFER HEALTH INSURANCE AND WHAT TYPE ARE THEY BUYING?

PERCENT OF FIRMS OFFERING HEALTH INSURANCE BY FIRM SIZE

- 3-9 employees 49 percent
- 10-24 employees 78 percent
- 25-49 employees 90 percent
- 50-199 employees 94 percent
- Small Firms (3-199) 62 percent
- Large Firms (200 or more) 99 percent

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.

- Less than 10 employees 35 percent
- 10-24 employees 63 percent
- 25-99 employees 82 percent
- Less than 50 43 percent
- 50 or more employees 96 percent

Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

- 1-9 employees 39 percent
- 10-19 employees 60 percent
- 20-249 employees 78 percent

NFIB Research Foundation, Purchasing Health Insurance, 2007.

AMONG FIRMS OFFERING HEALTH INSURANCE, PERCENTAGE THAT OFFER THE FOLLOWING PLAN TYPES

- Small Firms (3-199) Conventional 7% HMO 23% PPO 49% POS 22% HDHP/SO 13%
- Large Firms (200 or more) Conventional 7% HMO 31% PPO 79% POS 22% HDHP/SO 17%

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003.

- Small Firms (less than 50) Any Managed Care 86% Exclusive Provider 37% Mixed Provider 57%
- Larger Firms (50 or more) Any Managed Care 97% Exclusive Provider 37% Mixed Provider 87%

Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

Exclusive providers - Enrollees must go to providers associated with the plan for all non-emergency care in order for the costs to be covered. (Examples: Most HMO, IPA, and EPO-type plans)
Any providers - Enrollees may go to providers of their choice with no cost incentives to use a particular group of providers. (Examples: Most fee-for-service plans)
Mixture of preferred and any providers - Enrollees may go to any provider, but there is a cost incentive to use a particular group of providers. (Examples: Most PPO and POS-type plans)
Conventional - Employees have the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

WHAT IS THE AVERAGE MONTHLY COST OF HEALTH INSURANCE PREMIUMS FOR SMALL FIRMS IN GENERAL AND BY TYPE OF PLAN?

AVERAGE MONTHLY PREMIUMS FOR COVERED EMPLOYEES FOR <u>SINGLE</u> COVERAGE BY PLAN TYPE (PER EMPLOYEE)

- Small Firms (3-199) All Plans $382 HMO $381 PPO $402 POS $372 HDHP/SO $326
- Large Firms (200 or more) All Plans $397 HMO $404 PPO $399 POS $402 HDHP/SO $328

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.

- Small Firms (less than 50) All Plans $355 Exclusive Provider $346 Mixed Provider $361
- Larger Firms (50 or more) All Plans $340 Exclusive Provider $326 Mixed Provider $344

Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

- Firms with 1-9 Employees All Plans $393
- Firms with 10-19 Employees All Plans $402
- Firms with 20-249 Employees All Plans $439
- Firms with 1-249 Employees All Plans $402

NFIB Research Foundation, Health Insurance, 2003.

AVERAGE MONTHLY PREMIUMS FOR COVERED EMPLOYEES FOR <u>FAMILY</u> COVERAGE BY PLAN TYPE (PER EMPLOYEE)

- Small Firms (3-199) All Plans $1,009 HMO $1,086 PPO $1,042 POS $972 HDHP/SO $816
- Large Firms (200 or more) All Plans $1,081 HMO $1,097 PPO $1,091 POS $1,081 HDHP/SO $882

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.

- Small Firms (less than 50) All Plans $925 Exclusive Provider $925 Mixed Provider $929
- Larger Firms (50 or more) All Plans $953 Exclusive Provider $951 Mixed Provider $957

Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

- Firms with 1-9 Employees All Plans $668
- Firms with 10-19 Employees All Plans $887
- Firms with 20-249 Employees All Plans $852
- Firms with 1-249 Employees All Plans $732

NFIB Research Foundation, Health Insurance, 2003.

WHAT PERCENT OF HEALTH INSURANCE PREMIUM COSTS ARE PAID FOR BY THE EMPLOYER AND THE EMPLOYEE?

AVERAGE PERCENTAGE OF PREMIUM PAID BY EMPLOYER AND EMPLOYEE FOR SINGLE COVERAGE (EMPLOYER/EMPLOYEE COST SHARING)

- Small Firms (3-199) Employer 86 percent / Employees 14 percent
- Large Firms (200 or more) Employer 83 percent / Employees 17 percent

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.

- Small Firms (less than 50) Employer 83 percent / Employees 17 percent
- Larger Firms (50 or more) Employer 80 percent / Employees 20 percent

Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

- 1-9 Employees Employer 85 percent / Employees 15 percent
- 10-19 Employees Employer 82 percent / Employees 18 percent
- 20-249 Employees Employer 78 percent / Employees 22 percent

NFIB Research Foundation, Health Insurance, 2003.

AVERAGE PERCENTAGE OF PREMIUM PAID BY EMPLOYER AND EMPLOYEE FOR FAMILY COVERAGE (EMPLOYER/EMPLOYEE COST SHARING)

- Small Firms (3-199) Employer 65 percent / Employees 35 percent
- Large Firms (200 or more) Employer 76 percent / Employees 24 percent

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.

- Small Firms (less than 50) Employer 72 percent / Employees 28 percent
- Larger Firms (50 or more) Employer 75 percent / Employees 25 percent

Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

- Firms with 1-9 Employees Employer 65 percent / Employees 35 percent
- Firms with 10-19 Employees Employer 50 percent / Employees 50 percent
- Firms with 20-249 Employees Employer 55 percent / Employees 45 percent
- Firms with 1-249 Employees Employer 61 percent / Employees 39 percent

NFIB Research Foundation, Health Insurance, 2003.

WHAT IS THE PERCENTAGE DISTRIBUTION OF PREMIUM PAID BY FIRMS FOR SINGLE EMPOLOYEE COVERAGE?

Distribution of Percentage of Premium Paid by Firms for Single Employee Coverage

	Percent of Premium Cost Paid by Employer				
	100%	99-75%	76-50%	less than 50%	Total
Small Firms (3-199)	40%	40%	16%	5%	100%
Large Firms (more than 200)	10	68	20	1	100

Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008.