

The Small Business Perspective on Health-Care Reform

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California has 6.5 million uninsured adults, 55 percent of whom work for companies that do not provide health insurance.² This percentage accounts for 3.5 million individuals. According to a recent study conducted by the California Healthcare Foundation, roughly 30 percent of the more than 700,000 employers in California do not offer health insurance to their employees. In California, only 76 percent of businesses with 10–49 employees offer health coverage. Most of these noninsuring businesses are small- and medium-sized firms with up to 50 employees. These businesses cannot afford the insurance premiums and their low-income workers are unable to afford an employee match. Poor access to health-care takes a tremendous toll on individuals, the community, and the productivity of the state’s workforce.

Pacific Community Ventures has pioneered an innovative, market-based approach to meeting a critical need of California’s small- and medium-sized businesses and their employees—convenient and affordable access to basic medical care. This alternative, VidaCard, is relevant today despite health-care reform, which will still leave hundreds of thousands of people without access to health care. VidaCard gives small- and medium-sized business owners a new option for providing medical care to their employees: an employer-funded prepaid debit card that can be used exclusively at qualified health-care merchants, from providers to pharmacies. VidaCard MasterCard is not health insurance. Although we believe that health insurance is the gold standard of care, we designed VidaCard to try to meet the unmet needs of workers who currently do not have access to any health care.

The Health-Care Market for Small Business

In its ten years of providing services to and building a network of business owners and leaders throughout California, Pacific Community Ventures has developed deep knowledge of the challenges that many small businesses face in providing health insurance. Specifically, PCV has worked closely with hundreds of small businesses that employ significant numbers of individuals who live in California’s low- to moderate-income communities in the Bay Area, Los Angeles, San Diego, and the Central Valley. While many of the businesses that PCV encounters would like to offer their hourly workers health benefits, they struggle to find health insurance options that (1) they can afford, given the size and stage of their business,

1 This article was made possible with support from The California Endowment.

2 Insure the Uninsured Project, May 21, 2008. Available at www.itup.org.

and (2) that will generate high enrollment and utilization rates among their employees. With limited alternatives, many businesses simply go into a holding pattern with health insurance until they are larger and better equipped to offer traditional, comprehensive plans.

The Health Policy Environment

In the national health-care debate, the needs and role of small businesses in health-care reform have been argued vigorously over the last several months. From mandated coverage for workers to exemptions based on the number of employees, the size of revenues, and the geographic location of the business, it is still unclear what level of responsibility and accountability the government will ask small business to take in trying to improve access to health care for individuals. While the exact parameters of the final bill are unknown, there is clearly some consensus about what core reforms are needed. Congress and the Obama administration are committed to maintaining the current combination of private and public health-care providers and expanding access to care by requiring all individuals to purchase health insurance.

With the proposed universal insurance model, an urgent question is how to help low- to moderate-income individuals pay for it. It's commendable to have the guaranteed insurance mandate, but those plans still charge monthly premiums that must be paid. Most lawmakers agree that the federal government should provide subsidies to people with modest incomes to help make insurance more affordable. The model they see as having been most successful is Medicaid, which is why there is a push to expand the Medicaid program to provide health care for more poor people.

And finally, there seems to be general agreement in Washington that the government should save money by reducing the growth of Medicare payments to hospitals and other health-care providers. The Centers for Medicare and Medicaid Services (CMS) have created a value-based purchasing initiative designed to tie Medicare payments to performance on the quality and efficiency of care given and is part of the effort by CMS to transform Medicare from a passive payer to an active purchaser of higher-quality, more efficient health care. As House Speaker Nancy Pelosi put it, "We need to bend the curve of health-care costs."³ In other words, health-care inflation must be capped. Capping Medicare payments could save hundreds of billions of dollars by shifting the emphasis on providers from volume of patients to quality of care. Lawmakers agree that we should reward high-quality care and emphasize preventive programs, which will save money in the long run.

This significant health-care reform initiative may improve access to care (because if everyone has insurance, they are more likely to get consistent health care), and it will implement cost-saving measures that will improve the system and, in the long run, partially control health-care inflation. What the current reform agenda is missing, however, is a cap on the costs of insurance. As a result, the current reform may be only a partial fix for small businesses that want to provide health insurance for their employees but face real cost barriers when they consider comprehensive medical plans.

3 Nancy Pelosi, Speech to City Summit: "Healthcare Reform and Economic Inspiration," Mission Bay Conference Center at UCSF, San Francisco, September 2, 2009. Hosted by San Francisco Chamber of Commerce.

The Private Health-Care Market

Before health-care reform surfaced again on a national level this year, we identified the need to figure out the options for small businesses and found that in California a “small group,” defined as an employer with 2–50 employees, has several options, although none currently represents a perfect solution. On the federal level, the law has required for years that small-group health insurance be offered on a “guarantee-issue” basis for the group. In other words, a small business cannot be denied an insurance option because of the health status or illness of its employees or their dependents. Although this is a great benefit to the small-group status, “guaranteed issue” does not mean affordable access.

In 2008, the average premium for small group health insurance was \$346 per month (\$4,155 per year) for single coverage and \$913 per month (\$10,956 annually) for family coverage. This is a significant amount for any business and, when looking deeper into the various analyses, one finds that these costs are highest for the smallest employers, making it that much more out of reach for businesses that do not bring in large revenues.

To curb premium costs, many small employers are turning to an alternative to comprehensive health-care for their workers: low-premium, high-deductible plans. High-deductible plans (also called “catastrophic” or “major medical” plans) provide protection for major medical events but shift the burden to employees for all health-related costs with deductibles ranging from \$1,100 to \$5,000. These plans tend to have much lower monthly premiums. The concern then shifts to the low-income worker, who does not have the cash to cover his or her deductible, sometimes up to \$5,000. Employees covered by a high-deductible plan often forgo preventive health care and may not seek medical attention until a routine infection spirals out of control because they did not have the money to pay for an out-of-pocket doctor visit that could have cured the illness early on. This type of behavior leads to much larger burdens on our health-care system overall. Further, the individuals covered by these plans may have coverage should they suffer an accident, but paying that initial \$5,000 deductible could be enough to put that individual into severe medical debt. While potentially more affordable for the employer, many high-deductible plans simply shift the costs to employees who are least prepared to shoulder the burden.

MiniMed plans provide an even lower-cost alternative than high-deductible plans for significantly reduced coverage. In exchange for \$50–\$100 monthly premiums and no individual deductible, MiniMed plans cover a certain number of trips to the doctor each year, a monthly allowance for pharmaceuticals, and short-term inpatient and outpatient hospital care. The employee is responsible for anything beyond that simple package. Some MiniMed plans have high co-payment (over \$30), which can be burdensome for lower-income workers. MiniMed plans have also been criticized for being confusing, according to John Carroll in *Managed Care* magazine, “smoke and mirrors plans [that] look comprehensive, but . . . are designed to prey upon unsophisticated employees.”⁴ Problems arise when employees seek

4 Carroll, John. “For More and More Workers, Small Pay Means Small Plans.” *Managed Care*, July 2005.

care and do not realize the true limits of their coverage benefits until after the fact. While on the surface a MiniMed plan might seem like a good alternative to a high-deductible plan, it too might have a construct that could mislead many employees and again result in cost shifting to those least equipped to pay.

Specialized Health-care Accounts

There are three types of health-care accounts for small businesses that have tax benefits associated with them. These accounts vary according to who contributes to them, whether they are portable, what the tax benefits are, and, in the end, who owns the remaining money in the account at the end of the year or at the end of employment should there be a remainder.

Flexible Spending Accounts, or FSAs, allow an employee to set aside a portion of his or her earnings for qualified medical expenses. These contributions are deducted from an employee's pay and therefore are not subject to payroll taxes, resulting in a substantial payroll tax savings. The contributions, however, have limits and are based on a "use it or lose it" construct. If the employee does not use all of their set-aside funds by the end of the year, the unused funds actually go to their employer.

The second type of account is the Health Savings Account (HSA), which an employer can offer alongside high-deductible plans to help employees pay for day-to-day medical expenses. Both the employer and employee can contribute to HSAs. Most HSAs, however, assume that employees are able to contribute wages beyond their share of insurance premiums toward health care and that employees are equipped to pay for medical expenses up front and submit claims for reimbursement later. For lower-wage workers with limited access to cash and credit, paying up front is not an option. And it helps explain the Government Accountability Office's finding in 2005 that the average income among HSA holders in the United States was \$135,000. HSAs have even been criticized for providing wealthy people a means to avoid taxes while doing nothing to give the uninsured greater access to health care.

Finally, Health Reimbursement Arrangements (HRAs) are exclusively employer-funded accounts in which the employers can make tax-benefited contributions to their employees' health-care costs. This is an employer-friendly account because employers make their contributions throughout the year. This is a great advantage for smaller cash-constrained businesses in particular because any money the employee does not spend by the end of the year can return to the business.

While the market currently offers some choices for small businesses, for many these choices do not meet the health-care needs of their workers and their families. In some cases, the employees' shares of the premiums or their deductibles are so expensive that they cannot afford to take advantage of the plan even with the employer covering a portion of the costs. In addition, small businesses that want to help their workers obtain affordable health care face fundamental problems with access and affordability in the current insurance market.

In 2006 and 2007, average health insurance premiums in California increased by 8.4

percent, more than twice the rate of inflation (3.4 percent).⁵ And consistent with the trend, smaller companies bore a disproportionate share of this burden. Companies with 50–199 employees saw rates rise by 8.2 percent in 2007, compared to 10.2 percent for companies with 10–49 employees and 13.5 percent for companies with 3–9 employees.⁶ Rising costs limit the ability, particularly of small companies, to cover employee health premiums. Small business owners can hardly provide health insurance for themselves, and more than 26 million of the uninsured indeed are small business owners, employees, and their dependents.⁷ These numbers contrast dramatically with the experience of large firms that held stable from 2000 with 99 percent consistently providing coverage. Employees at smaller firms pay a larger percentage of premiums than those at larger firms. The cost-shifting to employees can create significant hardships for lower-income workers and forces them to make difficult trade-offs in paying for other basic necessities such as food, housing, clothing, and transportation. Yet many businesses are finding themselves in the unfortunate position of having to reduce significantly or change their benefit plans because of rising and unpredictable premium costs.

Even those employers who have figured out a way to pay for health coverage cannot provide it to all of their workers. For example, only 10 percent of seasonal farm workers have employer-provided health care.⁸ Only 21 percent of part-time and other nonstandard workers participated in employer-provided health insurance compared to 76 percent of standard workers. Nearly one in five family members of nonstandard workers were uninsured (18 percent of children and 16 percent of spouses).⁹ When coverage is offered, nonstandard workers are significantly less likely to buy the insurance, either because it is unaffordable or because they have insurance through another family member.¹⁰

In addition to affordability and access problems for small businesses, many owners complain that the options, costs, and benefits are so complicated, even with the help of an insurance broker, that a human resources manager almost becomes a necessity.

Though it may represent a rational decision for most employers, the holding pattern they find themselves in—struggling between which health-care option is right for them—leaves many California workers and their families in dire straits in terms of paying for basic health care and maintaining their precarious financial stability.

Further, the crisis of being uninsured is more acute for some lower-income workers

5 California Healthcare Foundation Employer Benefits Survey, 2007.

6 Ibid.

7 Employee Benefit Research Institute, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey,” September 2008. Available at http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3975.

8 Sara Rosenbaum and Peter Shin, “Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care,” Kaiser Family Foundation, April 2005. Available at <http://www.kff.org/uninsured/upload/Migrant-and-Seasonal-Farmworkers-Health-Insurance-Coverage-and-Access-to-Care-Report.pdf>.

9 “Health Benefits Rare for Temps, Part-Timers,” Commonwealth Fund Digest, January–February 2006. Available at <http://www.commonwealthfund.org/Content/Newsletters/The-Commonwealth-Fund-Digest/2006/Jan/January-February-2006/Main-Features/Health-Benefits-Rare-for-Temps—Part-Timers.aspx>.

10 Ibid.

than others. Many of the employees in Pacific Community Ventures' investment portfolio earn wages that are well below the area median income level (average of 40 percent to 65 percent of AMI), putting them in the very low income bracket for their surrounding community. However, because they live in California, these workers earn wages that put them at 200 percent to 400 percent of the national poverty level, which disqualifies them from most public health programs as well as subsidized rates at community clinics. For this segment of the lower-income working population in California, not having health insurance is a double whammy. The situation not only creates adverse health outcomes but financial hardships as well. It is no surprise that medical debt is one of the leading causes of personal bankruptcy in the United States. Given this health-care reality for small businesses and their employees, PCV created the VidaCard Prepaid MasterCard® program.

How the VidaCard Works

VidaCard provides an additional option for many current health-care challenges. The VidaCard program is affordable and empowers employers to determine the amount they can contribute each month to their employees' health care (\$25 minimum per employee); even the most cash-constrained business can participate. We designed the program for VidaCard to be entirely online and administratively light—it takes just ten minutes each month for employers to manage. Employers simply upload a roster of participating employees, select a standard benefit amount, select manual or auto-reloads, provide payment information, and personalized debit cards are issued within 15 days. Employers can reload VidaCards automatically and add or remove employee names at any time via www.MyVidaCard.com. Funds can roll over year to year and are always returned to the employer 90 days after an employee's termination. Reloads can even be suspended without penalty fees in the event of a cash-flow shortage. VidaCard is the only HRA program with a discount dental plan integrated into a single point of purchase, and the program allows employees significant discounts at participating dentists and local clinics. Among the lower-income and predominantly Hispanic workers that PCV surveyed in its 2007 feasibility study, dental care was cited as the top health-care priority.

For employees, the program is even easier. VidaCard debit cards are activated over the phone and can be used anywhere that MasterCard is accepted to pay for doctor visits, medications, eyeglasses, flu shots, and blood tests. Each employee receives a "welcome kit," in English and Spanish, that explains how the debit card works and provides specific information on nearby retail and community clinics that offer basic, lower-cost care. One of the important attributes of the program is that there is no lengthy application process or additional documents required to enroll. Employees can call anytime to check their account balance or find a clinic near them. VidaCard and its benefits are available to any employee regardless of income level, age, immigration status, or area of residence.

By linking an HRA to an electronic debit card, PCV created a program that eliminates the need for employees to stretch their own credit or financial position to pay for basic health care. VidaCard relieves employees from having to navigate the confusing health-care system by themselves. While the VidaCard program is not insurance, it does give workers the tools and resources they need to access basic health care in the language and setting familiar to them.

In the context of health-care reform, the VidaCard program will continue to have a place in the market because, for the foreseeable future, an employer mandate remains a strong possibility. VidaCard is a way for small employers to feel more empowered about their contributions: it is more flexible than most options and gives both employers and employees more choices about how to spend their health-care dollars. Additionally, there could be a real gap for employees of small businesses who are required to have insurance (individual mandate), but who do not receive employer contributions. The VidaCard is a way for employers to help employees pay for their insurance. Further, the policy we have seen does not account for part-time and seasonal workers. PCV's VidaCard allows an employer to help contribute to these nonstandard workers' health-care costs in the new system. Finally, as a stop-gap measure, a stand-alone HRA product like VidaCard will always make sense for companies with long probationary periods before their health-care benefits go into effect, for seasonal workers, and for other individuals who are somehow excluded from the coverage as it evolves under the new policy plan.

The health-care market is complicated and current health insurance plans are often not small-business-friendly in terms of access and cost. Whereas federal health reform might offer some benefits that small business owners can support, there is no simple solution. Innovations such as the VidaCard will need to continue to proliferate and penetrate the market segments that unfortunately may be left out of policy reform to ensure that everyone has access to quality and affordable health care.

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