

Part 1:
The State of Employer-Sponsored Health Insurance in Tennessee

and

Part 2:
The Health of Tennessee's Health Insurers

to

Cover Tennessee

A project of the Tennessee Department of Commerce and Insurance

Parts 1 and 2 of the *Cover Tennessee* project were funded under an agreement with the Tennessee Department of Commerce and Insurance and the University of Tennessee Center for Business and Economic Research made possible by a State Planning Grant through the Health Resources and Services Administration (HRSA), US Department of Health & Human Services. The views encompassed in this research do not necessarily reflect the views of the Tennessee Department of Commerce and Insurance.

Project Background and Purpose

The state of Tennessee Department of Commerce and Insurance was awarded a grant sponsored by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) State Planning Grants (SPG) Program. In performance of this grant, the Tennessee Department of Commerce and Insurance contracted with the Center for Business and Economic Research (CBER) at the University of Tennessee to 1) research employer-sponsored health insurance coverage in Tennessee (Part 1: The State of Employer-Sponsored Health Insurance in Tennessee), and 2) review existing data on health insurance companies (also referred to as “market participants”) and similar entities providing coverage to Tennesseans (Part 2: The Health of Tennessee’s Health Insurers).

Part 1 of the project discusses the methodology and findings of the employer-sponsored health insurance research. This research was specifically designed to fill in gaps and supplement data provided by the 2002 Medical Expenditure Panel Survey (MEPS), which provided the only base of information in its survey of 600 Tennessee businesses.

The report then turns to Part 2 of the project and discusses the methodology and findings of the research into the health of Tennessee’s health insurers.

The State of Employer-Sponsored Health Insurance in Tennessee

May 13, 2005

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Acknowledgements: CBER would like to thank the following people and organizations: Joe S. Cummings, Director of Research and Statistics at the State of Tennessee Department of Labor and Workforce Development and his colleague Mike Ballard, for providing the employer database for this project; Carol Lavin, Benefits Consultant and former hospital benefits manager, for her valued professional input during the development and design stages of the survey; special thanks to our employers who made time to participate in the pilot test group for the survey; the Tennessee Chamber of Commerce and Industry; National Federation of Independent Businesses; Dr. Amy Cathey for her counsel and expertise as a focus group moderator and researcher; Julie D. Cassidy for transcription services; and finally, sincere thanks and appreciation to all the Tennessee employers who took the time to complete and return the survey and/or to participate in the focus groups.

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Part 1: Background and Purpose

The goal of Part 1 of the study was to gain an accurate profile of employer-sponsored health insurance across the state. In order to accomplish Part 1 of the State Planning Grant Program, the Center for Business and Economic Research adopted a two-tiered research approach. First, CBER solicited quantitative data from a sample of non-governmental employers across the state of Tennessee via a mail survey. Second, CBER conducted focus groups of employers with 50 employees or less in Tennessee's three largest cities—Memphis, Nashville, and Knoxville—to gain qualitative insight into the health-insurance challenges facing employers and employees in the state. As stated earlier, the overarching goal of Part 1 of this project is to determine the state of employer-sponsored health insurance from the perspective of the employer.

I. The Mail Survey

Objectives of the mail survey

The mail survey gathered specific information from all employers, as follows:

- How long the firm has been in business
- Number and category (full-time, part-time, seasonal) of employees
- Category of principal business activity
- The most important reason for providing health insurance
- Average annual salary of salaried employees
- Average annual salary of hourly employees

Then, the mail survey sought specific information based on whether the employers offer insurance to *all* of their employees, to *some* of their employees, or to *none* of their employees.

The survey collected the following information for those employers who offer insurance to *all* or *some* of their employees:

- How many years health insurance has been offered
- Whether health insurance decisions are made at the location being surveyed
- How many health insurance plans are offered
- Employer/employee premiums, contribution, and shares
- Trends in health insurance costs and plan changes
- Employee eligibility requirements and restrictions
- Characteristics of the health plan with the most participants
- Information on self-funded plans

Finally, the mail survey collected the following information for those employers who *do not offer insurance* to any of their employees:

- Reasons the employer does not offer health insurance
- Incentives that might motivate the employer to offer health insurance
- Maximum premium contribution the employer could afford if it were to start offering insurance

The survey allowed for additional comments from the respondents as well as a space where respondents could provide contact information if they were willing to participate in a “voluntary group discussion about the health insurance challenges” facing their business. This contact information was later used to recruit focus-group participants.

Survey methodology and procedures

Initially, an extensive literature review was conducted that included reports and surveys of former State Planning Grant grantees, the 2002 MEPS-IC survey and Tennessee dataset, and articles, reports, and surveys provided by numerous sources, among them the Kaiser Family Foundation, The National Center of Health Statistics, and The Robert Wood Johnson Foundation. A benefits consultant advised on various aspects of health insurance coverage, types of plans, appropriate terminology and question design.

The survey was designed in four sections and pages. A draft of the first survey was sent to a test group of Knoxville employers for their input and feedback which resulted in changes to both the letter and survey. The survey was also reviewed by the Nashville Chamber of Commerce and the National Federation of Independent Businesses for their careful review of the content and format from a business perspective.

Firms with two or more employees were randomly selected from a database provided by the Tennessee Department of Labor and Workforce Development that included all Tennessee employers. A sample of 9,600 businesses was drawn and stratified by employee size [small (2-19), medium (20-99) and large (100+)], with over-sampling of large- and medium-sized firms in order to get good representation of large- and medium-sized firms. The sample did not include any government entities. The goal was to have a large enough sample in order to achieve a reasonable level of statistical significance and to be able to conduct tests at all three levels. It was especially important to have enough representation from large businesses to be meaningful.

Two survey mailings were sent. Both mailings included a letter (Appendix A co-signed by Commissioner Flowers and CBER Director Fox), the survey (Appendix B), and a self-addressed business reply envelope. The first mailing—9,600 surveys—was sent on February 3, 2005, and by March 10, 2,348 responses had been received. In order to reach the necessary response rate, a second mailing of 2,000 survey packets were sent on March 15. The second mailing over-sampled West Tennessee and improved the sample by 333 responses, thus reaching the target number for allowing the research team to conduct tests at all three employee levels (small, medium, and large) and also by Tennessee’s three Grand Divisions (West, Middle, and East). A total of 2,681 usable responses were received, representing a 27.9 percent response rate.

Findings from the mail survey

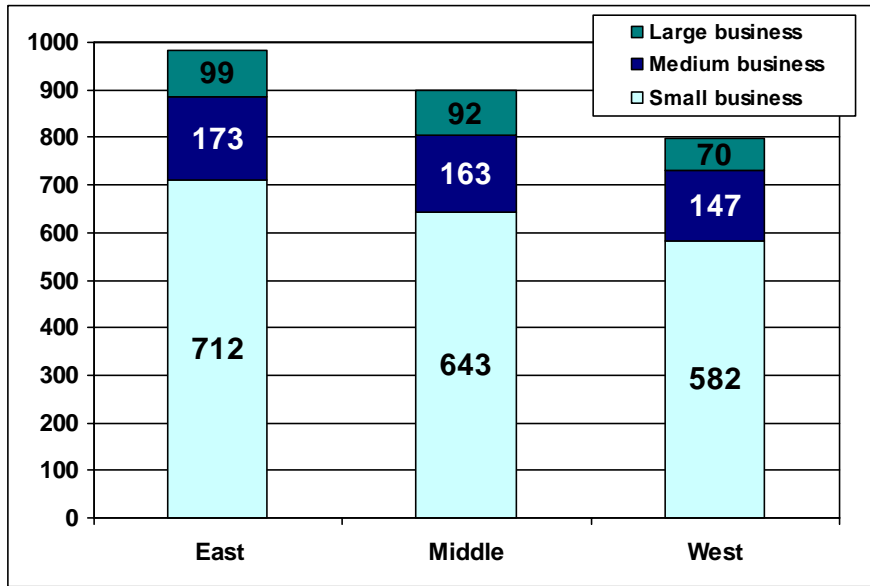
Data Introduction and Breakdown

Much of the analysis contained in this report is by company size rather than by Grand Division because there were no significant differences among the three regions for any of the data used in the report. Size, on the other hand, was a significant determinant for how businesses responded to many questions in the survey. For each figure with responses shown by company size, the difference among the sizes is significant to at least the .05 level unless otherwise mentioned.

Throughout this report, results will often be demonstrated by company size. “Small” businesses are those with two to 19 employees, “medium” businesses have 20 to 99 employees, and “large” businesses have 100 employees or more. Figure 1 below shows the total number of responses according to the three Grand Divisions (East, Middle, and West Tennessee) and company size. The sample is re-weighted to reflect the true proportion of businesses in the state in each size group whenever state or regional analysis is performed.¹ Weighting allows for accurate and unbiased statistics throughout the analysis.

¹ Based on the database provided by the Tennessee Department of Labor and Workforce and the definitions described in this report, small businesses make up 83.4 percent of Tennessee’s employers, while medium businesses account for 13.4 percent and large businesses, only 3.2 percent.

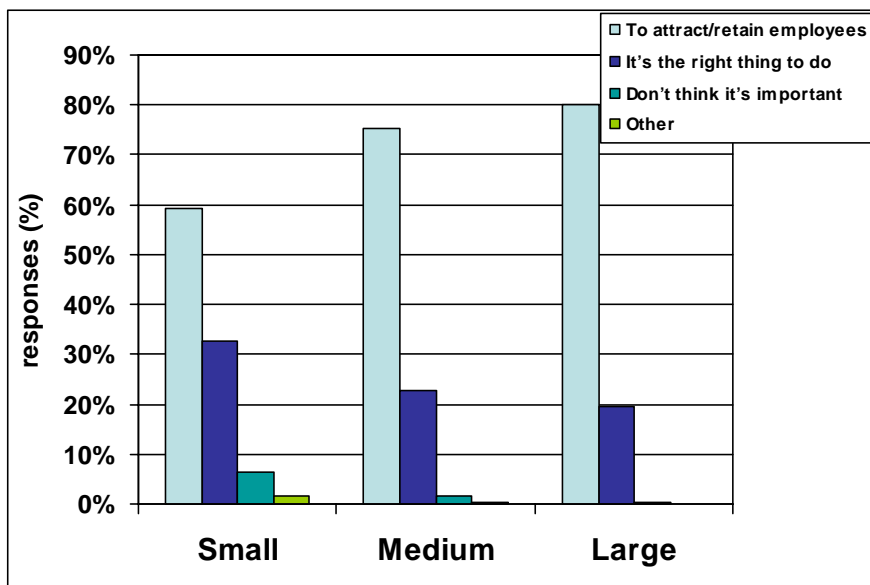
Figure 1: Total Responses by Grand Division and Company Size



Health Insurance Offerings and Eligibility: A Comparison of Companies by Size

In order to determine why companies feel it is important to offer health insurance, the survey asked respondents what they felt was the most important reason to offer insurance coverage to their employees. The responses were very different across small, medium, and large companies (see Figure 2).

Figure 2: Most Important Reason for Offering Insurance



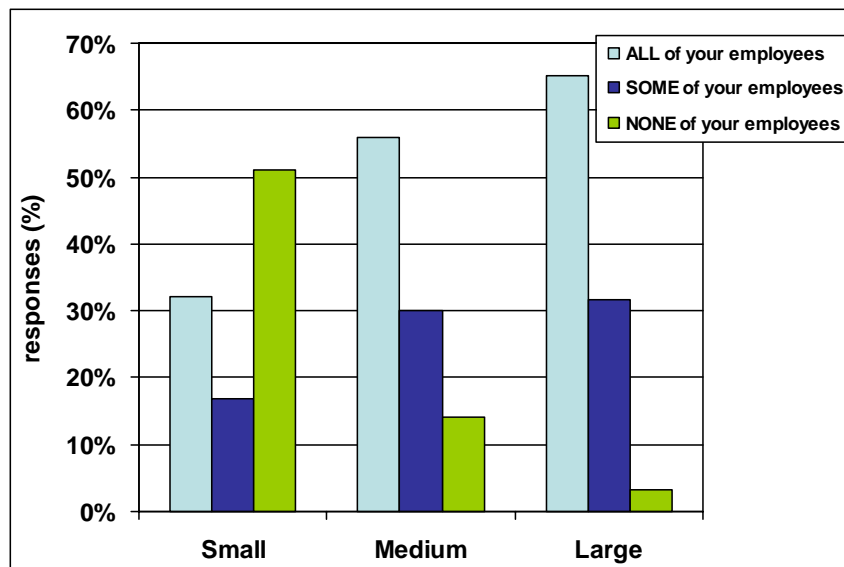
The vast majority of large companies think offering insurance is important mainly because it helps them attract and retain employees (about 80 percent), while only 20 percent respond that most importantly it is the “right thing to do;” a ratio of four-to-one. Small and medium-sized companies maintain this same order but are relatively more likely to believe that insurance should be offered mainly because it is the right thing to do (ratios of about two-to-one and three-to-one, respectively). While the percentages are low, we also find that smaller companies were more likely than their larger counterparts to respond that they “don’t think it’s important.”

“I think it’s rare for independent restaurants to have healthcare for their employees. I wanted to be a good employer. And really, it was the right thing to do.”

-- Nashville focus group, 5 employees

There is also a significant difference across firm size in the propensity to offer health insurance. Figure 3 illustrates this difference. More than 50 percent of small businesses do not offer health insurance to *any* of their employees.² The corresponding values are less than 15 percent for medium-sized employers and less than 5 percent for large employers. There is little difference in the type of insurance offered to employees; by and large, all employees are offered the same coverage. Most companies have a minimum number of hours that hourly employees must work to be eligible (the most common minimums being 30, 32, and 40 hours per week).

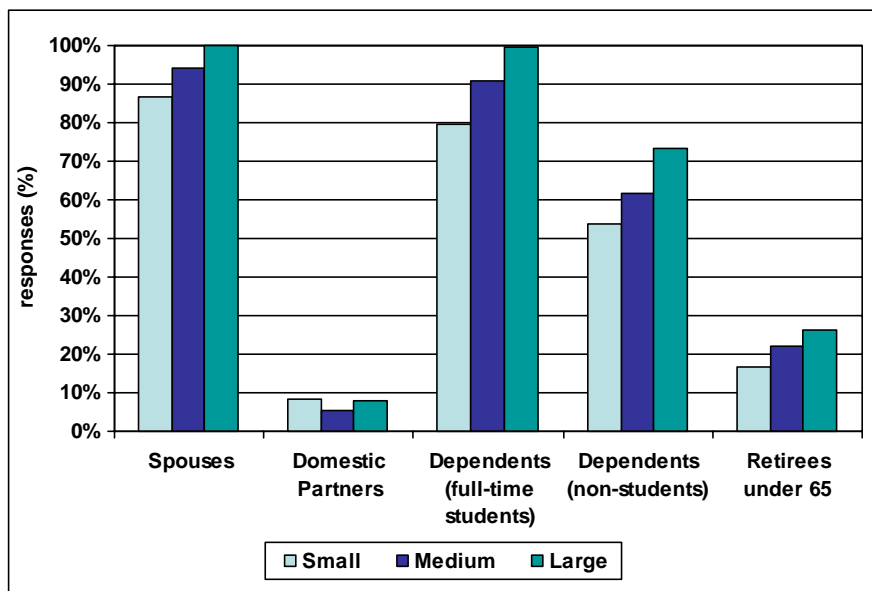
Figure 3: To Whom Do You Offer Health Insurance?



² According to survey results, 50 percent of small business employment accounts for approximately 420,000 employees.

Figure 4 shows the coverage offered to spouses, domestic partners, dependents, and retirees by size of business. Large businesses are more likely than small or medium businesses to offer coverage for spouses and dependents and are more likely to offer continued coverage to early retirees. Domestic partners are eligible for coverage in less than 10 percent of businesses, regardless of size. There is some variability among companies regarding the age at which dependents are no longer eligible; the median age for full-time students is 23 (with 24 and 25 being the most common limits), while the median age for non-students is 19 (with 18 and 19 being the most common).

Figure 4: Coverage Offered to Families and Retirees under Age 65

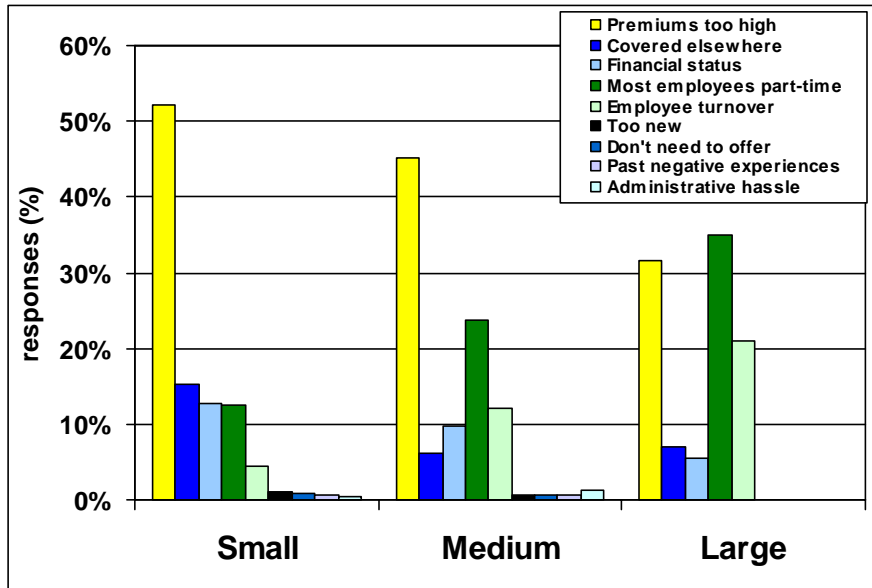


Cost is the most obvious reason that small businesses fail to offer health insurance to their employees (as well as restricting eligibility for family members and retirees). The percent of total payroll budget paid to health insurance is consistent across sizes (the median is 6.0 to 10.9 percent of total payroll costs for each size category), though many other features differ by size. Small businesses struggle the most with high costs, with more than 50 percent reporting that the primary reason for not offering insurance was high premiums. Figure 5 illustrates that high premiums dominate the reasons for small and medium-sized businesses, whereas for large businesses, employee turnover and mostly part-time staff were also major reasons.

“You want to offer the best things you can do to retain good employees, and so healthcare benefits was something I wanted to offer. I couldn’t afford it. There was just no way after that [premium increases] I could afford it. None of my employees could afford to make up the difference in the premium. And so we completely dropped all of our insurance coverage at that point.”

-- Memphis focus group, 23 employees

Figure 5: Primary Reason for Not Offering Health Insurance

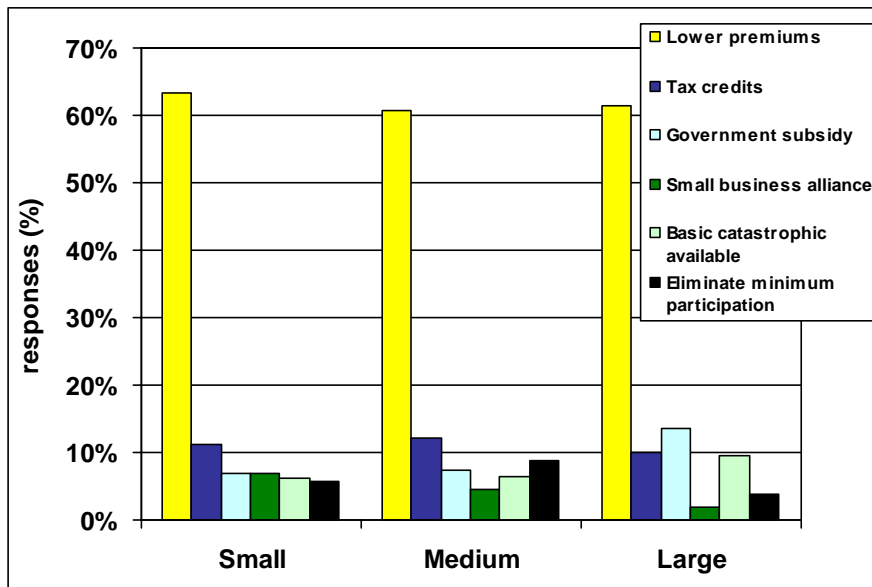


Similarly, the survey demonstrates that lower premiums are the major incentive that would enable employers to start offering insurance (see Figure 6). This is true across all business sizes, with no other incentives coming anywhere close.

“I was just trying to find a benefit that I could provide for them. It is strictly a cost issue. It is a benefit that I would love to be able to provide, but it’s just not cost effective. That’s the overriding issue.”

-- Nashville focus group, 8 employees

Figure 6: Primary Incentive to Start Offering Insurance



Firms that do not currently offer insurance to their employees also reported how much they could afford to pay in premiums. Figure 7 demonstrates how much employers would be able to pay if they did offer coverage. From Figure 7, we can see that almost 70 percent of companies who do not currently offer insurance but might in the future could only afford \$100 or less per employee per month, while only 14 percent could afford \$150 or more. In this same question, 16.8 percent of respondents declared that they “would not purchase (employee health insurance) *at any cost.*” Figure 8 shows the breakdown of these responses by size of company.

Figure 7: Maximum Premium Contribution Employer Could Afford

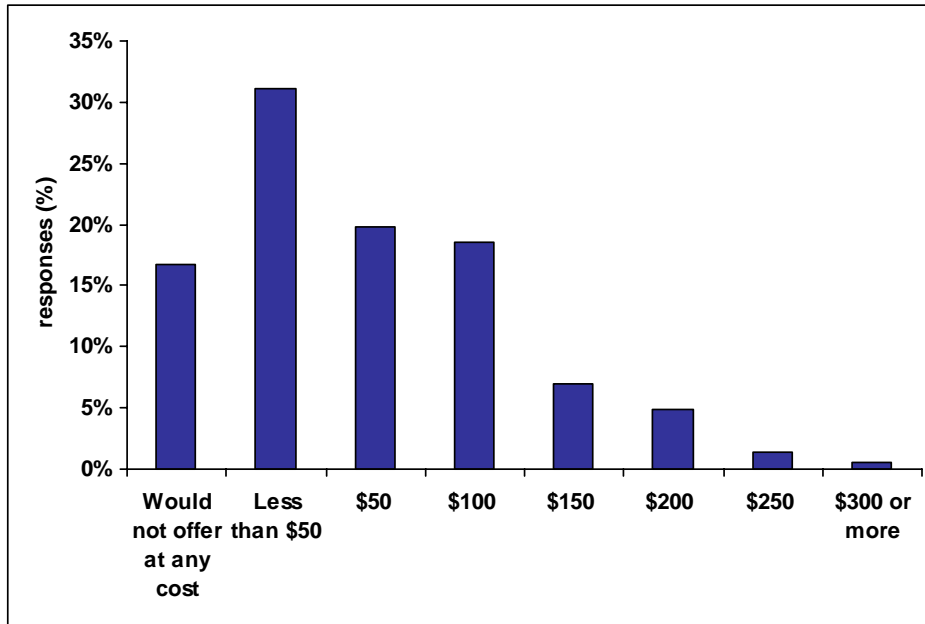
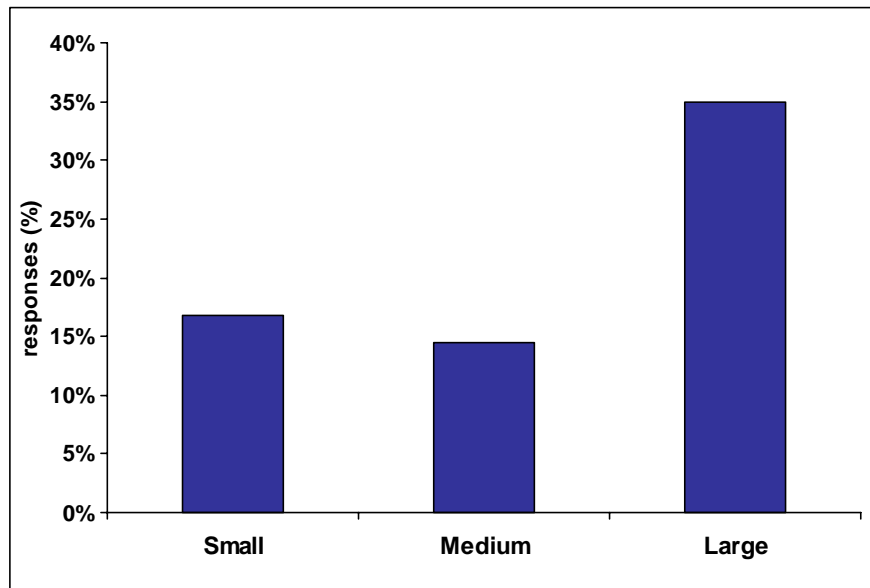


Figure 8: Companies that Would Not Offer Health Insurance at Any Cost



When analyzed by size, 16.9 percent of small businesses, 14.5 percent of medium businesses, and 35.0 percent of large businesses would not offer insurance at any cost. With an average number of employees of 8.6 (small), 40.2 (medium), and 274.8 (large) in each of these firm sizes, companies that do not currently offer health insurance to any of their employees and further *would not* offer health insurance at any cost employ approximately 100,000 individuals in Tennessee.

“Because really before, the whole reason why businesses started offering insurance is just as a benefits package, a perk to attract people. It shouldn’t be an expectation of any business at all. It should be voluntary. And so to mandate it through businesses is I think gonna be a problem. It’s not a fair solution. It’s not even fair to expect businesses to be the ones to take responsibility for the insurance of their employees.”

-- Knoxville focus group, 8 employees

Other Trends in Insurance Offerings

This section identifies a series of other findings including health insurance offerings based on average salaries of employees, on length of time the company has been in business, and on the company’s self-identified business category.

One trend indicates that insurance offerings vary based on the average salary of employees in each company. Figure 9

illustrates that companies that pay salaried employees a greater average amount are far more likely to offer insurance. Less than 10 percent of companies with average salaries below \$20,000 per year offer insurance to their employees. Not only is the employee pay low, making

“If you’re paying people \$10-12-15 an hour, they may not be able to afford that bit of insurance.”

-- Memphis focus group, 5 employees

it difficult to buy health insurance, but these employees are not offered health insurance by their employer. However, low wage employers are no more likely than higher wage employers to report that access to other health care (such as through TennCare) is important in their decision not to offer it. Employers responded to “Employees are generally covered under other plans obtained elsewhere, such as through a spouse, a union, or Medicaid” as a “somewhat important” or “very important” reason that they do

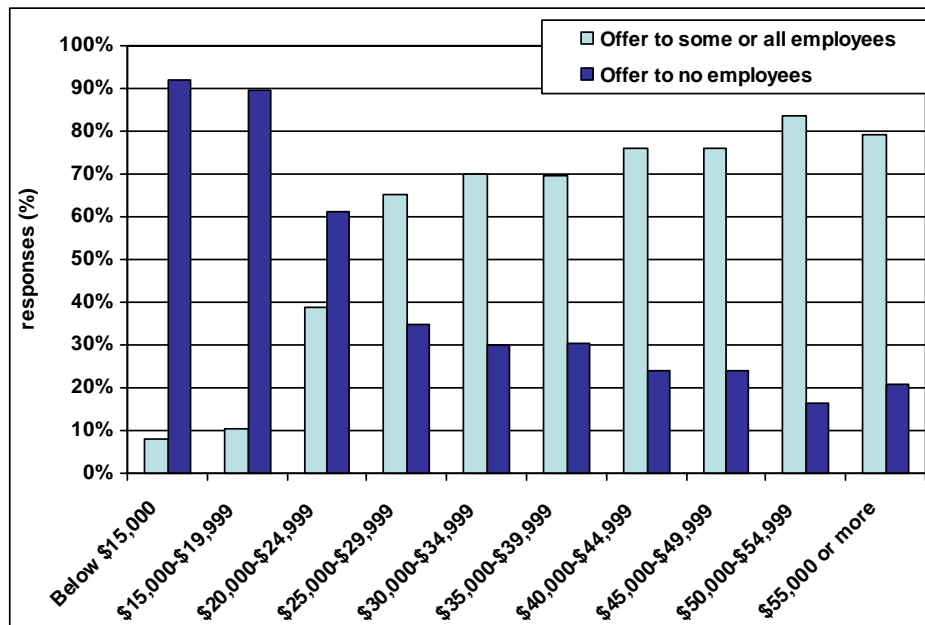
not offer health insurance at about the same rate, regardless of salary.

Additionally, there was no tendency for lower-paying employers to list this as their primary reason for not offering as compared to higher-paying employers.

“[W]ith our insurance, the employee pays \$100/month. When you make \$5.15/hour, you can’t pay that. So a lot of our employees, they are either on their wife’s insurance or their wife pays for their insurance elsewhere, because ours is just so expensive. And so this time around, we are debating on giving the employees raises. Saying here, we’re going to drop our insurance. Here’s extra money—use this money as you see fit. Go and buy insurance, or spend it on...”

-- Memphis focus group, 13 insured employees

Figure 9: Insurance Offerings by Average Salary for Salaried Employees



Assessment of the importance of offering healthcare is different. Companies differ in the importance placed on offering health insurance; firms with average salaries under \$25,000 are more than four times as likely (11.9 percent to 2.6 percent) to respond that they “Don’t think it’s important” to provide health insurance as companies with average salaries of \$25,000 or more.

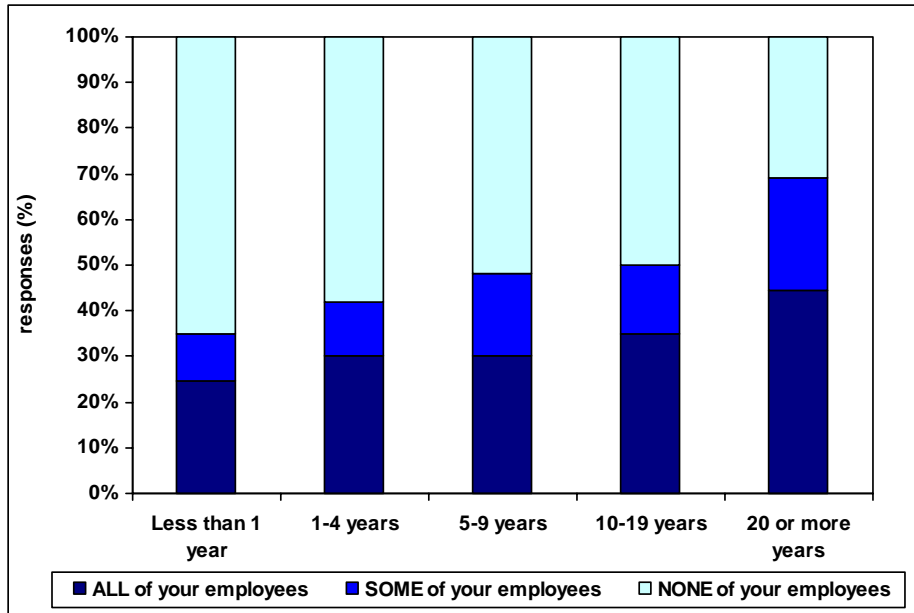
The longevity of the company is also a factor in whether or not it offers insurance to its

“It was quite simple for me. When I bought the company 15 years ago, group health insurance was part of the core benefit offering for full-time employees. So maintaining it was necessary. Group insurance is absolutely necessary. It is also the most expensive benefit we offer and is becoming increasingly so.”

-- Knoxville focus group, 23 employees

employees. Companies that have been in business longer are far more likely to offer insurance to at least some of their employees (see Figure 10).

Figure 10: Insurance Offerings by Age of Business



The propensity to offer insurance also differs by industry (see Table 1). Manufacturing, leisure/hospitality, and utilities are most likely while mining, construction, and agriculture/forestry/fishing/hunting³ are least likely.

“It’s employee retention, because from our standpoint being a manufacturer, most manufacturers have health plans. So if you want to keep employees with you, you compete with other manufacturers.”

-- Nashville focus group, 50 employees

Table 1: Insurance Offerings by Business Category

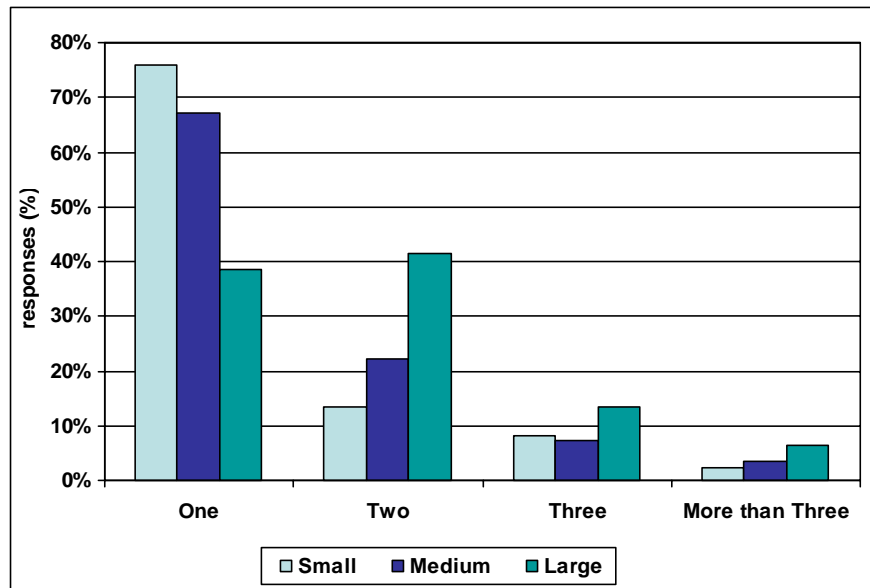
Business Category	Offer to some or all employees	Offer to no employees
Manufacturing (<i>n</i> =128)	77%	23%
Leisure/hospitality (<i>n</i> =138)	75%	25%
Utilities (<i>n</i> =50)	74%	26%
Other (<i>n</i> =224)	74%	26%
Financial activities (<i>n</i> =125)	67%	33%
Transportation (<i>n</i> =24)	65%	35%
Professional/business services (<i>n</i> =262)	61%	39%
Education (<i>n</i> =11)	59%	41%
Information (<i>n</i> =312)	54%	46%
Wholesale trade (<i>n</i> =527)	53%	47%
Warehousing (<i>n</i> =44)	53%	47%
Retail trade (<i>n</i> =69)	52%	48%
Religious/civic/non-profit (<i>n</i> =6)	52%	48%
Health services (<i>n</i> =100)	46%	54%
Mining (<i>n</i> =7)	45%	55%
Construction (<i>n</i> =233)	44%	56%
Agriculture/forestry/fishing/hunting (<i>n</i> =36)	29%	71%

Plan Offerings

Significant differences in plan options exist between small, medium, and large companies among those companies that offer health insurance to at least some employees. The vast majority of small and medium-sized businesses offer only one health plan option (76 percent and 67 percent, respectively), but large employers are equally likely to offer two plans (41 percent) and one plan (39 percent). Additionally, large businesses are nearly twice as likely to offer three or more plans than their small or medium counterparts (see Figure 11).

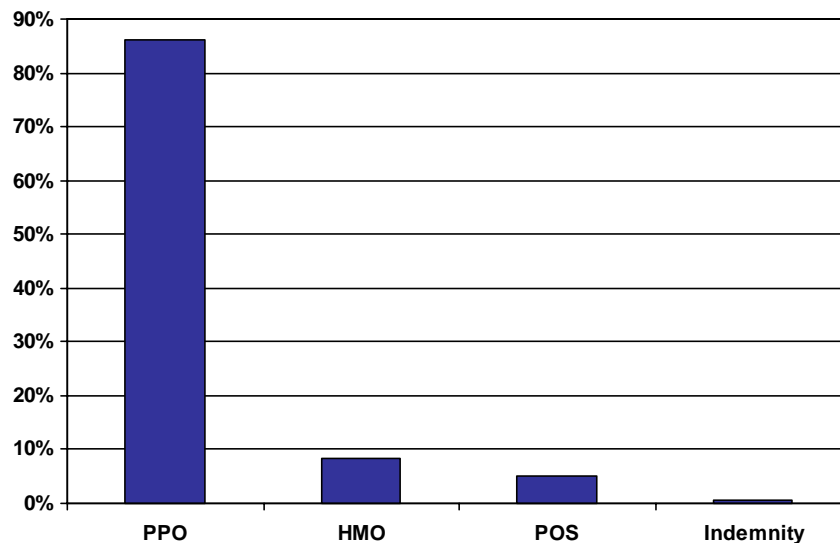
³ Again, government entities as employers are not included in this analysis.

Figure 11: Number of Health Plan Options Offered, by Size of Business



Companies of all categories report that Preferred Provider Organizations (PPOs) are the most common form of plan. Both Health Maintenance Organizations (HMOs) and Point of Service (POS) plans make up less than 10 percent of the companies' most utilized plans (see Figure 12). Not surprisingly, employees tend to favor the less expensive plans available from their employer. In 75 percent of companies, the plan with the most enrollees is also the least expensive.

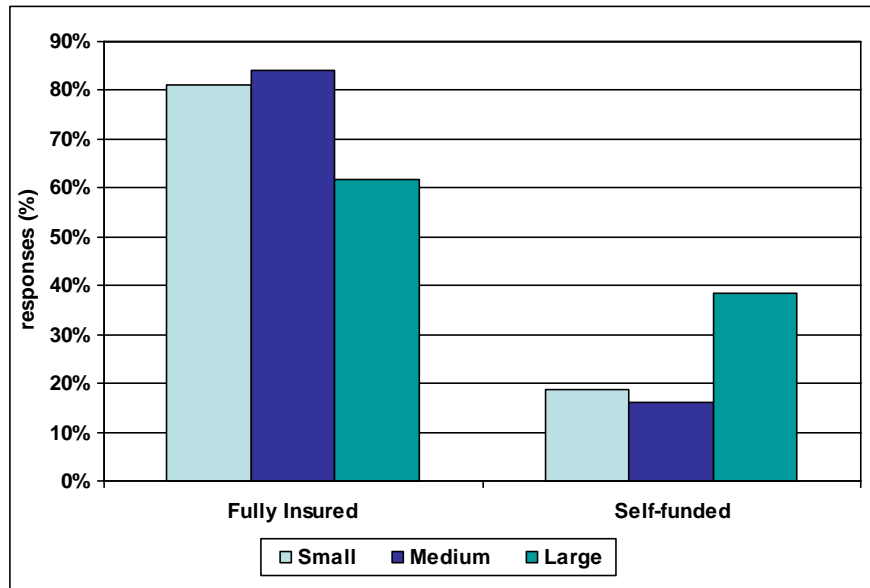
Figure 12: Insurance Plans with the Highest Number of Enrollees



Self-Funded Plans

Nineteen percent of companies report that the plan with the most enrollees is self-funded. In other words, they pay claims from their own resources, regardless of which insurance company administers the plan. There is a considerable difference by company size (see Figure 13). Nearly 40 percent of large businesses have decided to self-fund their largest plan, while less than 20 percent of small and medium-sized businesses do so.

Figure 13: Fully Insured vs. Self Funded for Most Popular Plan by Size of Business



On average, these companies have self-funded their plan for 11 years, and 87 percent hire a third party to administer the plan. Most companies list multiple reasons for deciding to self-fund, but nearly all respond that they expected cost savings (see Table 2).

Table 2: Reasons for Self-Funding

Reason for Self-Funding	Responses (%)
Expected savings	98%
To customize plans based on needs of company	90%
To offer competitive benefits	87%
To offer a richer benefits package	75%
Discretion to be free of state mandates	57%

Employer Expenses for Healthcare

Since cost clearly plays the largest role in whether employers offer insurance, it would be helpful to evaluate how much it costs companies who do offer coverage. Table 3 below shows the average dollar amount employer contributions, per employee per month.

Table 3: Employer Contribution per Employee per Month

Business Size	Mean Cost per Employee	Median Cost per Employee
Small	\$442	\$331
Medium	\$355	\$300
Large	\$349	\$400

Small businesses pay higher premiums on average for their employees than medium or large companies but the medium firms pay more than large firms. Of course, employers can pay different amounts of their employees'

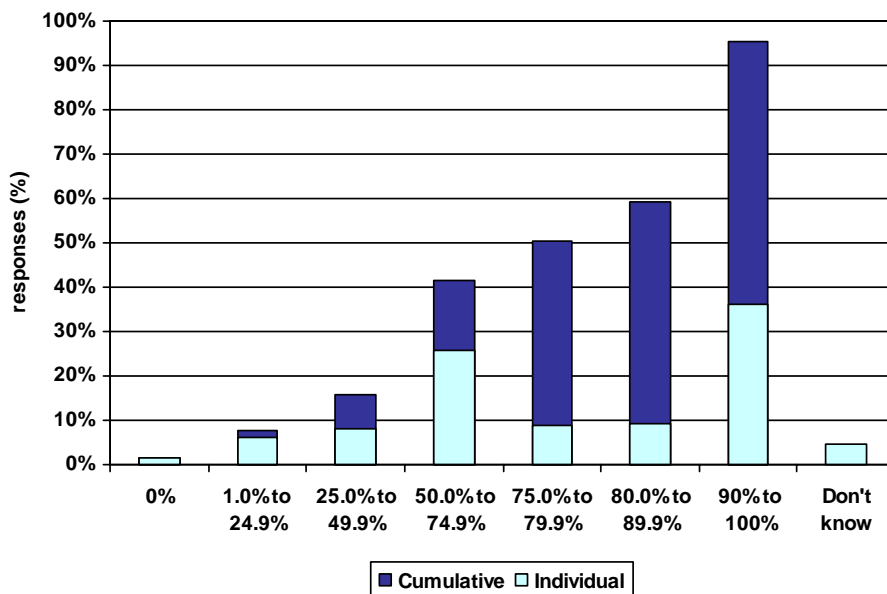
premiums to help defray the cost, as evidence from the focus groups indicates, wherein the majority of participants who employ 50 employees or less indicate

"We end up having to break up part of our expenses to our employees, because of the cost factors that are involved. Then we raise the deductibles on the insurance policies to make them where they can even afford their 20 percent."

-- Memphis focus group, 8 employees

that they have been raising the employer-share of premiums to reduce the overall cost to the company. Figure 14 shows what percentage of total insurance premiums the company pays, for all business sizes.

Figure 14: Share of Premiums Paid by Employer



Most companies (60 percent) responded that they paid less than 90 percent of the total insurance premiums, yet a substantial number (35 percent) paid for 90 to 100 percent of the cost. The percent paid differs by business size as well. Small employers are more likely to pay a higher percentage of the total premiums, with 42 percent responding that they pay 90 to 100 percent, while many fewer medium and large companies (26 percent and 13 percent, respectively) pay such a large share.

“We provide healthcare insurance for the employee and their spouse and family at 100 percent. We pay everything. We look at shifting our cost off to employees... the ones that least likely can afford it are the ones you’re going to whack the hardest. It’s just the reality of how it will hurt folks.”

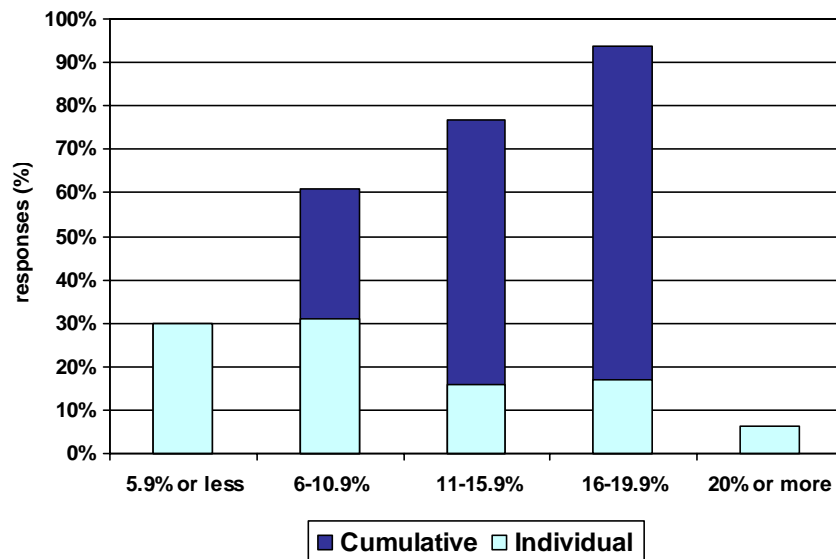
-- Nashville focus group, 13 employees

Figure 15 shows the percentage of payroll expense that is attributed to health insurance costs. There is little variation in the percentage by company size (the median is 6.0 to 10.9 percent of total payroll costs for each business size). Most businesses in Tennessee that offer insurance spend 6 percent or more of their payroll budget on health insurance.

“Even if I paid \$100 toward an insurance payment every month, that would cost me \$2,000 a month. And my margins are so slim that that’s just not something I could do. And because I have a capacity limit, it’s not like I can sell more, make more, do more to creep those margins. I mean, I have fixed margins, so there’s not going to be any huge increase in revenue that’s going to change the bottom line for me.”

-- Memphis focus group, 23 employees

Figure 15: Health Insurance Costs as a Percentage of Payroll Expense



Changes in Health Insurance Costs

The survey asked respondents whether their health insurance costs increased or decreased in 2004 and by what percentage. Figure 16 shows their responses. The overwhelming majority of businesses saw an increase in health insurance costs in 2004. For those who answered that their costs increased, the median increase was 12 percent. Those who answered that their costs decreased had a median decrease of 5 percent.

Additionally, respondents indicated whether they expected an increase or decrease in their health insurance expenses in 2005. The results are very similar, but it is interesting to view these responses while considering whether the company experienced an increase or decrease in 2004. Table 4 has the results of this analysis. Even companies that experienced a decrease in their healthcare costs expect that costs will increase in 2005, and few companies expect costs to be reduced.

“Every year it just goes higher and higher and higher, and the benefits get lower and lower. Because like you say, that’s all the companies can afford.”

-- Memphis focus group,
75 employees (2 businesses)

Figure 16: Did Your Health Insurance Costs Increase or Decrease in 2004?

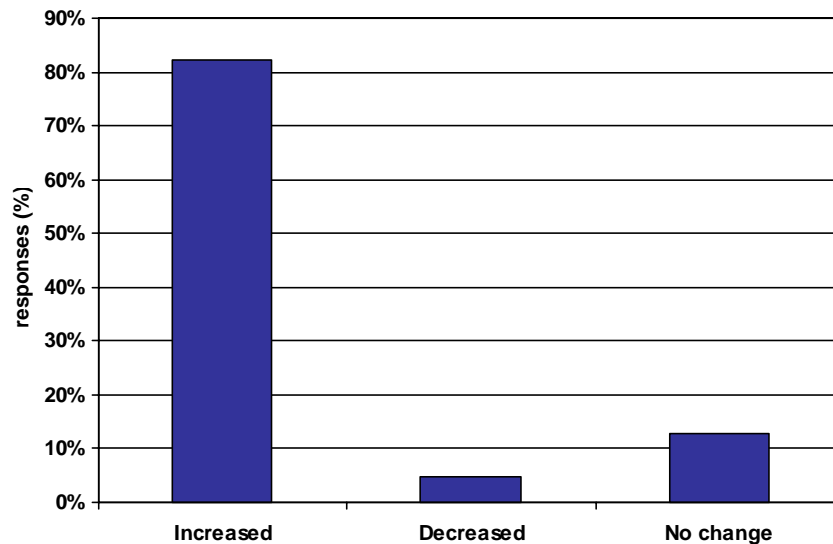


Table 4: Expected Change in 2005 Cost

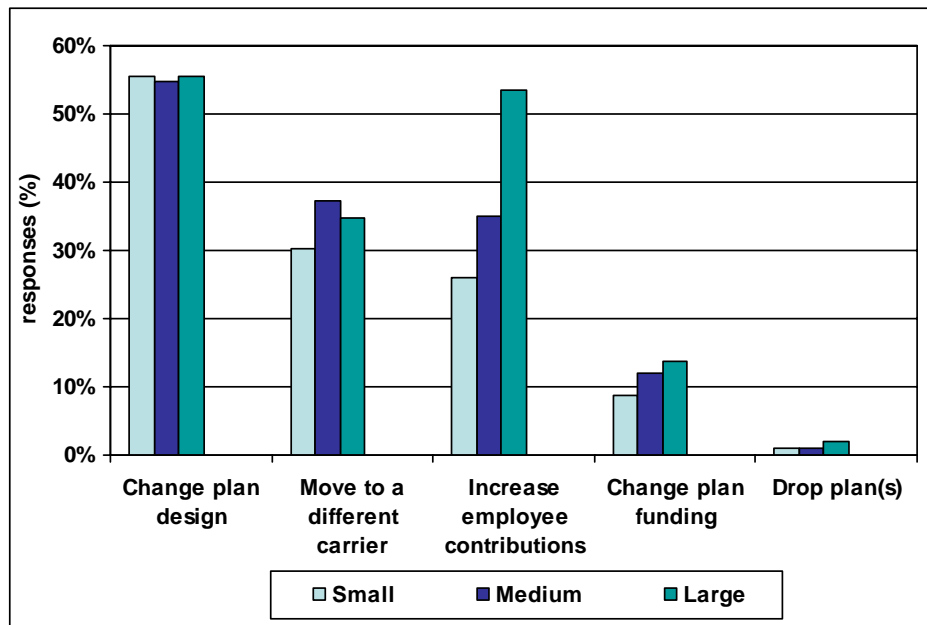
Change in 2004	Expect an Increase in 2005	Expect a Decrease in 2005	Expect No Change in 2005
Increase	91.7%	3.7%	4.6%
Decrease	64.9%	16.7%	18.4%
None	38.1%	5.8%	56.1%

This nearly across-the-board increase in health insurance costs has forced many companies to make changes to their insurance offerings. Figure 17 shows some of the changes these businesses have made in the past two years due to cost increases. The responses are similar regardless of business size with the exception of increasing employee contributions. Small businesses seem to be willing to make other changes to their plan but less willing to increase the contributions that their employees have to make.

“Do you offer health insurance and go broke in six months, and then they’re all out of a job as well as not having insurance? Or do you keep them employed? That’s basically the choice that most of us face.”

-- Nashville focus group, 10 employees

Figure 17: Changes Made Due to Health Insurance Cost Increases



II. The Focus Groups

Objectives of the focus groups

The goal of the focus group portion of Part 1 of this project was to identify more personal and qualitative information regarding:

- Qualities of employers that either offer or do not offer group insurance plans
- Reasons those companies either offer or do not offer group insurance plans
- Company owner or representatives' perspectives on the challenges of getting and keeping health insurance for their employees
- Effects of health insurance on retention and employee recruiting
- Alternatives to employer-sponsored health insurance via policy or practice

Methodology and study procedures

Six focus groups of business owners or their representatives were conducted across the state: two each in Knoxville, Memphis, and Nashville. One focus group in each city consisted of employers who offer insurance to their employees, and one focus group in each city consisted of employers who do *not* offer insurance to their employees. Participants were recruited either from the city's Chamber of Commerce or from interest they expressed in their responses to the mail survey. Each focus group had a minimum of three and a maximum of eight participants, and the participants were carefully screened to ensure that they were responsible for making the health insurance decisions for that employer. Only employers with 50 or less employees participated, limiting the qualitative research aspect of this project to those employers who represent the largest segment of total employers in Tennessee. Further, employers were recruited from a broad range of industries to avoid the presence of potential business competitors and to broaden the perspective of the research.

The two Knoxville focus groups occurred on March 3 and March 14, 2005 at Chesapeake's Restaurant in downtown Knoxville from 6:00 p.m. to 8:00 p.m. The two Memphis focus groups occurred on March 30 and March 31, 2005 at the University of Memphis Holiday Inn from 6:00 p.m. to 8:00 p.m. Finally, the Nashville focus groups occurred on April 6 and April 7, 2005 at the Loew's Vanderbilt from 6:00 p.m. to 8:00 p.m.

The moderator utilized a list of twelve research questions to guide the discussions (see Appendix D); however, each group was able to interact and share their experiences to the extent they felt comfortable doing so. The groups were observed by a researcher and tape recorded with the explicit permission of the participants, and the tapes were later transcribed for review and analysis.

Limitations of qualitative research

Focus groups are a qualitative research methodology. The technique is exploratory only and seeks to develop *directions* rather than quantitatively precise or absolute measures. Because of the limited number of respondents involved in this type of research, the results should be used to generate hypotheses for policy decision making and further testing. The non-statistical nature of qualitative research means the results cannot be generalized to the population under study with a known level of statistical significance.

Findings from the focus groups

In many ways, the findings from the focus groups mirrored the findings from the mail survey, and thus various evidence and quotes appeared in the above analysis. Due to the informal and dynamic nature of focus groups, however, it is important to note that the ***only issue*** on which participants agreed was that health insurance is an increasingly expensive benefit to offer. Participants debated and discussed the issues described below (and more), and in many cases, participants disagreed or expressed varying points of view.

Administration of Employer-Sponsored Health Insurance Plans

According to the focus group participants, administration and management of employer-sponsored plans is timely and expensive. The process for applying for group insurance, finding the “right” plan, understanding the rates and coverage, paperwork, phone calls, and changes in quotes and policies taxes business owners (particularly when they do not have a benefits specialist within their company). While all participating business owners and representatives report utilizing insurance broker services, they describe varying degrees of administrative challenges. Those businesses that do currently offer insurance to their employees spend time investigating different health insurance companies and plans to reduce costs as well as assisting their employees with claims and other paperwork. Many of the businesses that do not currently

offer insurance to their employees continuously investigate whether or not they might be able to afford it in the future; they also counsel their employees on how to find individual coverage, and in some cases, even invite individual policy representatives into the business to sell their products to the employees. One participant in Memphis, however, does not invest time or energy into investigating options and offers insight into why he does not: “My business has been open for not quite four years. I knew a couple of my employees had some health issues. I knew that would be a barrier and that the rates would be through the roof. So that was my frame of mind going into it. It’s just never been a thought, because I’ve maintained between two and six employees. It just wasn’t going to be practical.”

Business Practice and Behavioral Distortions

Focus group participants report two primary distortions in their business practices and in their behavior that they attribute directly to the availability and cost of employer-sponsored health insurance. First, some business owners evaluate the health and age of potential employees before making hiring decisions (even though they know they should not) because they fear that their health insurance costs will increase if they add an unhealthy or older individual to their plans. Along these same lines, business owners—because they know that they will have to complete the detailed application forms—find themselves stepping away from their employees, refusing to discuss family or health issues with their employees.

The second distortion focus group participants identified is behavioral. Many participants report that if and when they or their employees seek medical care depends primarily on their health insurance coverage, not on their health. If they do not have insurance coverage, they do not want to go to the doctor because they can not pay for it or because they are embarrassed. Even if they have insurance, they do not go to the doctor because they do not want to learn they have an illness that might increase the insurance cost for their entire group. In fact, one participant who was faced with serious health problems and knew that her health problems were raising the cost for her entire company offered to quit the job: “I offered to quit when this happened to us. I said, ‘Do you want me to leave? I’ll go deal with my own problems and buy off.’”

Solutions

In response to questions like “what would make it easier” to offer or keep health insurance and “what could the federal, state, or local government or the state’s Commissioner of Insurance do,” focus group participants’ responses varied.

“Not a Rescue, an Education” (Memphis)

In one focus group, participants list educational services they would like the government to provide—rather than any other kind of tax break or incentive. For instance, these participants suggest that the government (at whatever level) produce literature, commercials, billboards, workbooks, handbooks to 1) teach every individual to be responsible for their own health and to 2) educate individuals on budgeting such that health care cost enters into the budget on the individual level rather than on the employer’s level.

“Find a way to stop treating me differently than everybody else” (Nashville)

In these focus groups, employers with fewer than 26 employees report that insurance companies require them to fill out detailed paperwork on each employee, rate their risk based on that detail, and require at least 75 percent participation rates. Business owners perceive that they are either priced out of the market entirely (via risk assessments that lead to very high costs) or are eliminated from eligibility (via participation rates). One participant states: “Small business is a group just as much as big business. Let us have the same opportunities to negotiate and purchase that big business has.” Along those same lines, participants perceive a problem more-wide spread than health insurance: the government provides different opportunities to large firms than they do to small. “I don’t think [the government] has to give us health insurance. I think they need to offer small businesses some type of incentive to stay small, because there’s a benefit of being a large corporation. There’s no benefit to being a small corporation. Large corporations get all the tax benefits; they come into the state of Tennessee, and ‘we’ll give you this, you don’t have to pay taxes.’ A small business buys the same property, they don’t get a benefit. There’s no incentive for my company to stay small.”

“Be more responsible” (Memphis)

Focus group participants express concern over the attitudes of individuals, employers, health care providers, and the government toward health care. In some cases, participants report that health care and health insurance should be the responsibility of an individual—that each

individual should be vested in his/her plan and should take responsibility for maintaining his/her own health. In other cases, participants identify uninsurable individuals who can not necessarily care or pay for themselves and encourage government assistance for those individuals.

The solutions outlined above are just a few ideas that arose during these focus groups. As would be expected with qualitative research, neither the problems nor the solutions for one employer were necessarily the problems or solutions for another.

Appendix A: Mail Survey Cover Letter



STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-5065
615-741-6007

PHIL BREDESEN
GOVERNOR

PAULA A. FLOWERS
COMMISSIONER

January 28, 2005

Dear Tennessee Employer:

We need your help! In an effort to address the lack of affordable health care coverage in our state, the Tennessee Department of Commerce & Insurance (TDCI) and the Center for Business and Economic Research (CBER) at the University of Tennessee are asking you to **please** take time to complete the enclosed **Tennessee Employer Health Insurance Survey**. This survey is being conducted by CBER in order to provide TDCI with an accurate profile of employer-sponsored health insurance coverage statewide, and to identify key health care issues facing Tennessee businesses. *Your input is very important no matter whether you offer OR do not offer health insurance.* The results of this survey will help state officials identify ways to expand health care coverage for Tennesseans.

For survey results to be representative of all Tennessee employers, a scientific random sample of employers has been chosen to receive the enclosed questionnaire. Your input is vital to the success of the survey. *All information provided will be held strictly confidential. Data will be summarized and reported in the aggregate, preventing any identification of individual businesses. No data for individual establishments will be released to any other agency, state or federal, or used for any other purpose. If there is a question you do not want to answer, please skip it and go on to the next question.*

Because of the importance of this information, we ask that you complete the survey and return it to CBER by **February 22, 2005**. If your business has several different locations/branches/outlets, please restrict your answers to the site at the address above. A postage-paid, self-addressed envelope is enclosed for your convenience. Should you have any questions regarding the survey, please call Dianne Marshall in CBER at the University of Tennessee at 865-974-6080. You may also contact Dianne by e-mail (inssurvey@utk.edu) or by fax (865-974-3100).

Thank you in advance for your participation.

Paula A. Flowers
Commissioner
Department of Commerce & Insurance

William F. Fox
Director
Center for Business and Economic Research
The University of Tennessee

Appendix B: Mail Survey

Tennessee Employer Health Insurance Survey

Please return in postage pre-paid envelope to:
Center for Business and Economic Research
The University of Tennessee
804 Volunteer Blvd., 101A Temple Court
Knoxville, TN 37996-4334
Or fax to (865) 974-3100

Questions? Call (865) 974-6080

Please return by **February 22, 2005**

All responses will remain strictly confidential.

The following questions refer to the number of employees working for your organization **at this site or location**. The number of employees refers to both full- and part-time employees but excludes contract employees. The site or location could be a single site, office, or factory, or it could mean an office complex or group of buildings that make up this particular location for your business. Please do NOT include employees that work for your organization at other locations in Tennessee or elsewhere.

1. How long has your company (or Parent Company) been in business?
 less than 1 year 1-4 years 5-9 years 10-19 years 20 or more years
2. **On average in calendar year 2004**, approximately how many employees, including management, did your organization employ **AT THIS SITE?** (Exclude contract employees.)

	<i>Employee Category</i>	Number of employees	Don't know	None
a.	Full-time employees		<input type="checkbox"/>	<input type="checkbox"/>
b.	Part-time employees		<input type="checkbox"/>	<input type="checkbox"/>
c.	Seasonal employees (full-time and part-time)		<input type="checkbox"/>	<input type="checkbox"/>
d.	TOTAL NUMBER OF EMPLOYEES		<input type="checkbox"/>	<input type="checkbox"/>

3. Which category below **BEST DESCRIBES** the principal business activity at this location? If more than one apply, mark the category which generates the most revenue. (Check ONE only).

<input type="checkbox"/> agriculture/forestry/fishing/hunting	<input type="checkbox"/> wholesale trade	<input type="checkbox"/> utilities	<input type="checkbox"/> leisure/hospitality services
<input type="checkbox"/> mining	<input type="checkbox"/> retail trade	<input type="checkbox"/> religious/civic/non-profit	<input type="checkbox"/> other: _____
<input type="checkbox"/> construction	<input type="checkbox"/> transportation	<input type="checkbox"/> information	
<input type="checkbox"/> manufacturing	<input type="checkbox"/> warehousing	<input type="checkbox"/> professional/business services	
<input type="checkbox"/> financial activities	<input type="checkbox"/> education	<input type="checkbox"/> health services	
4. What do you think is the most important reason to provide health insurance?
 To attract/retain employees It's the right thing to do Don't think it's important Other _____
5. What is the average annual salary of all of your salaried employees?
 Below \$15,000 \$20,000-24,999 \$30,000-34,999 \$40,000-44,999 \$50,000-54,999
 \$15,000-19,999 \$25,000-29,999 \$35,000-39,999 \$45,000-49,999 \$55,000 or more
6. What is the average annual salary of all of your hourly employees?
 Below \$15,000 \$20,000-24,999 \$30,000-34,999 \$40,000-44,999 \$50,000-54,999
 \$15,000-19,999 \$25,000-29,999 \$35,000-39,999 \$45,000-49,999 \$55,000 or more
7. Do you offer health insurance benefits to:
 ALL of your employees? **SOME** of your employees? **NONE** of your employees? →

If NONE, please skip to Question 33 to complete this survey

General Questions for Organizations that Offer Health Insurance to All or Some Employees

8. How many years has your company (or Parent Company) offered health insurance?
 Less than one 1-2 years 3-5 years 6-10 years 11-15 years More than 15 years Don't know
9. Are health benefit decisions made at this location? Yes No Don't know
 If "No," does your company permit input or recommendations from local managers? Yes No Don't know
10. How many health plan options do you offer employees?
 One option Two options Three options More than three options Don't know
11. What percentage of your total budgeted payroll expense was spent on the employer portion of health insurance in calendar year 2004? (Total employer contribution ÷ total budgeted payroll)
 5.9% or less 6%-10.9% 11%-15.9% 16%-19.9% 20% or more Don't know
12. On average, what share of all health insurance premiums does your company pay?
 (Total employer contribution ÷ total premium cost)
 0% 1.0%–24.9% 25.0%–49.9% 50.0%–74.9% 75.0%–79.9% 80.0%–89.9% 90%–100% Don't know
13. On average, what is your employer contribution per employee for health insurance?
 (Total employer contribution ÷ employees enrolled) \$ _____ Don't know
14. Approximately what percent increase or decrease occurred in your company's total health insurance cost (employer + employee) in **2004**?
 _____% increase _____% decrease None Don't know
15. Approximately what percent increase or decrease do you anticipate in your company's total health insurance cost in **2005**?
 _____% increase _____% decrease None Don't know
16. Have insurance rate increases caused your company to do any of the following in the past 2 years? (check all that apply)
 Move to a different insurance carrier or network Change insurance benefit plan design Drop health insurance plan
 Change insurance plan funding Increase employee contributions Other _____
17. What is the minimum number of hours **per week** an employee must work to be eligible for health insurance coverage?
 No minimum Number of hours per week: _____ Don't know
18. Please identify which employee groups are eligible for health insurance benefits.
 (Check one box in each row and list the appropriate number of eligible employees in each row).

	Employment Category	Yes	Number Eligible	Don't know	No such employees
a.	Full-time / salaried	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
b.	Full-time / hourly	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
c.	Part-time employees	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
d.	Seasonal employees (full-time / part-time)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
e.	Other? (please describe) _____	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

19. Of the number **ELIGIBLE** for health insurance, approximately how many employees are **ENROLLED**?
 Number of eligible employees enrolled: _____ Don't know
20. Compared to the previous 2 years, did the percentage of employees who chose to waive or decline health insurance increase, decrease, or remain about the same in 2004? (Please check only one.)
 Increased Remained about the same Decreased Don't know
21. Do you offer health insurance that covers the following groups? (Please check one box in each row.)
- a. Spouses of employees? Yes No Don't know
- b. Domestic partners of employees Yes No Don't know
- c. Dependent children enrolled as full-time students? Yes No Don't know If yes, up to what age? _____
- d. Dependent children not enrolled as full-time students? ... Yes No Don't know If yes, up to what age? _____
22. For retirees under the age of 65 who have worked the required number of years, does your company allow retirees to continue coverage in the company's health plan (excluding coverage offered under COBRA or state of Tennessee's Continuation Plan)?
 Yes No Don't know

Please answer Questions 23 – 31 about the health plan with the **LARGEST** number of enrollees at this site.

23. What **type** of plan is the **largest health plan** (has the most participants) at this site (check one only.)
 Health maintenance organization (HMO) Point of service plan (POS)
 Preferred provider organization (PPO) Indemnity plan → **If Indemnity plan, Go to Question 32**

24. Is this plan with the largest number of employees, also the least expensive for the employee?
 Yes No Don't Know

25. Is this plan FULLY INSURED or EMPLOYER SELF-FUNDED? →→
 Fully insured → If Fully insured, **Go to Question 30**
 Employer self-funded

Your health plan is FULLY INSURED if it is purchased from an insurance company or other underwriter who assumes full risk for employees' medical expenses. A health plan is EMPLOYER SELF-FUNDED if an organization pays the claims from its own resources regardless of who administers the plan. If your company self-funds any part of its plan, please check the employer self-funded box.

26. How long has this plan been employer self-funded?
 Years _____ Don't know

27. How is this self-funded plan administered?
 Administered by a third party Administered by our company/organization → **Go to Question 29**

28. What is the name of the company that administers this self-funded health plan? _____

29. Which of the following reasons influenced your decision to self-fund? (Please check one box in each row.)

	Reason	Yes	No	Don't know
a.	The expected savings from self-funding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	To offer competitive health care benefits locally / nationally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	The discretion to be free from state mandates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	To offer a richer benefit package than is routinely available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	To customize benefit plans based on the needs of your company	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Other: please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Has the overall design of this health plan changed due to increases in employee health insurance costs in the past 12 months?
 Yes No → **Go to Question 31**

If Yes, did the plan change for any of the following reasons?

	Reasons for Health Plan Design Changes	Yes	No	Don't know
a.	Increasing co-payments for physician services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Introducing a new pharmacy co-payment structure such as a tiered structure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Increasing co-payments for diagnostic services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Increasing co-insurance? By how much? Amount: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Increasing maximum out-of-pocket expenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Increasing deductible?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Some other manner? If yes, what? Details: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Do you offer a sliding scale contribution, where you, the employer, pay more for lower-wage workers than for higher-wage workers?
 Yes No Don't know

32. **Please refer to Question 7 on Page 1.**

If you answered **ALL**, you have completed this survey. **We appreciate the time you have taken to complete this survey!**
 If you would like to provide additional written comments or participate in a voluntary group discussion about health insurance issues that are facing your company, please use the space at the **bottom of Page 4**.

If you answered **SOME** to Question 7 on Page 1, please respond to Questions 33-38 regarding **only the employee group or groups to which you do not offer health insurance coverage**.

General Questions for Organizations that Offer Health Insurance to SOME or NONE of their Employees

33. Following is a list of reasons why organizations might **not** offer employee health insurance to all or some of its employees. For each reason listed, please answer how important this reason was in your organization's decision not to offer health insurance. (Please check one box in each row.)

	Reason	Very Important	Somewhat Important	Not at All Important	Don't know
a.	Premiums were too high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Employee turnover is too great	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Employees generally are covered under other plans obtained elsewhere, such as through a spouse, a union, or Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	It is an administrative hassle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Most employees are part-time, temporary or contracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	We can attract good employees without offering health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	The organization is too newly established	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Financial status prohibits it at this time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	We've had either past negative claim experiences or past catastrophic claims	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Using reasons listed in Question 33a to 33i above, identify your organization's primary reason for not offering health insurance.

a b c d e f g h i Other: _____

35. Following is a list of possible incentives that might motivate an organization to start offering health insurance to all employees. For each reason listed, please answer how likely it would be to motivate your organization to offer health insurance. (Please check one box in each row.)

	Incentive	Very likely	Somewhat likely	Not likely at all	Don't know
a.	Lower premium rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Elimination of the required minimum employee participation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Implementation of a small business purchasing alliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Government subsidy of premiums for low-income employees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Tax credits for offering health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Being able to offer a very basic catastrophic hospital coverage plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. Using reasons listed in Question 35a to 35f above, identify what incentive would MOST motivate your organization to start offering health insurance.

a b c d e f Other: _____

37. If, in the future, you decided to offer employees health insurance, what is the maximum premium contribution the company could afford per employee per month?

Less than \$50 \$50 \$100 \$150 \$200 \$250 \$300 or more company would not purchase at any cost

38. Would you support and participate in a state of Tennessee sponsored "Insurance Partnership" which would help to pay for health insurance for both employers and employees in small business (up to 50 employees)? Yes No

We appreciate the time you have taken to complete this survey! If you would like to provide additional written comments, please use the space below. If you would like to provide more information, please attach additional pages.

<p>Please use the space below to provide any additional information you would like us to understand about the health insurance issues facing your company.</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>May we contact you later to participate in a voluntary group discussion about the health insurance challenges facing your business?</p> <p>Contact person: _____</p> <p>Phone number: _____</p> <p>Email address: _____</p>
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Appendix C: Raw Data for Selected Survey Questions

Below are the raw responses to certain survey questions of interest used in this report. Note: these are raw numbers and as such are unweighted. They may appear different from numbers reported in the body of this report, because the main analysis weighted responses to achieve the proper distribution of businesses across Grand Divisions and sizes. These numbers will be biased because of oversampling.

Table C-1: Years in Business

Response	Count	Percent
less than 1 year	24	1.0%
1-4 years	232	9.6%
5-9 years	349	14.5%
10-19 years	553	22.9%
20 or more years	1256	52.0%
Total	2414	

Table C-2: Principal Business Activity

Response	Count	Percent
agriculture/forestry/fishing/hunting	36	1.6%
mining	7	0.3%
construction	233	10.1%
manufacturing	128	5.6%
financial activities	125	5.4%
wholesale trade	527	23.0%
retail trade	69	3.0%
transportation	24	1.0%
warehousing	44	1.9%
education	11	0.5%
utilities	50	2.2%
religious/civic/nonprofit	6	0.3%
information	312	13.6%
professional/business services	262	11.4%
health services	100	4.4%
leisure/hospitality services	138	6.0%
other	224	9.8%
Total	2296	

Table C-3: Most Important Reason to Offer Insurance

Response	Count	Percent
To attract/retain employees	1490	64.3%
It's the right thing to do	685	29.6%
Don't think it's important	112	4.8%
Other	30	1.3%
Total	2317	

Table C-4: Average Annual Salary for Salaried Employees

Response	Count	Percent
Below \$15,000	147	6.6%
\$15,000-\$19,999	104	4.7%
\$20,000-\$24,999	233	10.4%
\$25,000-\$29,999	305	13.7%
\$30,000-\$34,999	328	14.7%
\$35,000-\$39,999	225	10.1%
\$40,000-\$44,999	218	9.8%
\$45,000-\$49,999	150	6.7%
\$50,000-\$54,999	143	6.4%
\$55,000 or more	379	17.0%
Total	2232	

Table C-5: Average Annual Salary for Hourly Employees

Response	Count	Percent
Below \$15,000	512	22.8%
\$15,000-\$19,999	434	19.3%
\$20,000-\$24,999	521	23.2%
\$25,000-\$29,999	335	14.9%
\$30,000-\$34,999	229	10.2%
\$35,000-\$39,999	90	4.0%
\$40,000-\$44,999	57	2.5%
\$45,000-\$49,999	17	0.8%
\$50,000-\$54,999	11	0.5%
\$55,000 or more	41	1.8%
Total	2247	

Table C-6: Do You Offer Insurance?

Response	Count	Percent
to ALL employees	1045	39.7%
to SOME employees	541	20.6%
to NONE of my employees	1043	39.7%
Total	2629	

Table C-7: How Many Years have You Offered Insurance?

Response	Count	Percent
Less than one	24	1.5%
1-2 years	60	3.8%
3-5 years	182	11.6%
6-10 years	267	17.0%
11-15 years	140	8.9%
More than 15 years	829	52.7%
Don't know	72	4.6%
Total	1574	

Table C-8: Decisions Made at this Location?

Response	Count	Percent
Yes	1087	68.5%
No	494	31.1%
Don't know	7	0.4%
Total	1588	

Table C-9: Input from Local Managers?

Response	Count	Percent
Yes	249	52.6%
No	187	39.5%
Don't know	37	7.8%
Total	473	

Table C-10: Number of Plans Offered

Response	Count	Percent
One option	1063	67.1%
Two options	316	19.9%
Three options	136	8.6%
More than three options	51	3.2%
Don't know	18	1.1%
Total	1584	

Table C-11: Healthcare as a Percent of Total Payroll

Response	Count	Percent
5.9% or less	289	19.9%
6%-10.9%	307	21.1%
11%-15.9%	159	11.0%
16%-19.9%	168	11.6%
20% or more	65	4.5%
Don't know	464	32.0%
Total	1452	

Table C-12: Employer Share of Insurance Premiums

Response	Count	Percent
0%	21	1.4%
1.0%-24.9%	97	6.3%
25.0%-49.9%	123	8.0%
50.0%-74.9%	408	26.5%
75.0%-79.9%	150	9.7%
80.0%-89.9%	154	10.0%
90%-100%	512	33.2%
Don't know	75	4.9%
Total	1540	

Table C-13: Insurance Cost Increase or Decrease in 2004

Response	Count	Percent
Increased	1114	72.2%
Decreased	63	4.1%
None	171	11.1%
Don't know	194	12.6%
Total	1542	

Table C-14: Minimum Number of Part Time Hours Required for Eligibility

Reponses:	1584
Mean:	27.73
Median:	30

Table C-15: Most Commonly Chosen Plan Type

Response	Count	Percent
HMO	131	8.6%
POS	80	5.2%
PPO	1308	85.8%
Indemnity	6	0.4%
Total	1525	

Table C-16: Self Funded vs. Fully Insured

Response	Count	Percent
Fully Insured	1185	79.1%
Employer Self-Funded	314	20.9%
Total	1499	

Table C-17: Primary Reason for not Offering Insurance

Response	Count	Percent
Premiums were too high	662	50.4%
Employee turnover is too great	80	6.1%
Employees are generally covered elsewhere	181	13.8%
It was an administrative hassle	8	0.6%
Most employees are part-time or temporary	193	14.7%
Can attract good employees without offering	10	0.8%
The organization is too newly established	13	1.0%
Financial Status prohibits it	159	12.1%
We've had past negative experiences	8	0.6%
Total	1314	

Table C-18: Primary Incentive to Begin Offering Insurance

Response	Count	Percent
Lower premiums	734	62.7%
Elimination of required minimum participation	69	5.9%
Implementation of small business alliance	75	6.4%
Government subsidy for low-income employees	88	7.5%
Tax credits	133	11.4%
Being able to offer basic catastrophic coverage	72	6.1%
Total	1171	

Table C-19: Maximum Contribution Company Could Afford

Response	Count	Percent
Less than 50	342	27.2%
\$50	213	16.9%
\$100	224	17.8%
\$150	99	7.9%
\$200	92	7.3%
\$250	41	3.3%
300 or more	49	3.9%
Could not purchase at any cost	199	15.8%
Total	1259	

Appendix D: Focus Group Moderator's Topic Guides

Focus Group Questions for Companies That Don't Offer Insurance

1. Tell us your name and in about two sentences tell us about your business.
2. At some point you decided that health insurance wasn't a benefit your business was going to offer to employees. Can you tell us what factors you considered in making the decision?
3. Have any of you offered employees health insurance or money to buy health insurance in the past? What prompted the change?
4. Have your employees ever indicated that they wished you offered coverage? Do they care?
5. What influence does not offering health insurance have on your ability to find and keep good quality employees?
6. Do you give your employees information about other health insurance options?
7. What do your employees do for health insurance? (Through spouse? Not get it?)
8. What makes it hard for you to offer health insurance? What gets in the way?
9. What would make it easier for you to offer health insurance?
10. What could state or federal government do to help you provide insurance to employees?
11. Here are three different kinds of programs that could be used to reduce the cost of insurance: (See handout)
 - Premium sharing
 - Small employer tax credits
 - Stop-loss protection
 - a. What do you see as the advantages and disadvantages of each of these?
 - b. How would you feel about participating in any of these programs?
12. Let's say you had a minute to give advice to the Commissioner of the Department of Insurance. What do you think should be done to help employers provide health insurance?

Focus Group Questions for Companies That Offer Insurance

1. Tell us your name and in about two sentences tell us about your business.
2. At some point you decided to offer health insurance as a benefit. Can you tell us what factors you considered in making the decision?
3. Have any of you not offered health insurance in the past? What prompted the change?
4. Do some employees choose not to enroll in the health insurance that is offered? Why? Tell us about those situations.
5. Do you have employees who aren't eligible for your health insurance? What makes them ineligible? Tell us about those situations.
6. What do you see as the value of health insurance to your company?
7. What is hard about offering health insurance? What makes it difficult?
8. What would make it easier for you to offer health insurance?
9. What could the state or federal government do to make it easier for you to provide health insurance to employees?
10. Here are three different kinds of programs that could be used to reduce the cost of insurance: (See handout)
 - Premium sharing
 - Small employer tax credits
 - Stop-loss protection
 - a. What do you see as the advantages and disadvantages of each of these?
 - b. How would you feel about participating in any of these programs?
12. Let's say you had a minute to give advice to the Commissioner of the Department of Insurance. What do you think should be done to help employers provide health insurance?

Focus Group Handout Three Programs that Could be Used To Reduce the Cost of Insurance

Premium Sharing

- An incentive to employers to offer coverage for their employees
- The employer pays \$50 per month per person for coverage.
- The employee pays \$25 per month
- The remaining cost of coverage per employee is split evenly between the state and federal governments.

Small employer tax credits

- Refundable tax credits to small employers newly offering coverage.
- In years 1 and 2, credit is \$35 per month per employee or 50 percent of total annual premium, whichever is less.
- The tax credits phase out over 5 years.

Stop-loss protection (or also referred to as Risk Sharing)

- Requires health plans to offer:
- Scaled-down health plans (exempt from certain state-mandated benefits)
- Provides stop-loss protection (90 percent of claims that fall from \$30,000 to \$100,000 for each member) to health plans, thereby making low-cost plans available.
- This would be a government subsidy to health plans for small employers
- This protection reduces the volatility of premiums by limiting the impact that high cost cases can have on employer premiums.

The Health of Tennessee's Health Insurers

May 13, 2005

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Acknowledgements: The Tennessee financial information was graciously supplied by Robert Ripe and Trey Hancock of the Financial Affairs Section (State of Tennessee). The other state and US financial data was purchased from A.M Best Company.

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I. Project Overview and Background

According to project guidelines set forth by the Department of Commerce and Insurance representatives Jay Harrington and Kristin Coile, a report was to be prepared on the health of Tennessee's health insurers for years 2003, 2002, and 2001, similar to a report prepared for the Rhode Island health insurers ("The Health of RI's Health Insurers," Cryan, 2003). The following Tennessee organizations, which represented the majority of the premium income in the state, were to be included in the analysis: Aetna Health Inc. TN Corp., BCBS of TN Inc., Cariten Health Plan, Cariten Ins. Co., Cigna Healthcare of TN Inc., Humana Health Plan Inc., John Deere Health Plan Inc., and United Healthcare of TN. Each of these organizations was to be analyzed individually. The Tennessee health insurer information was also to be compared with Missouri, Kentucky, and Georgia as well as the overall United States health insurer industry. This benchmark financial information was purchased from A.M. Best Company. The Tennessee financial information was graciously supplied by Robert Ripe and Trey Hancock of the Financial Affairs Section (State of Tennessee).

As with the Rhode Island report, ratio analysis is used to assess the performance of these health insurers. This report examines financial operations only. It does not include information on other aspects of performance such as access, utilization, and satisfaction, et cetera. All health insurers are evaluated regardless of tax status, product line or organizational structure differences.

In addition, an overall market and product business line summary reports were to be prepared on the Tennessee health insurance market for the same period. In other words, these reports would summarize by year the premium income and underwriting gain (loss) generated for each of the above health insurers and aggregate by specific business line by year premium income and underwriting gain (loss) for all the above health insurers. Again, this information was graciously supplied by Robert Ripe and Trey Hancock of the Financial Affairs Section (State of Tennessee). The data was drawn from page 7 of the Annual Statement Health Blank: "Analysis of Operation by Lines of Business (Gain and Loss Exhibit)." As Mr. Hancock pointed out, "The majority of the companies only have information completed for the Comprehensive (Hospital and Medical) line. The other lines of business reported are Medicare Supplement, Dental only, Vision Only, Federal Employees, Medicare, Medicaid, Stop Loss, Disability Income, Long Term Care, Other Health, and Other Non-Health."

The ratios shown in this report are developed from raw financial numbers in the statutory reports, which are not included in this report. The Tennessee state level numbers (i.e., the numbers used to compare Tennessee with the other states and US) are averages of each of the data items analyzed. For example, the number for cash and short-term investments—used in the development of the current ratio—would be the average of the eight companies noted above. A.M. Best Company numbers are also averages of all the health insurers writing policies in that particular state or (for the overall US) averages of all US health insurers. Consequently, more companies may be included in the average numbers reported for Georgia, Kentucky, Missouri and the US

Blue Cross Blue Shield of Tennessee is classified as a nonprofit organization¹ under the business type filings with the Tennessee Secretary of State. However, according to Susan Prudowsky, Manager, Corporate Communications of Blue Cross Blue Shield of Tennessee (BCBS), “BCBS plans are taxable as commercial insurance companies under IRS code section 833 and have the same filing requirements as other commercial insurance companies—and not as other not-for-profit foundations.” Accordingly, I have treated BCBS as a for-profit organization in line with the seven other organizations included in this analysis. Finally, Cariten Ins. Co. did not provide a health blank for 2001; only totals were provided. For uniformity in the segment analysis, all Cariten Ins. Co. numbers for 2001 were placed in the category Comprehensive Hospital and Medical.

To make the numeric and graphical information easier to follow, abbreviated names were used for the Tennessee health insurers and the states:

Tennessee Health Insurer:	Abbreviated Name:
Aetna Health Inc. TN Corp.	AHTN
BCBS of TN Inc.	BCBS
Cariten Health Plan	CAHP
Cariten Ins. Co.	CAIC
Cigna Healthcare of TN Inc.	CHTN
Humana Health Plan Inc.	HHPI
John Deere Health Plan Inc.	JDHP
United Healthcare of TN.	UHTN

States and US Averages:	Abbreviated Name:
Tennessee	TN
Georgia	GA
Kentucky	KY
Missouri	MO
United States	US

Business Product Line	Abbreviated Name:
Comp (Hospital & Medical)	COMP
Medicare Supplement	MS
Dental Only	DO
Federal Health Employee Benefit	FHEB
Title XVII – Medicare	XVII
Title XIX – Medicaid	XIX
Other	Other

¹ The nonprofit status of Tennessee Rural Health was also investigated and revealed that Tennessee Rural Health is not an tax-exempt organization according to IRS code and therefore is not required to provide a Form 990. Tennessee Rural Health was not included in this analysis.

II. Executive Summary

Overall Tennessee Health Insurer Market Summary

The eight health insurers in Tennessee constitute a \$5.1 billion dollar industry. The two largest health insurers in 2003 in terms of net premium income are Blue Cross Blue Shield (\$1.5 billion) and Humana Health Plan Inc. (\$2.2 billion). The two most profitable organizations in 2003 in terms of absolute value of underwriting gains are Blue Cross Blue Shield (\$113 million) and Humana Health Plan Inc. (\$43 million). The three most profitable companies in 2003 in terms of net underwriting margin (i.e., relative to net premium income) in 2003 are Aetna Health Inc. TN Corp. (15.58 percent), United Healthcare of TN (8.27 percent), and BCBS of TN Inc. (7.14 percent).

Overall Tennessee Product Business Line Summary

The three largest business lines of insurance written by these eight Tennessee organizations in 2003 are Comprehensive Hospital and Medical (\$3.8 billion), Title XVII – Medicare (\$782 million), and Federal Health Employee Benefit (\$367 million). The two most profitable product business lines in 2003 in terms of absolute value of underwriting gains are Comprehensive Hospital and Medical (\$112 million) and Title XVII – Medicare (\$43 million). The three most profitable business lines in 2003 in terms of net underwriting margin (i.e., relative to net premium income) in 2003 are Dental Only (11.48 percent), Medicare Supplement (10.69 percent), and Title XVII – Medicare (5.43 percent).

Overall Ratio Analysis

Table 1 compares Tennessee firms to their state counterparts (Kentucky, Georgia and Missouri) and overall US averages for the three-year period, 2001 to 2003, in terms of profitability, liquidity, leverage, and efficiency. Profitability measures the overall financial performance of an organization. Higher values are preferred. Two profitability measures are highlighted: net profit margin and return on assets. These two measures represent the organization's ability to translate revenue and assets into profits. Liquidity measures the ability of a health insurer to cover its current obligations. Two liquidity measures are highlighted: claims payment period and current ratio. From a liquidity standpoint, lower values are preferred for claims payment period while higher values are preferred for the current ratio. Deterioration in these measures can indicate potential cash flow problems and financial difficulty.

Leverage measures the extent of the firm's financing with debt and current liabilities. The amount and proportion of debt (current and long-term) is important in analyzing the potential risk of an organization. In this section, two leverage measures are highlighted: months reserves and debt ratio. From a leverage standpoint, higher values are preferred for months reserves and lower values are preferred for the debt ratio. Deterioration in these measures can indicate that organizations may have difficulty meeting their fixed commitments and therefore enterprise risk increases. Efficiency refers to how the health insurer is managing its business. Two efficiency measures are examined: total asset turnover and general administrative expense ratio. From an efficiency standpoint, higher values are preferred for asset turnover and lower values are preferred for the administrative expense ratio. Total asset turnover measures the organization's

efficiency in terms of generating revenues from the existing assets. Administrative expense ratio measures the efficiency of administrative activities in terms of each dollar of revenue generated.

**Table 1:
Overall Ratio Analysis of Tennessee Firms, Other States, and the US**

(Numbers and ratios below are averages over the 2001 - 2003 period)				
	Preferred Values	TN Firms	State Counterparts	US
Profitability Measures:				
Net Profit Margins	Higher	2.12%	2.63%	2.42%
Return on Assets	Higher	5.50%	8.84%	6.23%
Liquidity Measures:				
Claims Payment Period	Lower	42.38 days	44.99 days	46.87 days
Current Ratio	Higher	.70	.58	.80
Leverage Measures:				
Months Reserves	Higher	2.39	1.73	1.92
Debt Ratio	Lower	49.10%	57.74%	60.91%
Efficiency:				
Asset Turnover	Higher	2.60	3.16	2.62
Administrative Overhead	Lower	10.60%	9.72%	8.65%

Overall, Tennessee health insurers have:

- (1) lower profit margins and return on assets compared with their state counterparts and US industry averages,
- (2) a lower claims payment period compared with their state counterparts and the US average and have a higher current ratio than their state counterparts but lower than the US industry averages,
- (3) higher months reserves and lower debt ratios compared with their state counterparts and US industry averages, and
- (4) lower asset turnover and higher administrative overhead compared with their state counterparts and US industry averages.

It appears that Tennessee firms, on average, are less profitable, are in a better liquidity and leverage position, have higher administrative expenses, and lower ability to turn assets into revenues than their state counterparts and US averages.

III. Market Overview

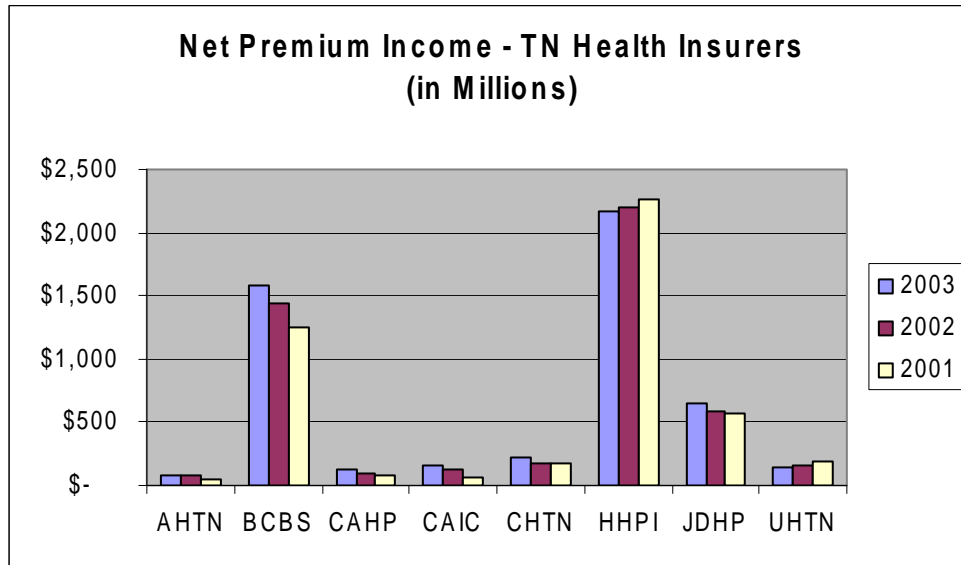
The eight health insurers in Tennessee constitute a \$5.1 billion dollar industry. The two largest health insurers in 2003 in terms of net premium income are Blue Cross Blue Shield (\$1.5 billion) and Humana Health Plan Inc. (\$2.2 billion). The two most profitable organizations in 2003 in terms of absolute value of underwriting gains are Blue Cross Blue Shield (\$113 million) and Humana Health Plan Inc. (\$43 million). The three most profitable companies in 2003 in terms of net underwriting margin (i.e., relative to net premium income) in 2003 are Aetna Health Inc. TN Corp. (15.58 percent), United Healthcare of TN (8.27 percent), and BCBS of TN Inc. (7.14 percent).

Net premium income increases 10.56 percent from 2001 to 2003 (see Table 2 and Figure 1). Underwriting gains (losses) change from a loss of \$33 million in 2001 to a gain of \$164 million in 2003 (see Table 3 and Figure 2). Overall, it appears that the industry net premium income is growing at an approximate annual rate of 5.28 percent and the financial strength (e.g. profitability) of the industry is improving. Net industry underwriting margins increase from a -.7 percent in 2001 to a 3.21 percent in 2003 (see Table 4 and Figure 3). However, this net underwriting margin increase is not equally distributed across the eight Tennessee health insurers. Cariten Ins. Co., Cigna Healthcare of TN Inc., and John Deere Health Plan Inc. report net underwriting margin losses for 2003 of -\$ 7 million, -\$ 6 million, and -\$ 5 million. In fact, Cariten Ins. Co. reports net underwriting margin losses for all three years.

Table 2:
Net Premium Income for Tennessee Insurers

	(in millions)		
	2003	2002	2001
Aetna Health Inc. TN Corp.	\$ 84	\$ 86	\$ 44
BCBS of TN Inc.	\$ 1,577	\$ 1,445	\$ 1,247
Cariten Health Plan	\$ 132	\$ 103	\$ 75
Cariten Ins. Co.	\$ 157	\$ 121	\$ 65
Cigna Healthcare of TN Inc.	\$ 221	\$ 172	\$ 174
Humana Health Plan Inc.	\$ 2,171	\$ 2,200	\$ 2,259
John Deere Health Plan Inc.	\$ 642	\$ 586	\$ 572
United Healthcare of TN.	\$ 136	\$ 165	\$ 196
Total	\$ 5,119	\$ 4,878	\$ 4,630

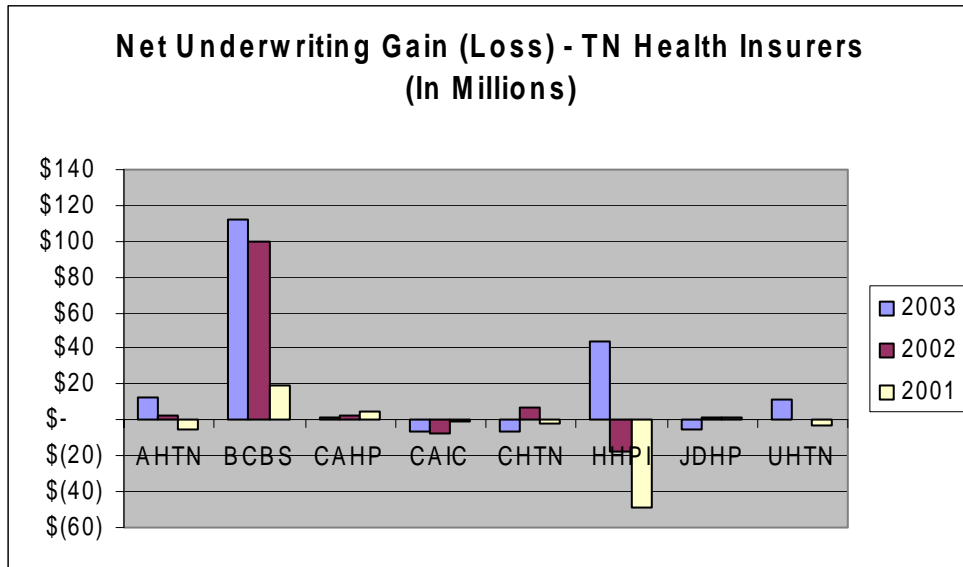
Figure 1:



**Table 3:
Net Underwriting Gain (Loss) for Tennessee Insurers
(in millions)**

	(in millions)		
	2003	2002	2001
Aetna Health Inc. TN Corp.	\$ 13	\$ 2	\$ (5)
BCBS of TN Inc.	\$ 113	\$ 99	\$ 19
Cariten Health Plan	\$ 2	\$ 3	\$ 5
Cariten Ins. Co.	\$ (7)	\$ (7)	\$ (1)
Cigna Healthcare of TN Inc.	\$ (6)	\$ 7	\$ (2)
Humana Health Plan Inc.	\$ 43	\$ (18)	\$ (48)
John Deere Health Plan Inc.	\$ (5)	\$ 1	\$ 2
United Healthcare of TN.	\$ 11	\$ 0	\$ (3)
Total	\$ 164	\$ 88	\$ (33)

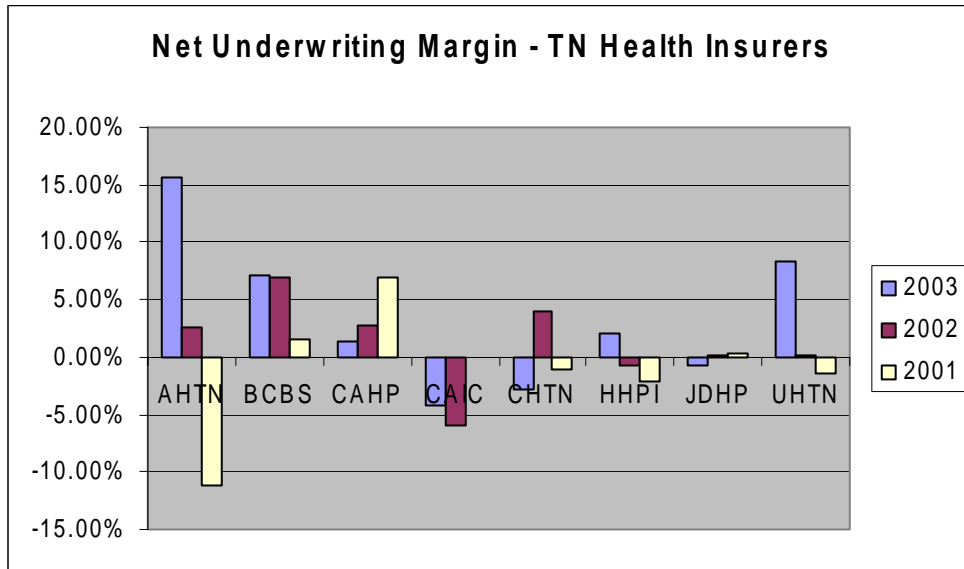
Figure 2:



**Table 4
Net Underwriting Margin for Tennessee Insurers**

	2003	2002	2001
Aetna Health Inc. TN Corp.	15.58%	2.55%	-11.09%
BCBS of TN Inc.	7.14%	6.87%	1.52%
Cariten Health Plan	1.33%	2.73%	7.02%
Cariten Ins. Co.	-4.26%	-5.89%	-1.11%
Cigna Healthcare of TN Inc.	-2.83%	3.97%	-1.05%
Humana Health Plan Inc.	2.00%	-0.80%	-2.15%
John Deere Health Plan Inc.	-0.80%	0.20%	0.34%
United Healthcare of TN.	8.27%	0.23%	-1.48%
Total	3.21%	1.81%	-0.70%

Figure 3:



IV. Product Business Line Overview

The three largest business lines of insurance written by these eight Tennessee organizations in 2003 are Comprehensive Hospital and Medical (\$3.750 billion), Title XVII – Medicare (\$782 million), and Federal Health Employee Benefit (\$367 million). The two most profitable product business lines in 2003 in terms of absolute value of underwriting gains are Comprehensive Hospital and Medical (\$112 million) and Title XVII – Medicare (\$43 million). The three most profitable business lines in 2003 in terms of net underwriting margin (i.e., relative to net premium income) in 2003 are Dental Only (11.48 percent), Medicare Supplement (10.69 percent), and Title XVII – Medicare (5.43 percent).

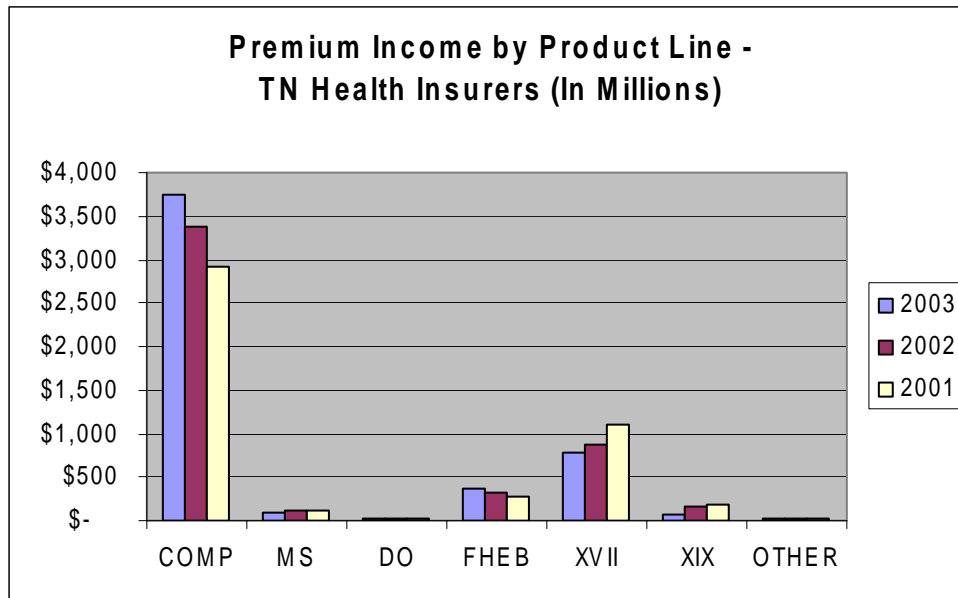
From 2001 to 2003, Comprehensive Hospital and Medical premium income increases 28.61 percent and Federal Health Employee Benefit premium income increases 29.0 percent (see Table 5 and Figure 4). Over the same period, Title XVII – Medicare premium income decreases -28.57 percent and Title XIX – Medicaid XIX premium income decreases -63.94 percent. Thus net premium income increases 10.56 percent from 2001 to 2003 (i.e., average rate of 5.28 percent) while the decrease in Title XVII and Title XIX premiums appears to offset with increases in Comprehensive Hospital and Medical and Federal Health Employee Benefit premiums. Net industry underwriting margins also increase from a -.7 percent in 2001 to a 3.21 percent in 2003, but this increase is not equally distributed among product business lines (see Tables 6 and 7 and Figures 5 and 6 for both dollars and percent of premium gains (losses)). From 2001 to 2003, Title XVII – Medicare, Comprehensive Hospital and Medical and Federal Health Employee Benefit net underwriting margins increase approximately 8.09 percent, 3.76 percent and 2.70 percent respectively. However, Title XIX – Medicaid net underwriting margins decrease approximately -12.27 percent over this same period. Thus, it appears that net premium income is increasing (decreasing) for product lines with positive (negative) underwriting margins, with the exception of Title XVII – Medicare. While premiums decrease 28.57 percent from 2001 to

2003, net underwriting margins increase 8.09 percent. Two possible interpretations of this result are: 1) overhead expenses related specifically to XVII product line have decreased over this time period or 2) health insurers are making more underwriting profits on the business they kept in place.

**Table 5:
Premium Income by Product Line**

	(in millions)		
	2003	2002	2001
Comp (Hospital and Medical)	\$ 3,750	\$ 3,383	\$ 2,915
Medicare Supplement	\$ 102	\$ 105	\$ 104
Dental Only	\$ 33	\$ 33	\$ 31
Federal Health Employee Benefit	\$ 367	\$ 321	\$ 284
XVII – Medicare	\$ 782	\$ 870	\$ 1,095
XIX – Medicare	\$ 68	\$ 151	\$ 188
Other	\$ 17	\$ 15	\$ 12
Total	\$ 5,119	\$ 4,878	\$ 4,630

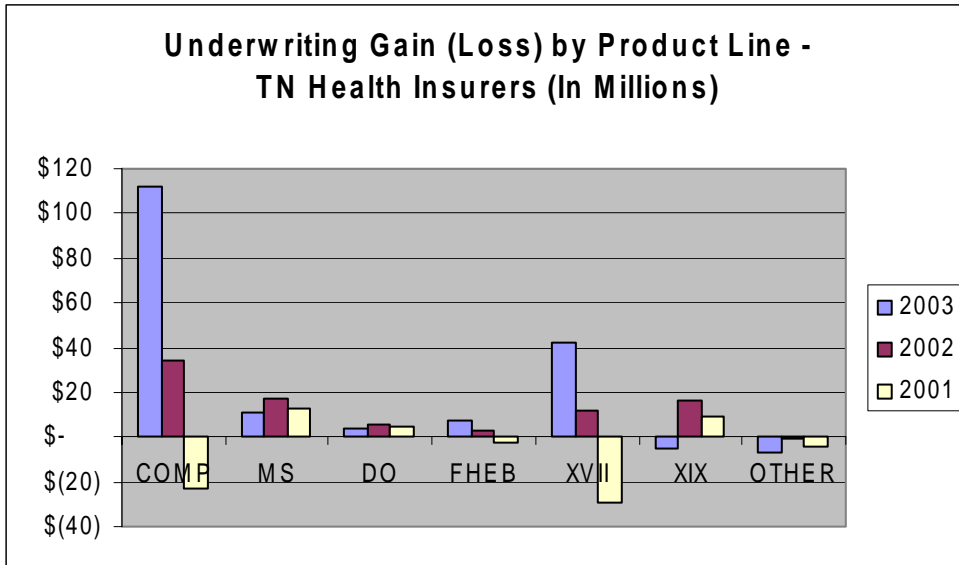
Figure 4:



**Table 6:
Underwriting Gain (Loss) by Product Line**

	(in millions)		
	2003	2002	2001
Comp (Hospital and Medical)	\$ 112	\$ 34	\$ (23)
Medicare Supplement	\$ 11	\$ 17	\$ 13
Dental Only	\$ 4	\$ 6	\$ 5
Federal Health Employee Benefit	\$ 7	\$ 3	\$ (2)
XVII – Medicare	\$ 43	\$ 11	\$ (29)
XIX – Medicare	\$ (5)	\$ 17	\$ 9
Other	\$ (7)	\$ (1)	\$ (5)
Total	\$ 164	\$ 88	\$ (33)

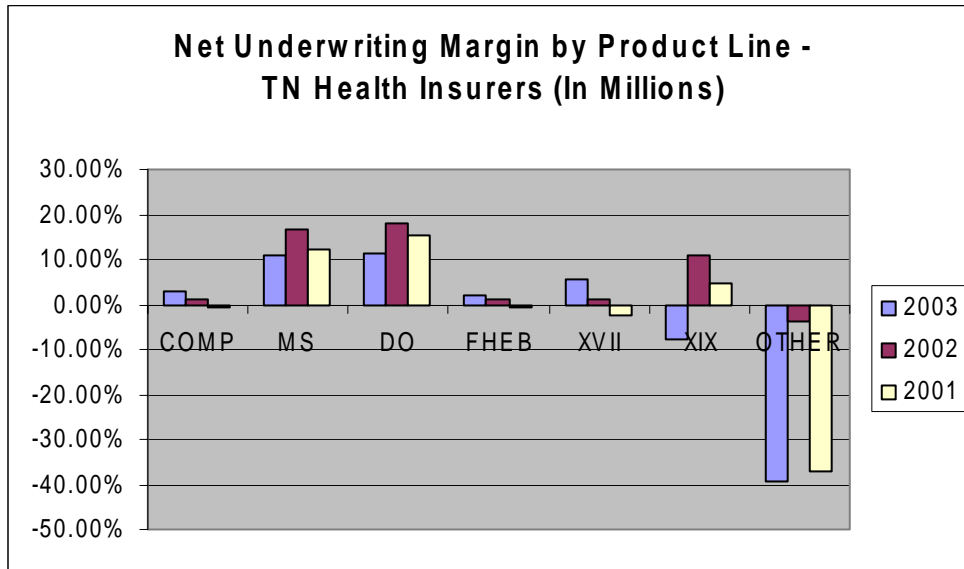
Figure 5:



**Table 7:
Net Underwriting Margin by Product Line**

	2003	2002	2001
Comp (Hospital and Medical)	2.98%	1.01%	-0.78%
Medicare Supplement	10.69%	16.67%	12.06%
Dental Only	11.48%	17.98%	15.12%
Federal Health Employee Benefit	1.93%	0.89%	-0.77%
XVII – Medicare	5.43%	1.32%	-2.66%
XIX – Medicare	-7.60%	10.96%	4.67%
Other	-39.52%	-3.92%	-36.95%
Total	3.21%	1.81%	-0.70%

Figure 6:



V. Profitability Ratio Analysis

Profitability measures the overall efficiency and performance of an organization. Higher values are preferred. In this section, two profitability measures are highlighted: net profit margin and return on assets. These two measures represent the organization's ability to translate revenue and assets into profits.

Net Profit Margin

Net Profit Margin is defined as net income after taxes divided by total revenue. It measures profit generated after consideration of all operating expenses. Below are numeric and graphical depictions of the net profit margins for the Tennessee health insurers, along with various state and US averages.

**Table 8:
Net Profit Margin**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	9.92%	2.29%	-7.22%
BCBS of TN Inc.	7.10%	6.69%	3.21%
Cariten Health Plan	1.61%	4.97%	10.35%
Cariten Ins. Co.	-3.07%	-4.50%	2.15%
Cigna Healthcare of TN Inc.	-1.50%	4.59%	-0.06%
Humana Health Plan Inc.	1.69%	-0.07%	-0.68%
John Deere Health Plan Inc.	0.32%	1.11%	1.38%
United Healthcare of TN.	7.11%	1.26%	0.44%
Tennessee, Other States and US			
TN	3.18%	2.32%	0.85%
GA	3.95%	2.98%	2.42%
KY	2.29%	2.07%	0.48%
MO	5.40%	3.40%	0.66%
US	3.66%	2.18%	1.43%

Figure 7:

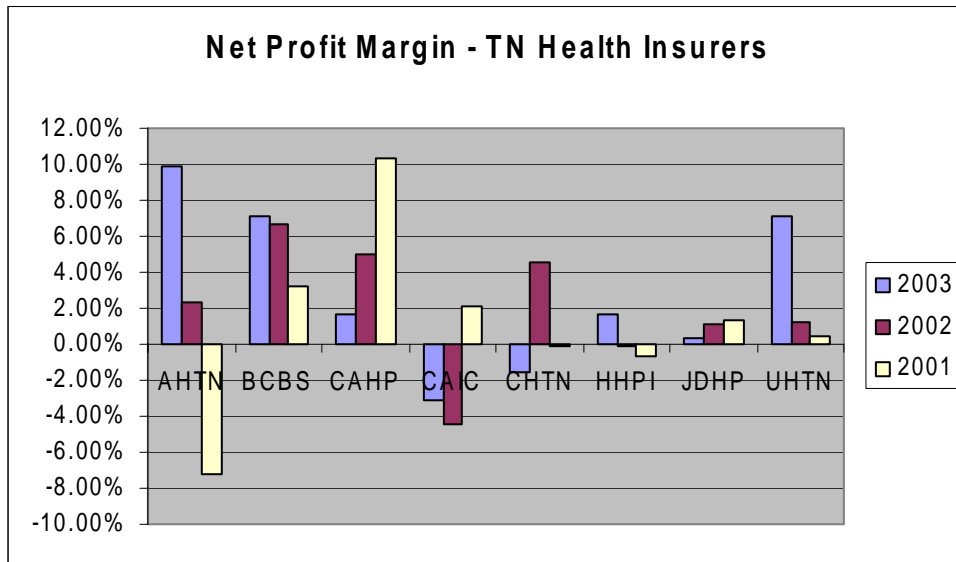
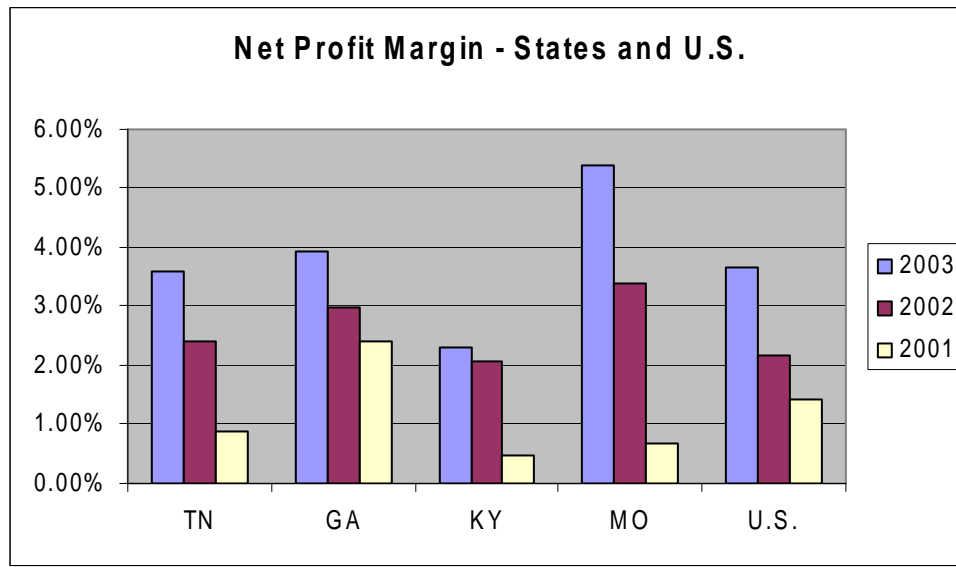


Figure 8:



The three most profitable Tennessee companies in 2003 in terms of net profit margin are Aetna Health Inc. TN Corp. (9.92 percent), United Healthcare of TN (7.11 percent), and BCBS of TN Inc. (7.10 percent). Cariten Ins. Co. and Cigna Healthcare of TN Inc. have negative net profit margins in 2003 of -3.07 percent and -1.50 percent respectively. Net profit margins for Tennessee companies increase 2.33 percent from 2001 to 2003. However, this net profit margin increase is not equally distributed across the eight Tennessee health insurers. From 2001 to 2003, Aetna Health Inc. TN Corp. and United Healthcare of TN have increased net profit margins of 17.14 percent and 6.67 percent respectively. Over the same period, Cariten Health Plan and Cariten Ins. Co.'s net profit margins decrease -8.74 percent and -5.22 percent respectively.

Tennessee firms have a lower net profit margin than the overall US average for 2003 and the average across the three years. Tennessee and US firms average 3.18 percent and 3.66 percent for 2003 and average 2.12 percent and 2.42 percent over the 2001 to 2003 period. Compared with their state counterparts for 2003, Missouri appears to be on the high end at 5.40 percent and Kentucky on the low end at 2.29 percent. For the three-year period, Missouri and Georgia have the highest overall net profit margin average at 3.15 percent and 3.12 percent respectively. Kentucky has the lowest net profit margin average of 1.61 percent over the same period. Missouri has the highest net profit margin average annual increase from 2001 to 2003 of 357.94 percent. In general, it appears that TN health insurers' net profit margins are lower than the average US health insurer and less than its state counterparts (except for Kentucky); however, the Tennessee organizations vary widely.

Return on Assets

Return on Assets is defined as net income after taxes divided by total assets. It measures the overall efficiency of the organization in managing its total investment in assets by examining how much revenue can be generated for each dollar of assets employed. Below are numeric and graphical depictions of return on assets for the Tennessee health insurers, along with various state and US averages.

**Table 9:
Return on Assets**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	17.97%	4.10%	-27.48%
BCBS of TN Inc.	10.47%	9.61%	4.04%
Cariten Health Plan	3.66%	10.34%	16.70%
Cariten Ins. Co.	-10.31%	-14.63%	4.29%
Cigna Healthcare of TN Inc.	-6.13%	17.65%	-0.22%
Humana Health Plan Inc.	7.55%	-0.38%	-3.53%
John Deere Health Plan Inc.	1.05%	3.51%	4.20%
United Healthcare of TN.	27.11%	5.10%	1.97%
Tennessee, Other States and US			
TN	8.17%	6.14%	2.20%
GA	11.19%	9.90%	8.29%
KY	8.29%	7.21%	6.63%
MO	15.13%	10.64%	2.26%
US	8.85%	5.99%	3.85%

Figure 9:

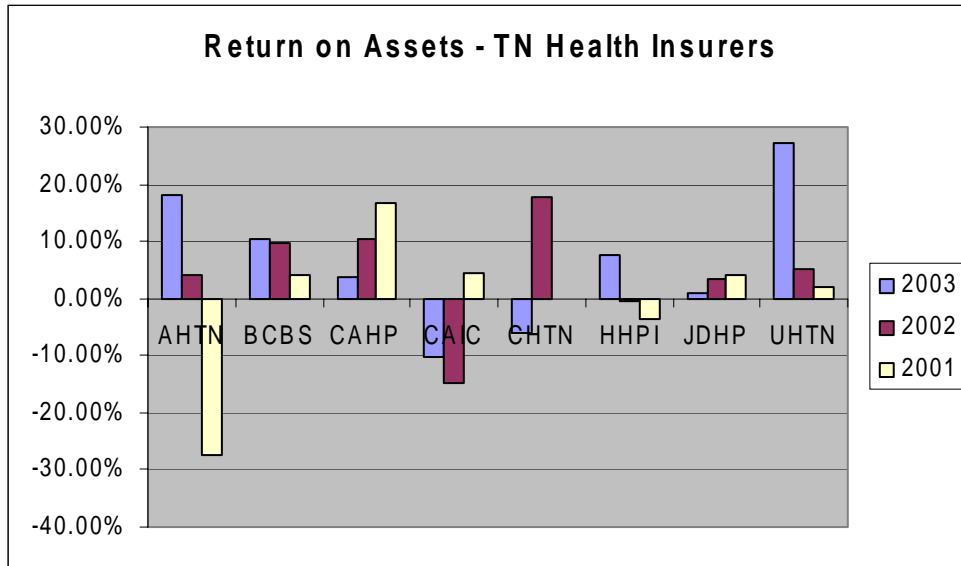
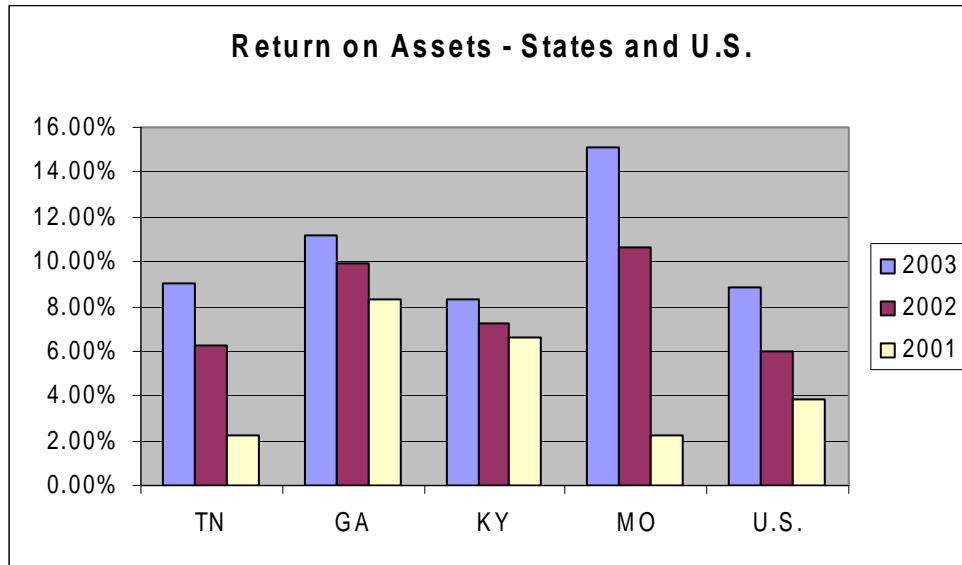


Figure 10:



The three most profitable Tennessee companies in 2003 in terms of return on assets are United Healthcare of TN (27.11 percent), Aetna Health Inc. TN Corp. (17.97 percent), and BCBS of TN Inc. (10.47 percent). Cariten Ins. Co. and Cigna Healthcare of TN Inc. have negative return on assets in 2003 of -10.31 percent and -6.13 percent respectively. Return on assets for Tennessee companies increases 5.97 percent from 2001 to 2003. However, this return on assets is not equally distributed across the eight Tennessee health insurers. From 2001 to 2003, Aetna Health Inc. TN Corp. and United Healthcare of TN increase their return on assets 45.45 percent and 25.14 percent respectively. Over the same period, Cariten Ins. Co. and Cariten Health Plan's return on assets decreases -14.60 percent and -13.04 percent respectively.

Tennessee has a lower return on assets than the overall US average for 2003 and the average across the three years. Tennessee and US firms have an average return on assets of 8.17 percent and 8.85 percent for 2003 and 5.50 percent and 6.23 percent over the 2001 to 2003 period. Compared with their state counterparts for 2003, Missouri appears to be on the high end at 15.13 percent and Tennessee on the low end at 8.17 percent. For the three-year period, Georgia and Missouri have the highest overall return on assets average at 9.79 percent and 9.34 percent respectively. Tennessee has the lowest return on asset average of 5.50 percent over this same period while Missouri has the highest return on asset average annual increase from 2001 to 2003 of 285.17 percent. Overall, it appears that TN health insurers' return on assets percentages are improving (i.e., showing better management of their assets), but they are worse than their regional counterparts and the US national averages for the three-year period.

VI. Liquidity Ratio Analysis

Liquidity measures the ability of a health insurer to cover its current obligations and relative amount of claims outstanding. In this section, two liquidity measures are highlighted: claims payment period and current ratio. From a liquidity standpoint, lower values are preferred for claims payment period and higher values are preferred for the current ratio. Deterioration in these measures can indicate potential cash flow problems and financial difficulty.

Claims Payment Period

Claims Payment Period is defined as claims payable divided by medical expenses (divided by 365). It provides a relative measure of how long it would take to pay off outstanding medical claims at the current average rate of reimbursement. Lower numbers are preferred to indicate the soundness of health insurers from a pure liquidity standpoint (and the point of a typical provider). However, as long as health insurers can maintain good provider relationships, they would probably want to extend these terms (e.g. higher numbers are preferred). Below are numeric and graphical depictions of the claims payment period for the Tennessee health insurers, along with various state and US averages.

**Table 10:
Claims Payment Period**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	48.71	61.41	49.32
BCBS of TN Inc.	45.26	45.73	46.46
Cariten Health Plan	50.57	78.38	109.19
Cariten Ins. Co.	37.74	53.47	77.26
Cigna Healthcare of TN Inc.	68.85	47.66	40.08
Humana Health Plan Inc.	30.52	31.39	31.79
John Deere Health Plan Inc.	31.79	61.01	59.44
United Healthcare of TN.	41.97	49.19	48.85
Tennessee, Other States and US			
TN	41.92	42.27	42.95
GA	40.63	44.34	45.81
KY	39.31	43.44	47.20
MO	43.91	47.29	52.98
US	45.07	46.42	49.11

Figure 11:

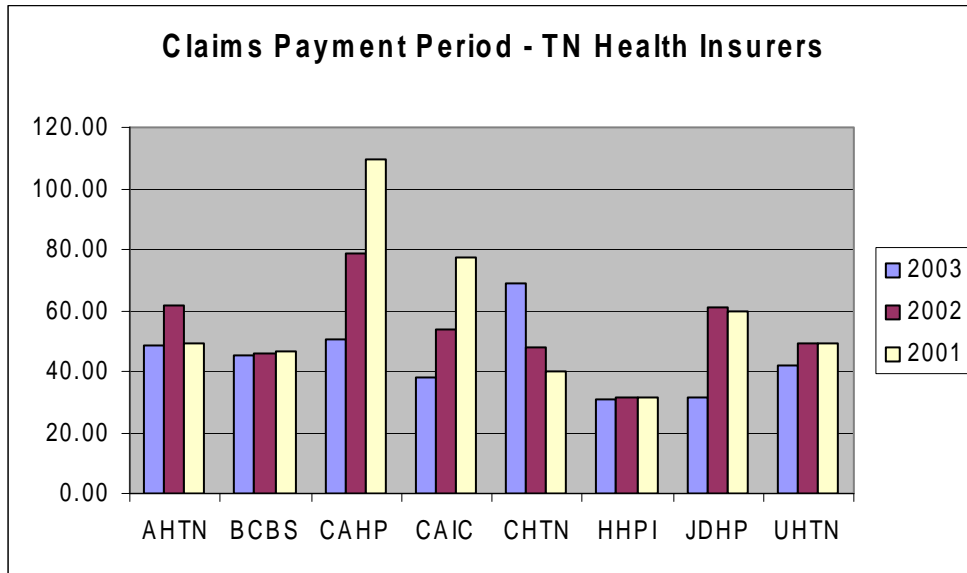
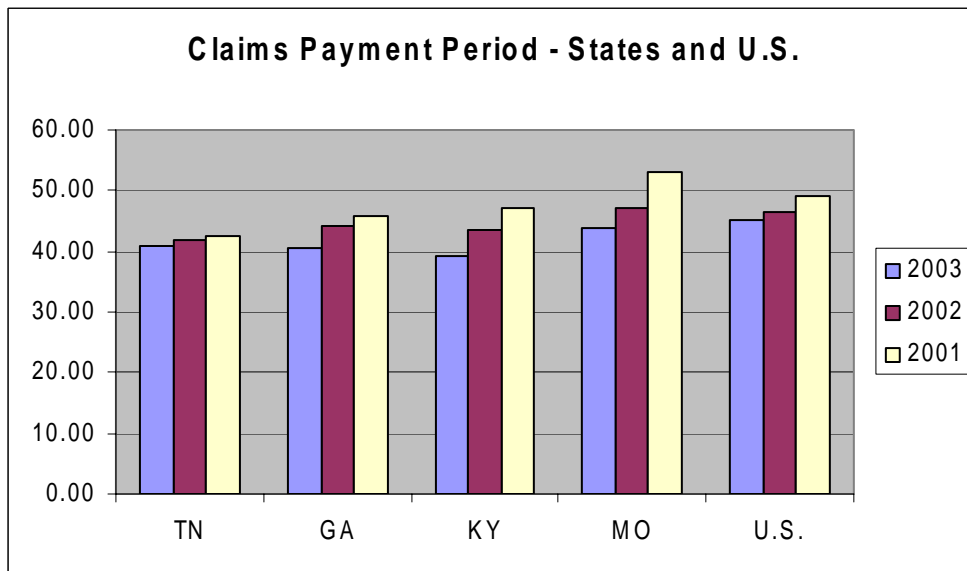


Figure 12:



The three Tennessee companies in 2003 with the lowest values in terms of claims payment period are Humana Health Plan Inc. (30.52 days), John Deere Health Plan Inc. (31.79 days) and Cariten Ins. Co. (37.74 days). Cigna Healthcare of TN Inc. and Cariten Health Plan have the highest numbers in terms of claims payment period in 2003 of 68.85 days and 50.57 days respectively. The claims payment period for Tennessee companies decreases 1.03 days from 2001 to 2003. However, this claim payment period change is not equally distributed across the eight Tennessee health insurers. From 2001 to 2003, Cariten Health Plan and Cariten Ins. Co. decrease the claims payment period -58.62 days and -39.52 days respectively. Over the same period, Cigna Healthcare of TN Inc.'s claims payment period increases 28.77 days.

Tennessee has a lower claims payment period than the overall US average for 2003 and across the three years. Tennessee and US firms averaged 41.92 days and 45.07 days for 2003 and averaged 42.38 days and 46.87 from 2001 to 2003. Compared with their state counterparts for 2003, Missouri appears to be on the high end at 43.91 days and Kentucky on the low end at 39.31 days. For the three-year period, Missouri and Georgia have the highest claims payment period average at 48.06 days and 43.60 days respectively. Tennessee has the lowest claims payment period average of 42.38 days over this same period. Missouri has the most significant decrease in average annual claims payment period 2001 to 2003 of -8.56 percent. It appears that Tennessee health insurers' claims payment period days are lower (e.g., in a better liquidity position) than their regional counterparts and national averages.

Current Ratio

Current ratio is defined as cash & short-term investments and premium receivables divided by claims payable and unearned premiums. This term can be used as a measure of short-run solvency, the ability of firm to meet its obligations as they come due. The availability of cash resources to satisfy these short-term obligations can be important in analyzing an insurer's financial health. From a liquidity standpoint, higher numbers are preferred. However, as with claims payment period, as long as health insurers can maintain good relationships with their vendors (and providers), health insurers would probably want to extend these terms (e.g. lower numbers are preferred). Below are numeric and graphical depictions of the current ratios for the Tennessee health insurers, along with various state and US averages.

**Table 11:
Current Ratio**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	3.57	3.43	1.73
BCBS of TN Inc.	1.02	1.23	1.12
Cariten Health Plan	0.49	0.25	0.27
Cariten Ins. Co.	0.26	0.40	0.38
Cigna Healthcare of TN Inc.	0.72	0.84	0.40
Humana Health Plan Inc.	0.73	0.55	0.55
John Deere Health Plan Inc.	0.21	0.44	0.33
United Healthcare of TN.	0.45	0.01	0.02
Tennessee, Other States and US			
TN	0.72	0.76	0.63
GA	0.38	0.37	0.57
KY	0.60	0.60	0.54
MO	0.70	0.75	0.67
US	0.88	0.78	0.74

Figure 13:

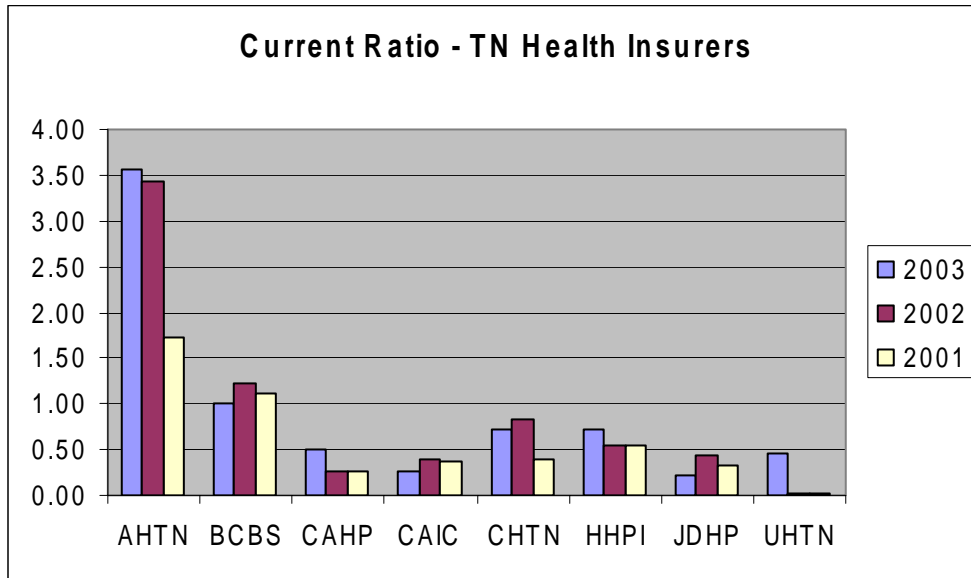
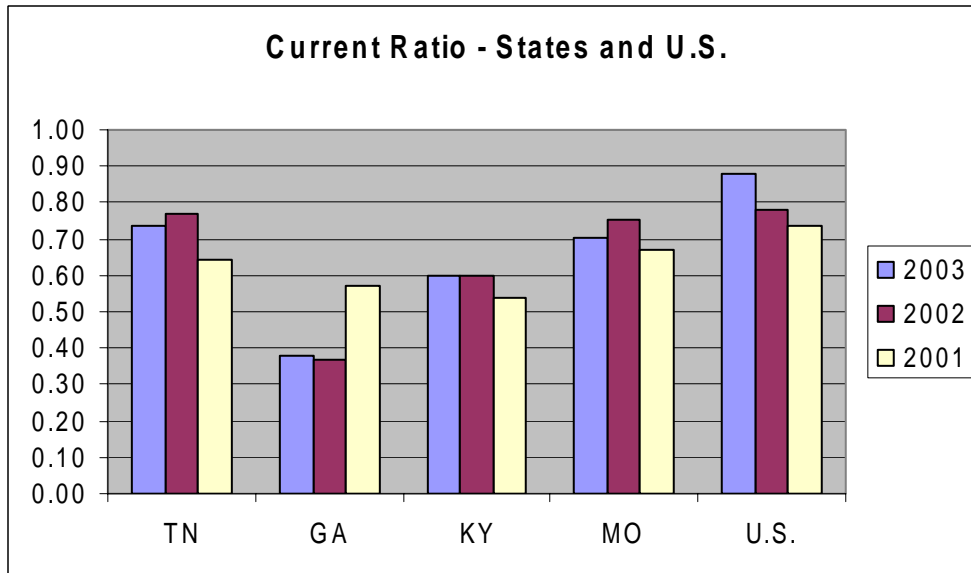


Figure 14:



The two Tennessee companies in 2003 with the highest current ratios are Aetna Health Inc. TN Corp. (3.57) and BCBS of TN Inc. (1.02). John Deere Health Plan Inc. and Cariten Ins. Co. have the lowest current ratios in 2003 of .21 and .26 respectively. Current ratios for Tennessee companies have increased .09 from 2001 to 2003. However, this current ratio change is not equally distributed across the eight Tennessee health insurers. Aetna Health Inc. TN Corp. and United Healthcare of TN. have increased the current ratio 1.84 and .43 from 2001 to 2003, respectively. Over the same period, John Deere Health Plan Inc. and Cariten Ins. Co.'s current ratios decrease -.12.

Tennessee has a lower current ratio than the overall US average for 2003 and across the three years. Tennessee and US firms have an average current ratio of .72 and .88 for 2003 and average

.70 and .80 over the 2001 to 2003 period. Compared to their state counterparts for 2003, Tennessee appears to be on the high end at .72 and Georgia on the low end at .38. For the three-year period, Missouri has the highest current ratio average at .71 while Georgia has the lowest current ratio average of .44 over this same period. Tennessee has the most significant average annual increase in current ratio period 2001 to 2003 of 6.95 percent. Georgia has the most significant average annual decrease in current ratio period 2001 to 2003 of -17.19 percent. Overall, it appears that Tennessee health insurers have a lower current ratio than the US average but higher current ratios than their state counterparts. Consequently, Tennessee health insurers seem to be in a better liquidity position than their state counterparts, but are still lower than an average US health insurer.

VII. Leverage Ratio Analysis

Leverage measures the extent of the firm's financing with debt and current liabilities. The amount and proportion of debt (current and long-term) are important in analyzing the potential risk of an organization. In this section, two leverage measures are highlighted: months reserves and debt ratio. From a leverage standpoint, higher values are preferred for months reserves and lower values are preferred for the debt ratio. Deterioration in these measures can indicate that an organization may have difficulty meeting its fixed commitments and therefore increase its enterprise risk.

Months reserves is defined as total assets divided by total underwriting expenses divided by twelve. It measures the number of months normal underwriting operations could be supported with existing assets. Below are numeric and graphical depictions of the months reserves of the Tennessee health insurers, along with various state and US averages.

**Table 12:
Months Reserves**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	6.25	1.17	0.59
BCBS of TN Inc.	5.32	5.37	5.96
Cariten Health Plan	2.18	2.05	3.02
Cariten Ins. Co.	1.39	0.69	2.37
Cigna Healthcare of TN Inc.	0.65	1.12	1.17
Humana Health Plan Inc.	1.20	0.91	0.80
John Deere Health Plan Inc.	1.36	1.63	1.56
United Healthcare of TN.	2.10	1.30	0.96
Tennessee, Other States and US			
TN	2.54	2.30	2.33
GA	1.84	1.74	1.67
KY	1.75	1.61	1.53
MO	2.29	1.72	1.43
US	2.30	1.76	1.70

Figure 15:

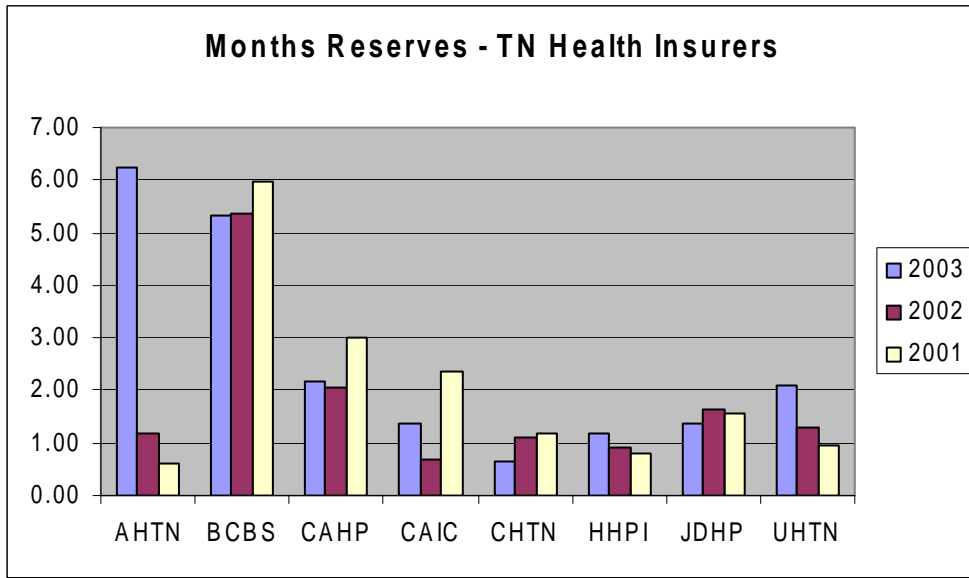
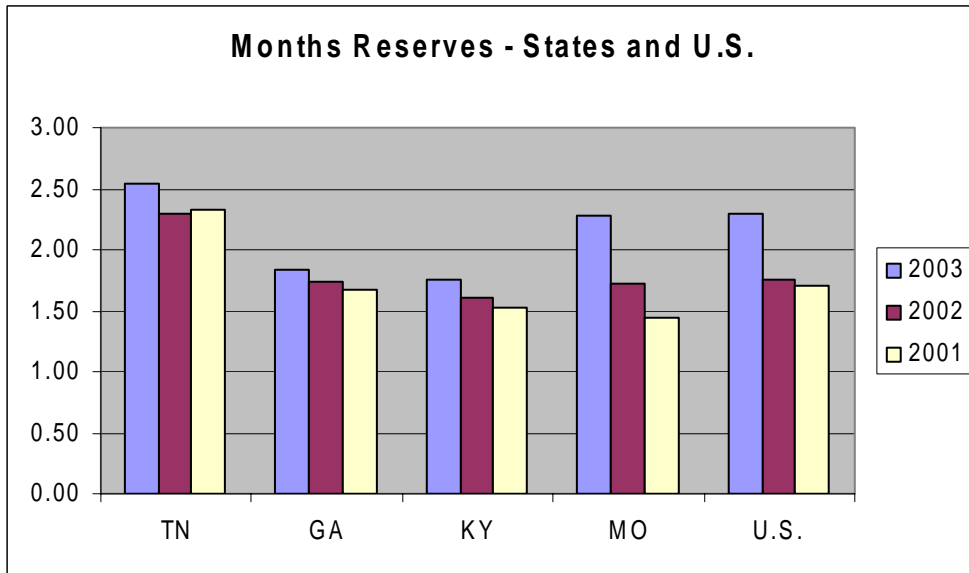


Figure 16:



The two Tennessee companies in 2003 with the highest months reserves are Aetna Health Inc. TN Corp. (6.25) and BCBS of TN Inc. (5.32). Cigna Healthcare of TN Inc. has the lowest months reserves in 2003 of .65. Months reserves for TN companies increase .21 from 2001 to 2003. However, this months reserves change is not equally distributed across the eight Tennessee health insurers. Aetna Health Inc. TN Corp. increases its months reserves 5.66 from 2001 to 2003. Over the same period, Cariten Ins. Co.'s months reserves decreases -.98.

Tennessee has a higher months reserves than the overall US average for 2003 and across the three years. Tennessee and US firms have an average months reserves of 2.54 and 2.30 for 2003 and average 2.39 and 1.92 during the 2001 to 2003 period. Compared with their state counterparts for 2003, Tennessee appears to be on the high end at 2.54 and Kentucky on the low

end at 1.75. For the three-year period, Tennessee has the highest months reserves average at 2.39 while Kentucky has the lowest months reserves average of 1.63. Missouri has the most significant average annual increase in months reserves from 2001 to 2003 of 29.63 percent. Tennessee has the smallest increase in months reserves from 2001 to 2003 of 4.47 percent. Overall, it appears that Tennessee health insurers have higher months reserves than the US average and are in a strong months reserves position compared with state counterparts.

Debt Ratio

Debt ratio is defined as total liabilities divided by total assets. The amount and proportion of company debt (both short and long-term) can be useful in analyzing organizational risk. Higher debt levels can present issues because debt represents fixed commitments that must be met through existing assets or future earnings. Lower ratios are preferred as an indication of the soundness of the health insurers from a leverage standpoint. Below are numeric and graphical depictions of the debt ratios for the Tennessee health insurers, along with various state and US averages.

**Table 13:
Overall Debt Ratio**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	20.29%	82.90%	79.13%
BCBS of TN Inc.	39.31%	40.15%	38.42%
Cariten Health Plan	59.34%	65.40%	62.24%
Cariten Ins. Co.	59.59%	80.14%	60.36%
Cigna Healthcare of TN Inc.	77.17%	65.63%	65.66%
Humana Health Plan Inc.	56.40%	60.88%	64.60%
John Deere Health Plan Inc.	62.36%	56.96%	60.56%
United Healthcare of TN.	38.58%	56.12%	63.54%
Tennessee, Other States and US			
TN	47.38%	50.26%	49.65%
GA	58.07%	57.09%	60.26%
KY	55.19%	57.76%	59.01%
MO	52.08%	57.44%	62.73%
US	57.46%	61.90%	63.35%

Figure 17:

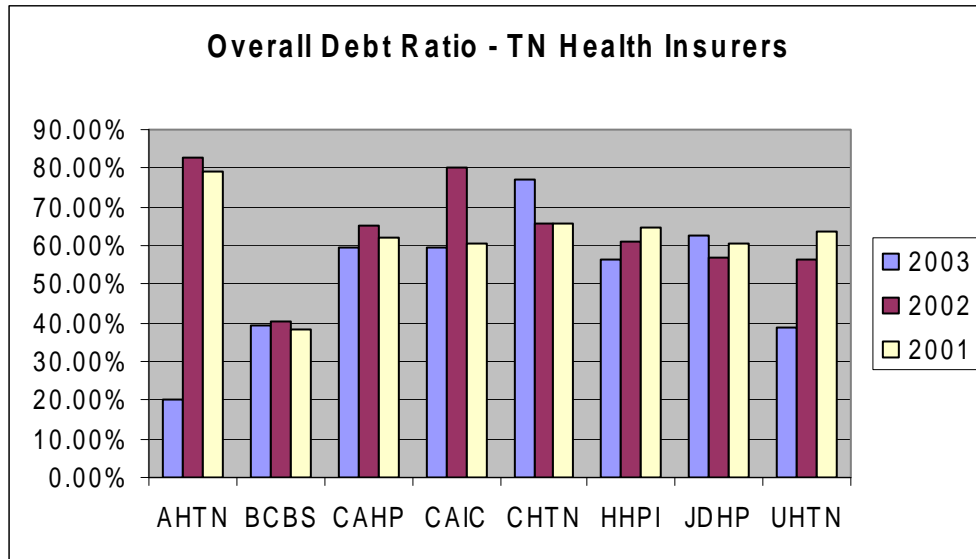
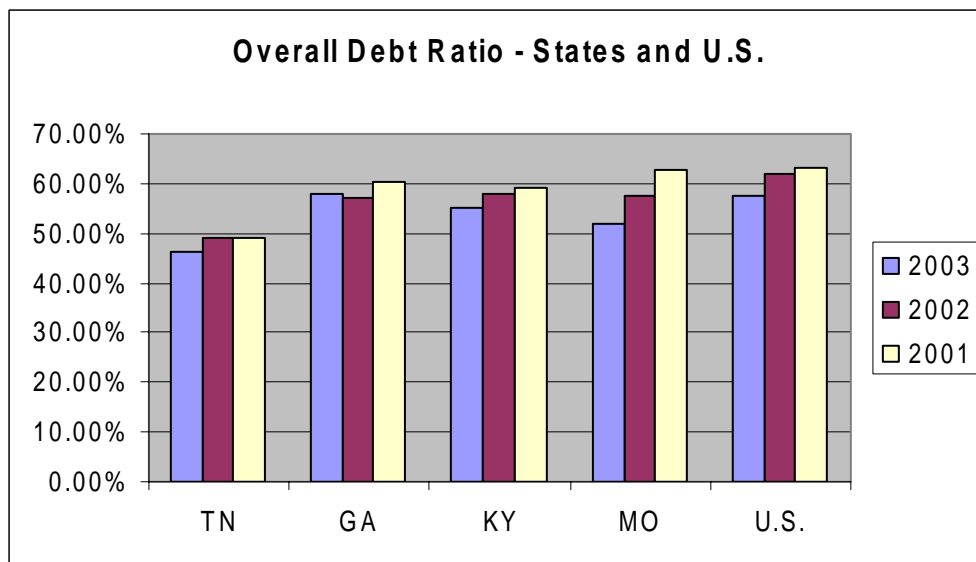


Figure 18:



The three Tennessee companies in 2003 with the lowest debt ratios are Aetna Health Inc. TN Corp. (20.29 percent), United Healthcare of TN. (38.58 percent), and BCBS of TN Inc. (39.31 percent). Cigna Healthcare of TN Inc. and John Deere Health Plan Inc. have the highest debt ratios in 2003 of 77.17 percent and 62.36 percent respectively. Debt ratios for Tennessee companies decrease -2.27 percent from 2001 to 2003. However, this debt ratio change is not equally distributed across the eight Tennessee health insurers. From 2001 to 2003, Aetna Health Inc. TN Corp. and United Healthcare of TN decrease their debt ratios -58.84 percent and -24.95 percent respectively. Over the same period, Cigna Healthcare of TN Inc.'s debt ratio increases 11.51 percent.

Tennessee has a lower debt ratio than the US average for 2003 and across the three years. Tennessee and US firms have debt ratios of 47.38 percent and 57.46 percent for 2003 and

average 49.10 percent and 60.91 percent over the 2001 to 2003 period. Compared with their state counterparts for 2003, Georgia appears to be on the high end at 58.07 percent and Tennessee on the low end at 47.38 percent. For the three-year period, Georgia and Missouri have the highest debt ratio at 58.46 percent and 57.41 percent respectively. Tennessee has the lowest debt ratio of 49.10 percent over this same period while Missouri has the most significant average annual decrease in debt ratio from 2001 to 2003 of -8.49 percent. In general, it appears that Tennessee health insurers have lower debt ratios than the US average and are in a stronger leverage position than state counterparts.

VIII. Efficiency Ratio Analysis

Efficiency refers to how the health insurer is managing its business. Two efficiency measures are examined: total asset turnover and general administrative expense ratio. Total asset turnover measures how efficient the organization is in terms of generating revenues from the existing assets. Administrative expense ratio measures how efficiently an organization's administrative activities generate revenue

Asset Turnover

Asset turnover is defined as total revenue divided by total assets. It measures the overall efficiency of the organization in managing its total investment in assets. Below are numeric and graphical depictions of asset turnover for the Tennessee health insurers, along with various state and US averages.

**Table 14:
Asset Turnover**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	1.81	1.79	3.81
BCBS of TN Inc.	1.47	1.44	1.26
Cariten Health Plan	2.27	2.08	1.61
Cariten Ins. Co.	3.36	3.26	2.00
Cigna Healthcare of TN Inc.	2.00	4.08	3.84
Humana Health Plan Inc.	4.46	5.09	5.22
John Deere Health Plan Inc.	3.29	3.17	3.04
United Healthcare of TN.	3.81	4.05	4.50
Tennessee, Other States and US			
TN	2.57	2.65	2.57
GA	2.84	3.32	3.42
KY	3.15	3.21	3.19
MO	2.80	3.12	3.41
US	2.42	2.75	2.69

Figure 19:

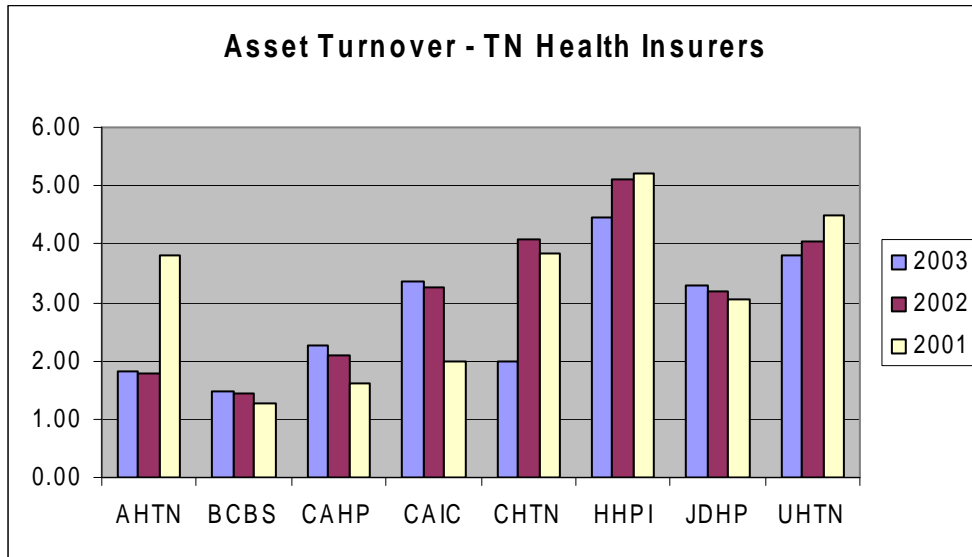
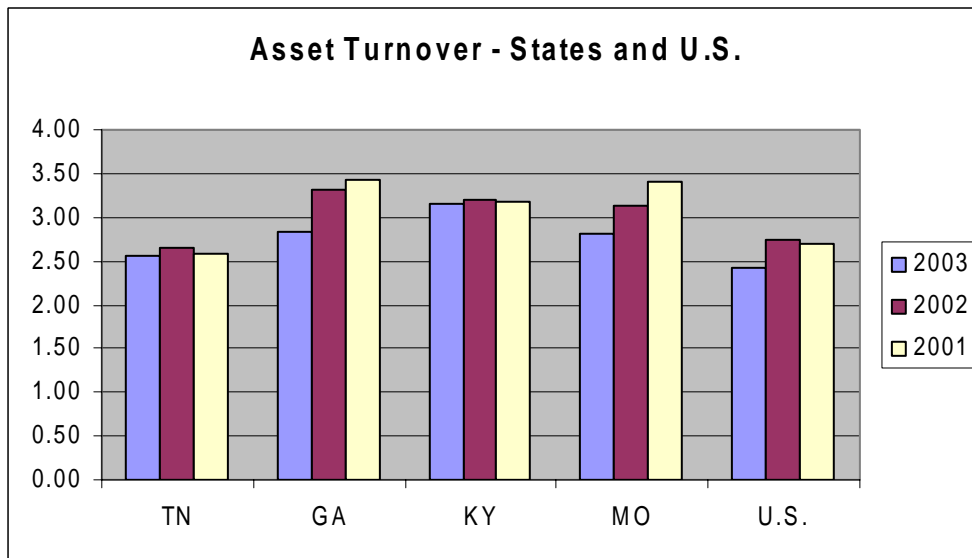


Figure 20:



The two Tennessee companies in 2003 with the highest asset turnover are Humana Health Plan Inc. (4.46) and United Healthcare of TN. (3.81). BCBS of TN Inc. has the lowest asset turnover in 2003 of 1.47. Asset turnover for TN companies remained the same from 2001 to 2003. However, this asset turnover change is not equally distributed across the eight Tennessee health insurers. Cariten Ins. Co. has increased its asset turnover 1.36 from 2001 to 2003. Over the same period, Aetna Health Inc. TN Corp. and Cigna Healthcare of TN Inc.'s asset turnover decrease -1.99 and -1.84 respectively.

Tennessee has a higher asset turnover than the overall US average for 2003 but has a lower turnover across the three years. Tennessee and US firms have an average asset turnover of 2.57 and 2.42 for 2003 and average 2.60 and 2.62 for the 2001 to 2003 period. Compared with their state counterparts for 2003, Kentucky appears to be on the high end at 3.15 and Tennessee on the

low end at 2.57. For the three-year period, Georgia has the highest asset turnover average at 3.19 while Tennessee has the lowest asset turnover average of 2.60. Missouri has the most significant average annual decrease in asset turnover period 2001 to 2003 of -8.92 percent. Overall, it appears that Tennessee health insurers' asset turnover is similar to the US average but lower than their state counterparts over the three years. However, in terms of percentage annual changes from 2001 to 2003 it appears that Tennessee firms are doing better compared to US national averages (i.e., TN average did not change while the US has an average annual decrease of -5.05 percent).

Administrative Overhead

Administrative Overhead is defined as general administrative expenses divided by total revenue. It measures how much a health insurer spends for administrative expenses for each dollar of revenues received. Lower percentages are preferred. Below is a numeric and graphical depiction of administrative overhead ratios for the Tennessee health insurers, along with various state and US averages.

**Table 15:
Administrative Overhead**

	2003	2002	2001
Tennessee Health Insurers			
Aetna Health Inc. TN Corp.	12.61%	11.89%	11.68%
BCBS of TN Inc.	8.53%	7.39%	7.74%
Cariten Health Plan	4.96%	6.58%	10.10%
Cariten Ins. Co.	12.50%	14.94%	19.02%
Cigna Healthcare of TN Inc.	10.51%	12.58%	7.70%
Humana Health Plan Inc.	10.60%	13.05%	11.49%
John Deere Health Plan Inc.	11.96%	11.13%	11.51%
United Healthcare of TN.	15.98%	15.78%	12.70%
Tennessee, Other States and US			
TN	10.22%	11.11%	10.45%
GA	8.94%	8.63%	8.12%
KY	9.53%	11.45%	10.76%
MO	9.76%	10.98%	10.43%
US	8.28%	8.60%	9.12%

Figure 21:

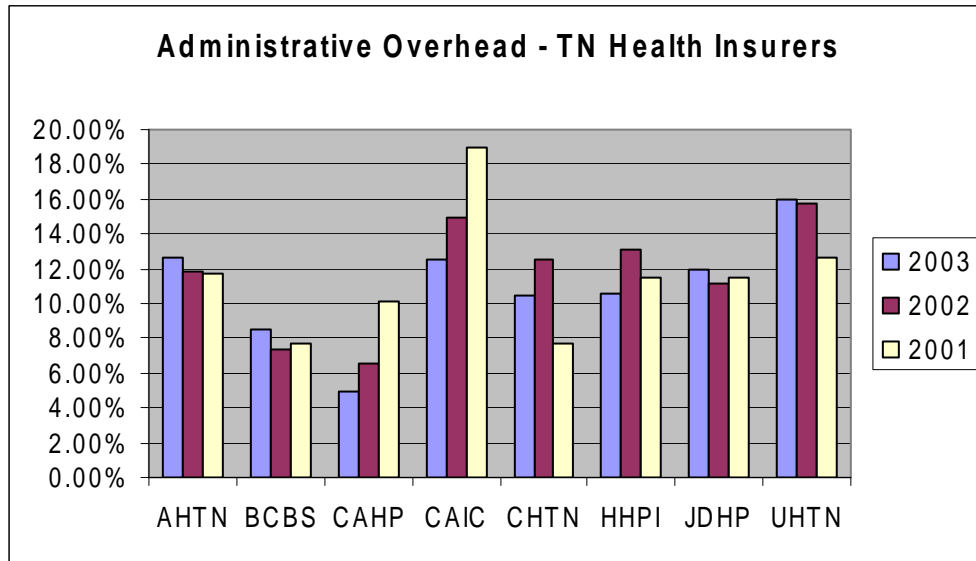
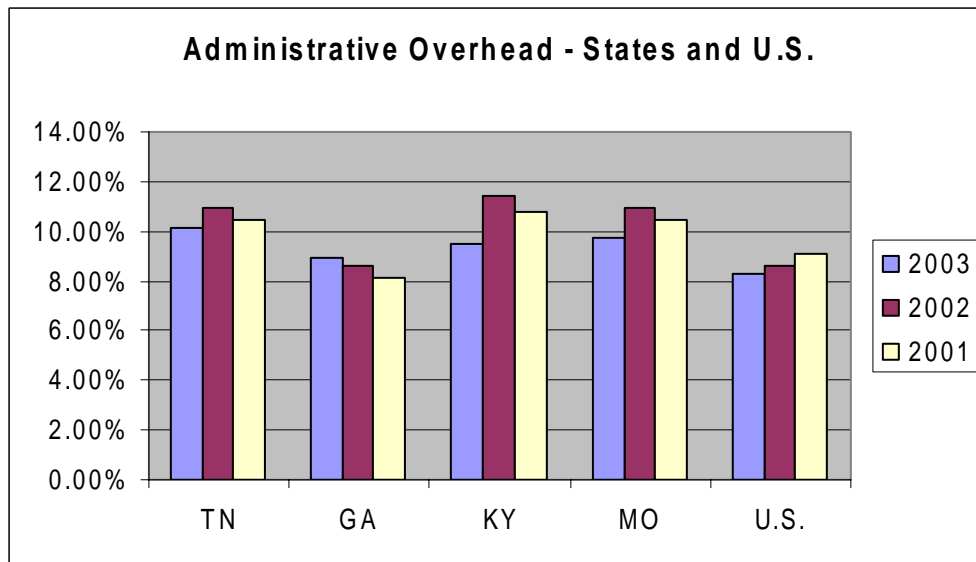


Figure 22:



The two Tennessee companies in 2003 with the lowest administrative overhead ratios are Cariten Health Plan (4.96 percent) and BCBS of TN Inc. (8.55 percent). United Healthcare of TN has the highest administrative overhead ratio in 2003 of 15.79 percent. The administrative overhead ratio for Tennessee companies decreases -.23 percent from 2001 to 2003. However, this administrative overhead ratio change is not equally distributed across the eight Tennessee health insurers. From 2001 to 2003, Cariten Ins. Co. and Cariten Health Plan decrease their administrative overhead ratio -6.38 percent and -5.11 percent respectively. Over the same period, United Healthcare of TN and Humana Health Plan Inc.’s administrative overhead ratios increase 3.09 percent and 2.81 percent respectively.

Tennessee has a higher administrative overhead ratio than the overall US average for 2003 and across the three years. Tennessee and US firms have an average administrative overhead ratio of

10.22 percent and 8.23 percent for 2003 and average 10.60 percent and 8.65 percent for the 2001 to 2003 period. For 2003, compared with their state counterparts, Tennessee appears to be on the high end at 10.22 percent and Georgia on the low end at 8.66 percent. For the three-year period, Tennessee has the highest administrative overhead average of 10.60 percent. For the same time, Georgia has the lowest administrative overhead average of 8.31 percent. Georgia also has the most significant average annual increase in administrative overhead ratio from 2001 to 2003 of 4.88 percent while Kentucky has the most significant decrease in administrative overhead ratio from 2001 to 2003 of -5.84 percent. In general, it appears that Tennessee health insurers have the highest administrative overhead ratios for 2003 as well as higher ratios than their US and state counterparts over the 2001 to 2003 period. In other words, it seems that Tennessee firms spend more, per dollar of revenue, on administrative services than US and state counterparts.

References

Cryan, B. 2003. "The Health of RI's Health Insurers (2002) – A Financial Analysis." Rhode Island Department of Health: 1 - 14.

Appendix A

Ms. Katherine A. Hossofsky of the Corporation Tax Division Rev. Proc. 87-51, 1987-2 C.B. 650

SECTION 1. PURPOSE

This revenue procedure provides an administrative procedure for existing Blue Cross or Blue Shield organizations, as defined in section 833(c)(2) of the Internal Revenue Code, and certain other organizations described in section 501(m)(1) and (m)(2) to expeditiously obtain the consent of the Commissioner to change their methods of accounting for federal income tax purposes.

SEC. 2. BACKGROUND

01 Prior to 1987, certain organizations that provided commercial-type insurance were exempt from tax as charitable or social welfare organizations under section 501(c)(3) or (c)(4) of the Code, respectively. Congress was concerned that these organizations were engaged in insurance activities the nature and scope of which were inherently commercial rather than tax exempt.

The Tax Reform Act of 1986 ('Act'), section 1012(a), 1986-3 (Vol. 1) C.B. 307, dealt with these concerns by adding section 501(m) to the Code. Section 501(m)(1) provides that, for taxable years beginning after December 31, 1986, an organization described in section 501(c)(3) or (c)(4) is exempt under section 501(a) only if no substantial part of the organization's activities consists of providing 'commercial-type insurance' as defined in section 501(m)(3) and (m)(4). Thus, for taxable years beginning after December 31, 1986, an organization described in section 501(c)(3) and (c)(4) is not exempt under section 501(a) if a substantial part of the organization's activities consists of providing commercial-type insurance. Under section 501(m)(2), if an organization is described in section 501(c)(3) or (c)(4) and is exempt from tax under section 501(a) after the application of section 501(m)(1) (because no substantial part of its activities consists of providing commercial-type insurance), then the activity of providing commercial-type insurance is treated as an unrelated trade or business, and the organization is treated as an insurance company for purposes of applying subchapter L of chapter 1 with respect to that activity.

02 For taxable years beginning before January 1, 1987, existing Blue Cross or Blue Shield organizations and other organizations described in section 501(m)(1) and (m)(2) of the Code filed returns as tax-exempt organizations on Form 990 (Return of Organization Exempt From Tax Under Section 501(c)). (In some cases, income from the activity of providing commercial-type insurance was reported on Form 990T (Exempt Organization Business Income Tax Return).) In accordance with the instructions for Form 990, these organizations were required to use the same method of accounting on that return that they regularly used to keep their books and records.

Generally they used either Generally Accepted Accounting Principles or statutory accounting principles established by the states for this purpose.

Section 1012 of the Act also added section 833 to the Code. Section 833(a)(1) provides that for taxable years beginning after December 31, 1986, existing Blue Cross or Blue Shield organizations and other organizations described in section 833(c)(3) are taxable as if they were stock property and casualty insurance companies. Property and casualty insurance companies are taxed under provisions of the Code contained in part II of subchapter L of chapter 1. These provisions contain a number of special tax accounting rules. Because they are subject to the provisions of subchapter L of chapter 1, existing Blue Cross or Blue Shield organizations and the other organizations described in section 501(m)(1) and (m)(2) of the Code may be required to use tax accounting methods different from those used in the past for reporting their insurance activity. For organizations subject to part II of subchapter L, section 832 generally requires the use of an accrual method of accounting with respect to their income and deductions. See Rev.

Rul. 77-266, 1977-2 C.B. 236. For any organization described in section 501(m)(1) or (m)(2) whose insurance activities are subject to part I of subchapter L, section 811(a) states that all computations entering into the determination of the taxes imposed by part I shall be made (1) under the accrual method of accounting, or (2) to the extent prescribed by the Secretary, under a combination of an accrual method of accounting with any other method permitted by chapter 1 (other than the cash receipts and disbursements method).

To the extent not inconsistent with the preceding sentence or any other provision of part I, all such computations shall be made in a manner consistent with the manner required for purposes of the annual statement approved by the National Association of Insurance Commissioners. In addition, organizations affected by section 501(m) may want to make other changes to existing methods of accounting, even though those changes are unrelated to the Act.

03 Section 446(e) of the Code and section 1.446-1(e) of the Income Tax Regulations state that, except as otherwise provided, in order to change a method of accounting for federal income tax purposes, the taxpayer must obtain the consent of the Commissioner. Section 1.446-1(e)(3)(i) requires that, in order to obtain such consent, generally an application, Form 3115 (Application for Change in Accounting Method), must be filed within 180 days after the beginning of the tax year for which the proposed change is to be made. Section 1.446-1(e)(3)(ii) authorizes the Commissioner to prescribe administrative procedures setting forth the limitations, terms, and conditions deemed necessary to permit a taxpayer to obtain consent to a change in its method of accounting in accordance with section 446(e). These requirements, generally, are applicable to taxable and tax-exempt organizations.

04 Section 481(a) of the Code requires that those adjustments necessary to prevent amounts from being duplicated or omitted be taken into account when the taxpayer's taxable income is computed under a method of accounting different from the method used to compute taxable income for the preceding tax year.

(1) Section 1012(c)(3)(A)(i) of the Act provides that an existing Blue Cross or Blue Shield organization (as defined in section 833(c)(2) of the Code) shall not make any adjustment under section 481 (or any other provision) on account of a change in its method of accounting for its first taxable year beginning after December 31, 1986. According to the legislative history, 'such organizations are given a fresh start with respect to changes in accounting methods resulting from the change from tax-exempt to taxable status.' 2 H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II-349 (1986), 1986-3 (Vol. 4) C.B. 349.

(2) As is described more fully below, similar treatment regarding the adjustment under section 481(a) of the Code and the regulations thereunder (section 481(a) adjustment) generally applies to other organizations that are described in section 501(m)(1) or (m)(2) and that, for their 1st taxable year beginning before January 1, 1987, treated the provision of commercial-type insurance as other than an unrelated trade or business.

SEC. 3. SCOPE

This revenue procedure applies to -- (1) existing Blue Cross or Blue Shield organizations (as defined in section 833(c)(2) of the Code), (2) other organizations that are described in section 501(m)(1), and (3) organizations described in section 501(m)(2) that, for their last taxable year beginning before January 1, 1987, treated the provision of commercial-type insurance as other than an unrelated trade or business.

For any organization to which this revenue procedure applies, it applies (subject to the limitations stated below) with respect to changes in method of accounting for the taxpayer's first taxable year (year of change) beginning after December 31, 1986. This revenue procedure applies only with respect to a change in the method of accounting or an activity that was treated in the year immediately preceding the year of change as other than an unrelated trade or business. For organizations described in section 501(m)(2) of the Code, this revenue procedure applies only with respect to a change in the method of accounting for the provision of commercial-type insurance.

Taxpayers to which this revenue procedure applies may not use Rev. Proc. 84-74, 1984-2 C.B. 736, for changes with respect to which this revenue procedure applies.

SEC. 4. APPLICATION

01 In accordance with section 1.446-1(e)(3)(ii) of the regulations, for taxpayers to which this revenue procedure applies and changes with respect to which it applies, the 180-day time period for filing requests to change a method of accounting is extended for the year of change to the earlier of (a) the date the taxpayer files its return for the year of change or (b) the 1st day of the 11th month following the close of the year of change. Under section 1.446-1(e)(2)(i), consent is hereby provisionally granted to an organization to which this revenue procedure applies to change methods of accounting if this revenue procedure applies with respect to that change.

This provisional consent is granted to a taxpayer that files a Form 3115 in the manner described in section 5 of this revenue procedure and that otherwise complies with the provisions of this revenue procedure. The consent becomes final on the date one year from the date the Form 3115 is filed, unless the Service sends notification to the taxpayer on or before that later date.

02 In reviewing the Form 3115, the National Office of the Service will consider all facts and circumstances, including: (1) whether the method of accounting requested is consistent with the Code, regulations, revenue rulings, revenue procedures, and decisions of the courts; (2) whether the use of the new method will clearly reflect income; and (3) whether the taxpayer's books and records will conform with the proposed method of accounting.

03 The Service will notify the taxpayer within one year from the date the Form 3115 is filed if the Service has initial questions concerning whether the taxpayer has adopted a new accounting method that is not a proper accounting method for federal income tax purposes. If a taxpayer complies with the provisions of this revenue procedure and the Service does not send notification to the taxpayer in the one-year period, the taxpayer has obtained the consent of the Commissioner to change its methods of accounting. If in the course of review the Service makes an initial determination that a method of accounting to which the taxpayer desires to change is not acceptable for tax purposes, the taxpayer will be granted the opportunity of a conference in the National Office before the Service makes a final adverse determination.

04 If a taxpayer obtains consent under this revenue procedure to change its method of accounting for a trade or business but the Service determines that the trade or business was an unrelated trade or business in the tax year before the year of change, then (notwithstanding section 5.06 below) the Service may require an appropriate section 481(a) adjustment with respect to that trade or business.

SEC. 5. MANNER OF EFFECTING THE CHANGE

01 If this revenue procedure applies to a taxpayer and if it applies with respect to a change in method of accounting, then the taxpayer must effect the change by filing a Form 3115 in duplicate. The original shall be attached to the taxpayer's federal income tax return for the year of change, and, at the time the federal income tax return is filed, the duplicate shall be filed with the National Office addressed to the Commissioner of Internal Revenue, Attention: CC:C:2:9, 1111 Constitution Avenue, N.W., Washington, D.C. 20224. If it is found that the taxpayer has not complied with the requirements for the automatic change in method of accounting under this revenue procedure, the National Office or the district director will so advise the taxpayer.

02 In order to assist in the processing of these changes in methods of accounting and to insure proper handling, reference to this revenue procedure shall be made a part of the Form 3115 by either typing or legibly printing the following statement at the top of page 1 of Form 3115: 'FILED UNDER REV. PROC. 87-51.' In the case of a change in the method of accounting for a trade or business that the taxpayer was not conducting on or before August 16, 1986, then, notwithstanding the preceding sentence, the statement to be placed at the top of page 1 of the Form 3115 shall be: 'FILED UNDER REV. PROC. 87-51 -- NEW BUSINESS.'

03 In completing Form 3115, the taxpayer should check the box labeled 'Other (specify)' and insert the following: 'Tax exempt organization (subject to section 501(m)) to taxable insurance company.' The taxpayer should complete the identifying information at the beginning of the form as well as the signature section. The taxpayer need not complete sections other than sections A (Applicable to All Filers Other Than Those Answering 'Yes' to 'Note' Above) and J (Change in Method of Accounting Not Listed Above).

04 In section J of the Form 3115, the taxpayer must also describe the accounting methods to which it is changing and the authority for using those methods. The taxpayer need not describe the methods of accounting from which it is changing.

05 The taxpayer must file its tax return for the year of change on the basis of the methods of accounting to which it proposes to change.

06 If the change in method of accounting is made under the provisions of this revenue procedure, the taxpayer is not required to compute the amount of any section 481(a) adjustment. In the event that the taxpayer subsequently changes a method of accounting from the method adopted under this revenue procedure, the section 481(a) adjustment with respect to any such subsequent change in method of accounting may take into account the fact that the activity being accounted for was not subject to tax prior to the year of change.

07 The signature of the person preparing the request for the change in method of accounting must appear in the space provided for it on the Form 3115. The application must be signed for the taxpayer requesting the change. The individual signing for a corporate taxpayer must be the president, vice president, treasurer, or chief accounting officer (such as the tax officer) who is authorized to sign for the corporation. See the signature requirements set forth in the General Instructions attached to a Form 3115 regarding those who are to sign. If the agent is authorized to represent the taxpayer before the Service, to receive the original or a copy of the correspondence concerning the request, or to perform any other act(s) regarding the application on behalf of the taxpayer, a power of attorney reflecting such authorization(s) must be attached to the application.

Taxpayer's representatives without a power of attorney to represent the taxpayer as

indicated in this subsection will not be given any information about the application. If the taxpayer is a member of an affiliated group that has elected to file a consolidated federal income tax return, a Form 3115 submitted on behalf of the taxpayer must be signed by a duly authorized officer of the common parent. (See section 1.1502-77 of the regulations.)

SEC. 6. EFFECTIVE DATE

This revenue procedure shall be effective October 13, 1987, the date of its publication in the Internal Revenue Bulletin. If a change in method of accounting qualifies under this revenue procedure, any request for permission to make that change must comply with section 5 of this revenue procedure, and all noncomplying requests that are received in the National Office after the effective date will be returned to the taxpayer. A taxpayer that has filed a Form 3115 with the National Office prior to the effective date of this revenue procedure may use the automatic provisions of this revenue procedure and will be notified to this effect by the National Office.

SEC. 7. CHANGES IN METHOD OF ACCOUNTING TO WHICH THIS REVENUE PROCEDURE DOES NOT APPLY

If an organization described in section 501(m)(1) or (m)(2) of the Code wishes to make a change in method of accounting for the year of change but this revenue procedure does not apply with respect to the desired change, the organization is required to follow Rev. Proc. 84-74. See, however, Announcement 87-89, this Bulletin, which in many cases provides an extension of time for filing the Form 3115 that is required by Rev. Proc. 84-74.

SEC. 8. INQUIRIES

Inquiries in regard to this revenue procedure should refer to its number and be addressed to the Commissioner of Internal Revenue, Attention: CC:C:2:9, 1111 Constitution Avenue, N.W., Washington, D.C. 20224.

DRAFTING INFORMATION

The principal author of this revenue procedure is Ms. Katherine A. Hossofsky of the Corporation Tax Division. For further information regarding this revenue procedure contact Ms. Hossofsky on (202) 566-4463 (not a toll-free call).

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