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Health Insurance Reform and Its Effects on the Small Employer Market: A Review of H.R. 3626

P. Anthony Hammond*

Abstract†

This paper provides a detailed analysis of H.R. 3626, a bill that is intended to improve employers' and employees' access to health care. H.R. 3626 attempts to accomplish this through the use of guaranteed availability, community rating, and generous standard benefits. A migration model is used to analyze the impact of H.R. 3626. Using this model, it is shown that while improving the availability and affordability of health insurance, its rating restrictions increase premiums disproportionately for the majority of small employers. In addition, H.R. 3626 increases the number of uninsured small employers.

Key words and phrases: rating restrictions, community rating, cost containment, redistributional effects, migration effects

1 Introduction

The majority of Americans obtain their health insurance coverage through an employer-provided health plan. In spite of this fact, many
working Americans are still uninsured, especially those who work for small employers. One may argue that the main reason why these workers are uninsured may have more to do with economics than insurance. Yet there are problems in the small employer health insurance market that are exacerbating the problem of the working uninsured. Basically, these are problems of access, affordability, and coverage.

Several small group reform proposals dealing with these problems have been presented to the United States Congress. These proposals generally promulgate restrictions on health insurance premiums and cost containment measures to improve affordability; require insurers to issue and guarantee renewal of policies to small employer groups in order to improve access (availability) of health insurance; and provide portability (continuity) of coverage when employers or individuals change carriers or jobs or when insurers leave the market.

In spite of their similarities, however, the various proposals are often quite different in their specific provisions. One major difference is how much premiums are allowed to vary (rating restrictions) and the definition of a small employer. The question remains, however, as to how effective these proposals are at resolving some or all of the problems in the small employer market and whether the cost exceeds the benefits to small employers, their employees, insurers, and society as a whole.

This paper examines the efficacy of H.R. 3626, The Health Insurance Reform and Cost Control Act of 1991. H.R. 3626 includes all of the approaches mentioned above and goes one step further. It establishes a minimum standard for benefits that must be covered by a small employer health insurance plan. H.R. 3626 does not include, however, reforms such as health risk adjusters, employer mandates, or individual health insurance reforms. Discussion of these reforms is beyond the scope of this paper.

The ability of H.R. 3626 to improve access, affordability, and coverage in the small employer market is analyzed using data from Health Insurance Association of America (HIAA) member companies and two

1 A small employer is defined throughout this paper to be an employer that employs two to 50 employees.

2 As of October 1994, the United States Congress has been unable to pass comprehensive health care reform legislation. So the focus of the health care reform debate has returned to insurance market reforms such as those proposed just a few years ago for small employers. Although these reforms are called incremental by policymakers, they will have a considerable impact on insurers, as these reforms represent a significant departure from past insurance practices.

3 The Health Insurance Association of America (HIAA) is a Washington, D.C.-based trade association of the United States' leading commercial insurance carriers. HIAA
actuarial models. One model analyzes the impact of rating restrictions on a sample of small employers insured by five different commercial insurers. The other model (called a \textit{migration model}) combines the relative morbidity (net claim cost) of each segment of the changing small employer population in order to estimate the change (as a result of H.R. 3626) in the average premium of all small employers insured by small group insurers.

The insurers chosen for this study represent five insurers with significant sales in the commercial, small employer, group health insurance market. The insurers reflect the broad spectrum of underwriting practices that are experienced in the market: from carriers with demographic rating (premiums vary based on age, sex, area, family status) to carriers with aggressive underwriting. Further, while an effort is made to obtain data from a group of carriers that is representative of the small employer group market, it is not possible to determine accurately how representative these carriers are. Therefore, the estimates should not be considered as industry estimates but as the composite experience of five insurers. The results presented in this paper are averages, so it always should be kept in mind that specific insurers and employers will have results that will be higher or lower than the average. In addition, it must be pointed out that small group reforms that already have been implemented in several states will limit the impact of implementing reforms on a national level.

I have tried to make this paper as detailed as possible, but the complexity of small employer market reforms contained in H.R. 3626 and other proposals have exceeded the available data. In response, I have concentrated on those areas that will have the greatest impact on the small employer market, highlighting those factors and effects that will be of greatest concern to policymakers, small employers, insurers, and the small employer population.

Findings from this actuarial study and their implications are presented in detail in the next five sections. Section 2 gives an overview of the results of this paper. Section 3 describes the redistribution of small employer premiums as a result of H.R. 3626 rating restrictions. Section 4 details the changes in the insured and uninsured small employer populations and the effect these population changes will have on small employer premiums. The impact on rates of standardized benefits is described in Section 5. Section 6 covers the impact of cost containment provisions. Section 7 deals with the provisions that can-

\hspace{1cm}\textsuperscript{represent the majority of the nation's commercial insurance companies. HIAA's activities range broadly from education to legislative analysis to collecting and disseminating data and information.}
not be quantified; it also gives suggestions for areas of further study. Section 8 contains the summary and conclusions. Appendix A contains a summary of the basic provisions of H.R. 3626. Appendix B contains a summary of the provisions of H.R. 3626 that affect rating. Appendix C describes the assumptions of the actuarial model under optimistic, best estimate, and pessimistic scenarios; and gives a quantitative evaluation (based on my best estimate) of H.R. 3626’s impact on small employers.

2 Overview of the Impact of H.R. 3626

If enacted, H.R. 3626 will make significant changes to the small employer (two to 50 employees) market for health insurance. In particular, it will:

- Guarantee that every small employer will have access to coverage;
- Guarantee that all employees (working at least 17.5 hours a week for a small employer with a health insurance plan) and their dependents will be eligible to participate in the employer-provided plan; and
- Make health insurance more affordable for higher risk small employers (thereby providing coverage to more high risk uninsureds).

But it also will

- Make health insurance less affordable for the majority of small employers (more than three-quarters of small employers will receive rate increases of 10 percent or more; see Table 1). For example, Table 1 shows that 19 percent of employees will receive a rate increase of more than 35 percent, 13 percent will retain their coverage, and 6 percent will choose to drop their coverage;
- Increase the small employer average premium per employee 8 to 24 percent, on average, adding an estimated three to nine billion dollars to small employer costs. This increase in the average premium is in addition to the rate increases most small employers will receive as a result of rating restrictions. Some small employers, however, will receive decreases in rates; and

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4This study only addresses the impact of H.R. 3626 on the small employer market, but H.R. 3626 also sets forth portability requirements that apply to all group health plans.

5My best estimate is that premiums will rise 12.3 percent, adding $5.6 billion to small employer costs.
Hammond: H.R. 3626, Health Insurance Reform

Table 1
Distribution of Rate Changes for Currently Insured Small Employers (two to 25 Employees) and the Percentage of Employees Keeping or Dropping Coverage Under H.R. 3626

<table>
<thead>
<tr>
<th>Percentage Rate Change*</th>
<th>Keep</th>
<th>Drop</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 35%</td>
<td>13%</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>19% to 35%</td>
<td>23%</td>
<td>3%</td>
<td>26%</td>
</tr>
<tr>
<td>7% to 19%</td>
<td>33%</td>
<td>1%</td>
<td>34%</td>
</tr>
<tr>
<td>-10% to 7%</td>
<td>13%</td>
<td>0%</td>
<td>13%</td>
</tr>
<tr>
<td>Less than -10%</td>
<td>8%</td>
<td>0%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Health Insurance Association of America.

*Includes 12.3 percent (best estimate) increase in market average rate.

- Increase the total number of uninsureds 2 to 5 percent, adding an estimated one to two million persons to the total uninsured. This occurs in spite of the one to two million uninsureds who rejoin the market. These new additions are offset by the one to four million (mostly low risk) employers and employees who leave the market. In addition, the tendency will be for these new uninsureds to be younger, to have lower incomes, and to work for the smallest of the small employers. Many will be children.

The percentage of employers receiving rate increases and the magnitude of those increases are related directly to the degree of rate compression created by rating restrictions. Consequently, the nearly flat community rating of H.R. 3626 leads to more and greater rate increases for employers than might other, less restrictive proposals.

Furthermore, these rate increases are in addition to trend increases and are a direct result of the combination of the access, rating, and benefit provisions of H.R. 3626. (See Table A1 in Appendix A for a summary of these provisions.) H.R. 3626 also will lead to significant changes in who will be insured in the small employer market. Some of these changes are described briefly below.

- Rating Restrictions: Under H.R. 3626 rating restrictions, the premium increase experienced by individual small employers will vary widely. Rating restrictions will increase rates significantly

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6My best estimate is that the total number of uninsureds will increase 3.4 percent, adding an estimated 1.3 million persons to the total uninsured.
for two-thirds of the currently insured small employers and their employees. Lower income employers and younger employees will be forced to subsidize higher income employers and older employees. Premiums no longer will reflect expected claims, except in the aggregate.

Rating restrictions also lead to a larger percentage rate increase for the smaller small employers than for the larger small employers. This probably reflects two factors: the greater likelihood of the smaller small employers purchasing coverage only if they have a lower than average risk (and, therefore, premium) and the impact of insurer underwriting.

- Changes in the Insured, Small Employer Population: The combined results of the H.R. 3626 rating, access, and benefit provisions will be to make health insurance more affordable and accessible for higher risk groups and less affordable for average and lower risk groups. This will lead to adverse selection, i.e., persons who have higher than average health care costs will tend to purchase insurance and those who have lower than average costs will tend not to do so.

Lower risk employers who don't want to drop their coverage also may switch to other forms of coverage that now may be less costly (as a result of H.R. 3626) than group insurance. In addition, the tight rating bands of H.R. 3626 will result in more adverse selection than proposals with less severe rating bands. Thus, H.R. 3626 leads to greater changes in the insured, small employer population than other proposals might. Altogether, H.R. 3626 leads to an 8 to 24 percent average increase in the average premium for small employers and to fewer small employers and their employees being insured.

- Standardized Benefits: H.R. 3626 standardizes benefits for small employer plans by preempting state mandates and promulgating a standard benefit package. The standard benefit package is similar to Parts A and B of Medicare, but it also includes certain preventive services with first dollar coverage.7

H.R. 3626 increases the self-employment deduction for health insurance and adds four portability provisions that will apply to all group health plans, regardless of size, including self-insured

7First dollar coverage refers to coverages with no deductible or coinsurance paid by the insured. All charges are fully covered by the insurer.
plans. The portability requirements are: (i) an excise tax (25 percent of gross premium for the plan) for failure to provide all of these portability benefits; (ii) a prohibition against denying, limiting, or conditioning coverage (or benefits) on health status; (iii) a maximum six month preexisting condition limitation (except for newborns); and (iv) a continuity of coverage provision that mandates credit for prior coverage if no more than a three month break in coverage has occurred.

The combination of these benefits is expected to increase premiums about 4 to 5 percent overall for small employers because these benefits, in aggregate, are more generous than the average plan of benefits that small employers currently offer.

- **Cost Containment Provisions**: H.R. 3626 calls for the establishment of a national health care cost containment commission soon after the bill’s enactment. It also requires the Secretary of Health and Human Services to develop optional, maximum payment rates for hospitals, physicians, and other health services by October 1, 1994 and annually thereafter. The rates are to be based on DRG (diagnosis-related group) and RBRVS (resource-based relative value scale) methodologies similar to what Medicare currently uses.

These cost containment provisions are too nebulous to justify any estimated reduction in costs at this time. While some studies have estimated significant savings from using current Medicare reimbursement maximums, it is by no means certain that the payment rates eventually approved will be so low. To the extent that the optional DRG and RBRVS rates are used uniformly by health care payors, including government, however, some reductions in cost shifting may occur.

Thus, although H.R. 3626 will improve the availability of coverage for small employers and portability of coverage for all employees, the severe rating restrictions in a voluntary market (without mandated universal coverage) will lead to more persons being uninsured than at present. It will force many small employers to pay a high price to make coverage more affordable for a few small employers. In short, its costs will far exceed its benefits.
3 Rating Restrictions

3.1 The Redistribution of Small Employer Premiums

Most of the provisions in H.R. 3626 that will have a direct impact upon rating are summarized in Appendix B. H.R. 3626 calls for community rating of all small employer (two to 50 employees) health insurance plans with only a ±25 percent adjustment in rates for age and gender if applied consistently to all small employers.

The redistributional effects (or first order effects as they sometimes are called) are the effects of applying the H.R. 3626 rating restrictions to premiums for currently insured employers before any changes occur in the insured population. That is, before anyone migrates to or from (enters or leaves) the small employer market.

Rating restrictions limit the range of premiums that insurers can charge small employers. They redistribute premium rates charged to employers about the average (mean) rate, but the mean rate remains unchanged. As a result, premiums will increase for some employers and decrease for others.

In the discussion of the redistributional effects of H.R. 3626's rating restrictions, the following must be kept in mind:

1. The insured population is held constant when examining the effect of H.R. 3626 rating restrictions on currently insured, small employer groups;

2. The redistributional effects do not include the effects of changes in the insured and uninsured small employer population. The changes in the insured and uninsured small employer population are in addition to the redistributional effects described in this section;

3. The aggregate premium generated from all small employer groups is assumed to be the same before and after rating restrictions are applied. Thus, the average premium is not changed by the effects of H.R. 3626.

4. The change in small employer premium due to redistributional effects is the premium the employer pays after rating restrictions less the premium it paid before rating restrictions. The after premium must not include any increases due to the trend increase employers will receive at renewal or any other increases resulting from H.R. 3626.
5. By definition, there is no redistributional effect on the uninsured because it is a first order effect, i.e., before migration.

3.2 Methodology

The estimates given in this section are derived from an analysis of a representative sample of actual small employer group data from five different HIAA member companies. Data are collected for similar fee-for-service, indemnity benefit plans (similar to a $200 deductible, 80 percent coinsurance plan), a representative mix of employers for each insurer, and a representative mix by age/sex, industry, area, size, and other small group rating factors for each insurer.

The data are normalized for each insurer before being run through an actuarial model that recalculates the premium each insurer charges each of the 3,750 small employers in the sample using the H.R. 3626 rating restrictions. Geographic factors also are normalized for each insurer, but otherwise are unaffected across insurers. The total premium for each insurer is not changed, but the premium for each employer group is restricted to the H.R. 3626 rating bands such that some employers receive increases and others receive decreases.

The insurers chosen for this study represent five insurers with significant sales in the commercial, small employer, group health insurance market. This group includes insurers with broad and tight underwriting practices. While aggregated estimates are provided, there are large variations between insurers. This suggests that the effect of rate limits will vary greatly from one insurer to another. Further, while an effort is made to obtain data from a group of carriers that will be fairly representative of the small employer group market, there is no way to determine accurately how representative these carriers are. Therefore, the estimates should not be considered industry estimates but should be considered as the composite experience of five insurers.

Representative databases of groups with two to nine employees and ten to 25 employees are obtained from each of the five insurance companies. The two to nine and ten to 25 data are analyzed separately and then combined. The results for groups with two to nine employees are in the same direction but more pronounced than the results for the combined market (i.e., groups with two to 25 employees). Results are somewhat less pronounced for groups with ten to 25 employees.

The database includes employer groups with two to 25 employees rather than groups with two to 50 employees (the definition of a small employer in H.R. 3626). But comparing the effect of H.R. 3626 on groups with two to nine employees versus its effect on groups with ten to 25
employees indicates that H.R. 3626 has relatively less impact on the ten to 25 employee groups. Thus, it seems reasonable to conclude that the effect of H.R. 3626 on groups with 26 to 50 employees will be even less. Hence, groups with two to 25 can serve effectively as proxies for the two to 50 employee groups without significantly affecting the conclusions of this study.

3.3 Impact on Small Employers

Even though the overall average premium remains unchanged, the premium per capita\(^8\) for almost every employer group either will increase or decrease as a result of H.R. 3626. Therefore, the distribution of rates will change. The change in the distribution of premium rates for insured employer groups before rating restrictions, and before migration and expanded benefits, is illustrated in Figures 1 and 2. Figure 1 shows the distribution of premium rates for insured employer groups before rating restrictions, and before migration and expanded benefits (i.e., before H.R. 3626) as a percentage of the mean rate, while Figure 2 shows the distribution after H.R. 3626 rating restrictions are applied.

The impact of the H.R. 3626 rating restrictions on individual small employer groups is examined by determining the premium increase (or decrease) each employer will receive under H.R. 3626's rating restrictions. The employers are grouped into five categories based on the level of the employer's percentage change from its current premiums. Then the subsidy provided by low average age employers to high average age employers is examined. Last, the subsidy provided by the smallest small employers to larger small employers and the price sensitivity of the smallest small employers are examined.

Rating restrictions will affect each small employer differently. H.R. 3626 restricts small employer rates to a narrow band, forcing all but a handful of employers to receive premium increases or decreases. These first order effects on the total premium for each small employer in the sample are illustrated in Tables 2, 3, and 4. Table 2, for example, shows that 19 percent of employers with two to 25 employees will have an increase in premium of more than 20 percent from H.R. 3626 rating restrictions alone. For this 19 percent of employers, however, increases will range from 21 percent to 238 percent, and the average increase for all employers receiving more than a 20 percent increase will be 36.6 percent. More than two-thirds of all employer groups (68 percent) will

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\(^8\)The premium per capita is the total premium for the employer group divided by the total number of employees and dependents covered by the employer.
receive premium increases from rating restrictions. Nearly half of all employer groups (45 percent) will receive premium increases greater than 5 percent.

Table 2
Distribution of Rate Changes for Currently Insured Small Employers (two to 25 Employees) Under H.R. 3626 Before Migration and Expanded Benefits

<table>
<thead>
<tr>
<th>Percentage Rate Change</th>
<th>% of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 20%</td>
<td>19%</td>
</tr>
<tr>
<td>6% to 20%</td>
<td>26%</td>
</tr>
<tr>
<td>-6% to 6%</td>
<td>34%</td>
</tr>
<tr>
<td>-20% to -6%</td>
<td>13%</td>
</tr>
<tr>
<td>Less than -20%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Health Insurance Association of America.
To examine the extent to which low average age employers subsidize high average age employers, increases in premiums for the one-fifth (the fifth quintile) of employers with the lowest average employee age are compared to the increases in premiums for all small employers. If the percentage of employers receiving a premium increase is similar in each premium-increase category, it indicates that little or no extra subsidy is demanded from the employers with a younger group of employees. The results, however, show that considerably more low average age employers will receive premium increases than will all employers. Compared to the 68 percent of employers receiving premium increases among all employers, 82 percent of low average age employers are expected to receive premium increases.

Table 3 shows that, in contrast to the 19 percent of employers that will receive a premium increase of more than 20 percent, 30 percent of low average age employers will receive premium increases of this magnitude. Additionally, only 10 percent of low average age employers
will receive a significant premium decrease versus 21 percent of all employers.

Table 3

| Distribution of Rate Changes for the Youngest Quintile of Small Employers (two to 25 Employees) Under H.R. 3626 Before Migration and Expanded Benefits |
|---------------------------------|-----------------|
| Percentage Rate Change          | % of Employees  |
| More than 20%                   | 30%             |
| 6% to 20%                       | 30%             |
| -6% to 6%                       | 30%             |
| -20% to -6%                     | 7%              |
| Less than -20%                  | 3%              |

Source: Health Insurance Association of America.

While the direction of this result is not surprising, its magnitude is significant and indicates the extent to which H.R. 3626 shifts rates from the actuarial goal of consistency between premiums and risk assumed (i.e., premiums no longer reasonably reflect expected claims, except in the aggregate). Also, because of the clear relationship between higher ages and higher incomes, this has the perverse effect of forcing lower income employees to subsidize higher income employees. Thus, the redistributional effect of H.R. 3626 is regressive.

To examine the extent to which the smallest of the small employers will subsidize larger small employers, increases in premiums for the largest size quintile of employers insured by each carrier (generally, employers with more than 15 employees) are compared to the increases in premiums for all small employers. Again, if the percentage of employers receiving a premium increase is similar in each premium increase category, it indicates that little or no extra subsidy exists. The results of this model, however, indicate that considerably fewer of the larger small employers will receive premium increases when compared to all small employers. Compared to the 68 percent of all employers that will receive increases (increases ranging up to 238 percent), only 59 percent of larger small employers will receive increases (increases ranging only as high as 131 percent).

Table 4 shows that 12 percent of these larger small employers (versus 19 percent of all employers) will receive a premium increase of more than 20 percent. Likewise, in contrast to the overall statistic that 32 percent of small employers will receive a premium decrease, 41 percent of
the larger small employers will receive a decrease. That is, larger small employers are almost one-third more likely to receive decreases than the smallest of the small employers.

**Table 4**

<table>
<thead>
<tr>
<th>Percentage Rate Change</th>
<th>% of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 20%</td>
<td>12%</td>
</tr>
<tr>
<td>6% to 20%</td>
<td>22%</td>
</tr>
<tr>
<td>-6% to 6%</td>
<td>42%</td>
</tr>
<tr>
<td>-20% to -6%</td>
<td>15%</td>
</tr>
<tr>
<td>Less than -20%</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Source: Health Insurance Association of America.*

There are several ways that Table 4 can be interpreted. The most simplistic way is that the smallest employers pay less because carriers underwrite the smallest employers more aggressively and select better risks, on average. If this is true, the fifth quintile of small employers will have the greatest increases. Upon reviewing the data on the fifth quintile of small employers and comparing it to all small employers, however, the results are ambiguous.

Alternatively, Table 4 can be interpreted as an illustration of the greater price sensitivity of the smallest of the small employers. Because the larger small employers have about the same percentage of premium decreases as all small employers, those larger small employers seem as willing as all small employers to pay the increases when premiums rise. But a smaller percentage of larger small employers receive premium increases than all small employers. As a result, the smallest small employers appear to be either less willing or unable to purchase coverage unless they have a lower than average risk and, as a consequence, receive a lower than average premium. This indicates the greater price sensitivity of the smallest small employers.

It is probably most reasonable to interpret Table 4 as demonstrating the combined result of underwriting decisions by carriers and the price sensitivity of the smallest small employers.
3.4 Impact on Insurers

All insurers are not affected equally under H.R. 3626. The impact of the H.R. 3626 rating restrictions on insurers varies depending on the mix of high and low cost insureds that the insurer underwrites. For example, in contrast to the 19 percent of employers that will receive a premium increase of more than 20 percent, one insurer in the sample will have 37 percent of employers with increases that large.

The rating restrictions in H.R. 3626 break the actuarial link between the premiums insurers charge and the risks they assume. Thus, premiums no longer will reflect the expected claims the insurer will incur for each class of risk. Solvency and actuarial soundness of rates will be affected any time reforms lead to an environment where it is difficult, if not impossible, to charge rates that reasonably reflect the expected costs the insurer will incur for each class of risk. Therefore, the reforms in this bill could place additional financial stress on insurers and could lead to their financial insolvency.

Insurer rate bands will be based on the insurer's own average rate. Some insurers will have lower average rates and some will have higher average rates. Insurers that, coincidentally or because of underwriting before reform, have insured populations with lower than average risk can be expected to have a lower average (or community) rate. Other insurers could insure a population that has a greater proportion of higher than average risks; their community rate is likely to be higher than the community rate of insurers with lower than average risks. Insurers may be able to absorb some losses for a period of time, but continued deterioration will force them out of the small group business. In addition, other lines may subsidize these losses.

Insurers that have the majority of their business in the small group market may not fare as well as insurers with a more diversified mix of business. Insurers that are only in the health business may not have the option of retaining losses until they can leave the market gracefully. Unrecoverable losses could force them into insolvency, further disrupting the market and threatening coverage for their existing policyholders. Furthermore, this will be particularly disruptive to policyholders in managed care networks and to provider-patient relationships.
4 Changes in Insured/Uninsured Small Employers

4.1 Migration Effects on Small Employers Populations

In this section, the migration effects (also called the second order effects) of H.R. 3626's rating restrictions, access provisions, and standardized benefits are examined. The migration effects are the effects of employers and employees entering and leaving the small employer group market as a direct result of the change in access rules and changes in premiums.

The rating restrictions (described in Section 3) limit the premium rate that insurers can charge high risk employers, making coverage more affordable for high cost risks. At the same time, access provisions guarantee employers and employees the right to purchase coverage. This combination encourages insured high risk employers and employees to retain their insurance coverage. The access provisions also encourage uninsured high risk employers and employees to purchase insurance coverage. Guaranteed eligibility provisions assure that all employees (working at least 17.5 hours a week for a small employer with a health insurance plan) and their dependents will be eligible to participate in their employer's plan. Guaranteed renewability provisions ensure that once an employer gets coverage, the employer will not lose it.

In addition, H.R. 3626 increases the self-employed deduction for health insurance benefits, and self-insurance is limited. The effects of the self-employed deduction and, to a lesser extent, the self-insurance provision lead to changes in the insured small employer population. The expanded benefits also increase premiums for small employers, thus exacerbating population changes.

In the absence of rating restrictions, H.R. 3626's access provisions will lead to some changes in who is insured. These provisions also will lead to either higher rates for the groups affected, to increases in the insurers' average rate for all small employers, or to a combination of both. When combined with the severe rate compression of the nearly flat community rating and the expanded benefits, however, access provisions will increase rates significantly. These increases either (i) add to the increases the majority of small employer groups receive; (ii) make the

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9The H.R. 3626 access provisions also are summarized in Appendix B. The most significant access reforms are guaranteed issue, guaranteed eligibility (whole group), and guaranteed renewability.

10H.R. 3626 limits the efficacy of self-insurance, but it does not prohibit it. Consequently, small employers for whom it is still advantageous to self-insure (even with the 25 percent excise tax) may choose to do so.
employers that receive small decreases instead receive rate increases; or
(iii) reduce the rate decreases that employers receiving larger decreases
will receive.

In the following discussion of the migration effects of H.R. 3626’s
rating restrictions, the following should be kept in mind:

1. In this section, the insured population is changing. Also, there is
   no mandate on the employer to provide, or on the employee to
   obtain, coverage, i.e., it is a voluntary market;

2. The effects of migration are examined using sensitivity tests on
   a range of assumptions regarding how many insureds enter and
   leave the market and the morbidity (net claim costs) of these mi­
   grants;

3. Because carriers are insuring a different population, the average
   premium of each employer group and the aggregate premium over
   all groups combined may change;

4. The difference in premium for all small employers is determined
   by comparing the market average of premiums before reforms to
   the market average of premiums after reforms. This difference is
   in addition to the trend increase employers may receive in their
   premiums and to the redistributional effects;

5. Migration effects also have an impact on the number of uninsured
   small employers.

4.2 Methodology

The estimates in this section are derived from sensitivity analysis us­
using the actuarial migration model described in Appendix C. The model
is a reasonable compromise between simplicity and complexity. It iden­
tifies those factors that need to be measured to understand the impli­
cations of small group reforms. In addition, the model shows which
of the factors have the greatest impact on premium changes as a re­
sult of reforms. The model splits the small employer health insurance
market into three blocks: (i) employer-provided insurance (including
self-insured employers); (ii) insurance from any other source; and (iii)
the uninsured.

The model addresses the movement of small employers into and out
of the health insurance market, but it does not attempt to simulate the
effect of employers moving between carriers within the market. While
movement within the market may lower a particular employer's premium, it will not change total costs in the market unless employers reduce their coverage at the same time. In the long run, any premium shortfalls from insufficient rates will show up as future trend rate increases.

Starting with the small employer population and the morbidity pattern of each block before reforms, the population and morbidity of insured small employers entering and leaving each of these blocks is combined algebraically in the migration model in order to estimate the small employer population and the morbidity pattern in each block after reforms.

The uninsured are segmented further into high and low risk individuals. Varying assumptions are used for how many individuals enter the insured market from these two segments, as high risk individuals and their employers have a greater incentive to enter the market and have a greater impact on the increase in premiums as a result of H.R. 3626. These assumptions are discussed in greater detail in Sections 4.6 and 4.7.

While population-based data are not consistent with developing exact numerical estimates, reasonable ranges can be developed for the model's assumptions. (See Appendix C.) Consequently, it is necessary to perform sensitivity tests on the results using different sets of assumptions, or scenarios, in order to test the full range of possible values for each variable. For purposes of illustration, these are narrowed to three scenarios that bound the full range of outcomes: low cost, most likely, and high cost. The results vary over a wide range and are sensitive to some of the assumptions.

4.3 Impact on Premium per Capita

Migration effects will increase the premium per capita for all small employer groups covered by an insurer equally. The premium per capita for every employer group will increase above what it would have been due to rating restrictions only. Employers scheduled to receive rate increases will get higher increases. Employers due to receive rate decreases will receive smaller decreases or no decreases. The distribution of premiums per capita for insured employer groups will change to reflect the migration effects as well as redistributional effects.

The distribution of premiums per capita for currently insured employer groups after migration will be similar to the distribution in Figure 2 except the average premium (the 100 percent level) will be higher, i.e., Figure 2 shifts to the right for currently insured employers.
4.4 Impact on Small Employers

H.R. 3626's access provisions, in conjunction with rating and benefit provisions, will lead to population changes that will cause the average premium per capita to rise for all small employers. This increase could range from 8 to 24 percent of current premiums. This range is broad because the estimated results are sensitive to critical assumptions that are used in the migration model. The upper and lower ends of the range can be considered extremes such that the most likely outcome falls somewhere close to the middle of the range.

The premium increase from migration will be in addition to any increase or decrease that employers will receive from redistributing premiums to meet rating restrictions. For example, if a carrier has to raise the average premium 12 percent for second order effects, any group that previously received a 24 percent increase now will receive a 39 percent increase. (The impact on rates is cumulative, e.g., $1.24 \times 1.12 = 1.3888$, which is roughly a 39 percent increase.) Likewise, any group that had received a 24 percent decrease from rate compression now will receive only a 15 percent decrease ($0.76 \times 1.12 = 0.8512$), effectively wiping out almost half of the benefit of the rating restrictions.

While it is possible to envision better or worse scenarios, it seems most likely that employers will experience premium changes from $-25$ percent to $+271$ percent at renewal when the effects of trend and H.R. 3626 are combined (assuming an 18 percent trend factor). Thus, the covariant effects of community rating in conjunction with guaranteed access and expanded benefits effectively could undermine the goals of greater access, affordability, and coverage in a voluntary market.

Some employers may respond to the rate increases caused by H.R. 3626 by dropping their coverage. Historically, however, employers receiving large trend or experience increases have not responded by dropping their coverage. Instead they try to retain their coverage by seeking less costly alternatives such as reducing plan benefits or increasing employee contributions. Failing that, they may seek coverage through the individual health insurance or self-insurance markets to the extent that these markets provide cheaper alternatives after H.R. 3626 reforms.

Employees experiencing large rate increases also will seek lower cost options. Some employees may choose to reduce their health insurance premium by dropping family coverage in favor of single coverage on the employee only or by increasing their deductibles and copayments.
4.5 Impact on Insurers

The H.R. 3626 rating, access, and benefit provisions will make health insurance more affordable and accessible for high risk groups and less affordable for low risk employers. This will increase adverse selection, i.e., persons who know that they have higher than average health care costs will increase their purchase coverage while those who know that they have lower than average costs will reduce their coverage. The tight rating bands of H.R. 3626 cause more adverse selection than other proposals with less severe rating bands. Thus, H.R. 3626 leads to greater adverse selection and greater changes in the insured, small employer population than other proposals to date.

Because low risk insureds tend to shop for coverage (replace their current coverage for lower cost coverage) more than high risk insureds, insurers with lower average rates can be expected to attract more low cost risks than those with higher average rates. This implies that, for competitive/antislection reasons, some companies will not be able to raise their rates high enough to cover expected claim costs. If their in-force business eventually deteriorates to the point that it contains a significantly disproportionate share of high cost insureds, the insurer will be left with two equally poor choices: reduce rates (and hope that the low cost risks will come) or raise rates and experience further deterioration of their claims experience.

Alternatively, those insurers experiencing enrollment losses as a result of employers dropping coverage (especially low risk ones) could be forced to (i) strengthen and apply participation requirements more strictly; (ii) expand self-insurance products for small employers; or (iii) seek reinsurers/partners in order to spread the risk and maintain market share. The impact on insurers of current migrations of both large and small employers toward self-insured, ERISA-protected plans\textsuperscript{11} provides strong empirical evidence of this tendency.

Insurers will be subject to the effects of adverse selection (even from employers that maintain their coverage) if employees who will have to contribute toward higher premiums choose to forego coverage instead. The insurer still may cover the employer, but now fewer employees and their dependents will be in the risk pool. It also can be presumed that employees foregoing coverage will be, as a group, lower risk than those remaining insured.

Insurers that guarantee issue coverage to a disproportionate share of high risk insureds will face an additional risk: their small group busi-

\textsuperscript{11}ERISA plans are self-insured medical plans established by the United States Congress in accordance with the Employee Retirement Income Security Act of 1974.
ness will have a higher percentage of high cost claimants than their rates anticipated. At the same time, rates only can be set within the allowable rate bands, and rate increases are limited. It may become impossible to offer an actuarially sound, competitive rate that attracts a reasonable mix of high and low risk insureds to assure the integrity of the risk pool. Insurers could find their total premium (from all small groups) insufficient to pay their claims. This increases insurer uncertainty that premiums will be sufficient to pay claims.

Risk margins in current rates are based upon the level of uncertainty (the probability that actual costs will vary from expected costs) that exists in the current market. The increased uncertainty of the market after reforms will encourage insurers to increase their risk margins. The magnitude of the increase will depend on each insurer's specific situation, and it is unlikely that any a priori estimate of its magnitude will be credible.

4.6 Impact on the Uninsured

Estimating the number of uninsureds attached to the small employer market is hindered by having to determine whether an establishment is a small employer or part of a larger firm. For example, six dry cleaners each with ten employees may be part of the same 60 employee firm or they may be six separate ten employee firms—in both cases they will be six establishments. The question of what to do about dependents when both spouses work and both are uninsured, but one works for a small firm and the other works for a large firm is also problematic. Also, the data are not always split into the employer size categories desired for analysis. In spite of these complications, algorithms have been developed that address these issues. Estimates of the number of small employer uninsured range from 11 to 15 million.

Even in the best scenario, indications are that the number of small group uninsureds will increase rather than decrease under H.R. 3626, contrary to the desired goal of this bill. As many as 0.6 million to 2.3 million Americans may reenter the market under H.R. 3626 reforms. An estimated 1.2 million to 4.1 million more Americans may drop or lose their coverage. The net effect will be an increase in the number of uninsureds of 0.7 million to 1.9 million, increasing the number of small group uninsureds 6 to 12 percent. Because small group uninsureds are about half of the uninsured, however, H.R. 3626 will increase the total number of uninsureds about 3 to 6 percent. If previous socioeconomic patterns hold for these new uninsureds, the tendency will be for these new uninsureds to be younger, lower income, and from the smallest
employers. Many also will be children.

Certain assumptions related to the uninsured have a profound impact on the results of this study, so a short discussion of these assumptions is presented below. The migration model assumptions used in each of the three scenarios are shown in Appendix C.

4.7 Number of High Risk Uninsureds

A key assumption is the number of high risk uninsured employees. High risk uninsureds are medically uninsurable individuals who may be denied health insurance under current medical underwriting practices. Prior to a recent AHCPR (Agency for Health Care Policy and Research, United States Department of Health and Human Services) study, reasonable estimates for this variable ranged from 7 to 12 percent. The AHCPR study shows that only 36.8 percent of the uninsured have investigated the cost of private health insurance; only 2.5 percent of that cohort have ever been denied coverage or had their coverage limited. The 2.5 percent includes more than just medically uninsurable individuals and includes those who have been excluded from individual (not just group) coverage. It also includes those who ever have been rejected for a policy, whether they will be today or not. It does present an upper bound for who may be medically uninsurable among the 36.8 percent who have investigated coverage. Assuming the same proportion of uninsurable persons among those who haven't investigated coverage as among those who have (a grossly conservative assumption), 6.8 percent of the uninsured at most could be medically uninsurable.

Medically uninsurable individuals may not be distributed uniformly among the various segments of the uninsured population. For example, small employers could have a higher percentage of medically uninsurable employees than large employers. In case there is a disproportionate share of these high cost insureds among small group uninsureds, 7 percent is assumed to be the low end of the range for small group uninsureds. Even with the possibility of a biased distribution, however, it appears that the 12 percent estimate for the top of the range for this assumption is too conservative. But the 7 to 12 percent range used in this study encompasses the most reasonable range of values available from current research.

4.8 The Morbidity of Medically Uninsurable Employees

Current studies show that the morbidity of medically uninsurable employees range anywhere from 200 percent of the net claim cost of
the current small employer group market to as much as 500 percent. Analysis of the experience of individual high risk pools, however, shows that even when considered as individuals rather than as groups, the experience for these high cost insureds only averages 350 percent of the current small employer group market experience. Because groups can be expected to have employees and dependents that are standard or better risks to offset the additional claim cost of high cost insureds, it is expected that, on average, the morbidity of high risk groups will be less than the morbidity of individual high risk pools. For this study a range of 248 to 300 percent of current small employer net claim cost is used for this variable.

5 Standardized Benefits and Deductions

H.R. 3626 mandates a generous preexisting condition limitation, the preemption of state mandates, the addition of preventive services with first dollar coverage, and a standard benefit package similar to Parts A and B of Medicare. In an attempt to place the self-employed on parity with all other employers, H.R. 3626 increases the self-employed deduction for health care expenses to 100 percent of expenses. These provisions are described in Appendix B.

The standardized benefits detailed below are expected to increase small employer premiums about 4 to 5 percent overall because these benefits are more generous in aggregate than the average plan of benefits small groups currently offer. The impact of the deductions is harder to quantify. The following is a description of the standardized benefits and deductions.

- **Preexisting Condition Limitation**: Based on data from HIAA’s employer survey and HIAA calculations using the 1994 *Tillinghast Group Medical Insurance Rate Manual*, it is estimated that reducing the preexisting condition limitation period to a required maximum of six months will add about 2 percent to an average policy.

- **Standard Benefit Package, Including Preventative Services**: The standard benefits package (except for some of the preventive benefits) will be less than a standard employer provided plan in some

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12 The *1994 Tillinghast Group Medical Insurance Rate Manual* is published by Tillinghast, 101 South Hanley Street, St. Louis MO 63105-3411, USA.
states, while in other states the H.R. 3626 plan will be more generous. The net effect is estimated to be about a 1 percent increase in the average premium from current levels.

- **Elimination of State Mandates:** The effect of eliminating state mandated benefits and policy provisions is included in the pricing of the standard benefit package. The reduction for eliminating state mandates is not readily apparent because H.R. 3626 mandates a package of benefits that, with the exceptions above, is similar to the average small employer plan. Furthermore, for a small employer that offers its employees a plan with fewer benefits than the H.R. 3626 minimums, rate increases will be even higher than this analysis otherwise indicates.

- **Self-Employed Deduction:** It is difficult to estimate the impact of the self-employed deduction provision. Though the self-employed population is small compared to the total population, it is reasonable to assume some increase. For example, increasing this deduction will tend to encourage the self-employed with above average costs to seek insurance more than it may encourage the self-employed with below average costs to seek insurance. This is evident in the results of the 1987 national medical expenditure survey\(^{13}\) that show individually insured persons have much higher cost and risk than group insureds. I estimate that this may add another 1 to 2 percent to the average premium.

6 **Cost Containment Provisions**

H.R. 3626 calls for the establishment of a national health care cost containment commission shortly after enactment of the bill. It also requires the Secretary of the Department of Health and Human Services to establish optional maximum payment rates for hospitals, physicians, and other health services by October 1, 1994 and annually thereafter. The rates are to be based on DRG and RBRVS methodologies similar to those Medicare currently uses.

This approach to cost containment will not contain health care costs effectively because it does nothing to control the fundamental sources of health care cost increases other than medical price inflation.

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\(^{13}\)The national medical expenditure survey is a detailed survey of the health expenditures of Americans and their families. This survey is sponsored by the US Agency for Health Care Policy and Research, Department of Health and Human Services, 200 Independence Avenue SW, Washington DC 20201.
The most important sources of health care cost increases are medical cost inflation, cost shifting, utilization (the number of health care services used), adverse selection, defensive medicine, and new technologies. In 1991 the medical cost inflation component was responsible for only about a third of health care cost increases. Thus, an approach that addresses only medical cost inflation addresses only about one-third of the problem.

But H.R. 3626 may not control medical cost inflation effectively. While some studies have estimated significant savings from using current Medicare reimbursement maximums, it is by no means certain that the payment rates eventually approved will be so low. Because the Secretary of Health and Human Services will be charged with establishing maximum payment rates (without guidelines for how high these rates could be), it is not certain that the maximum payment rates set by the Secretary will contain costs effectively.

The only positive point that can be made regarding this approach is that, to the extent that the maximum payment rates are used uniformly by health care payors (including government payors), some reductions in cost shifting may occur. It is reasonable to expect that insurers will use these rates if they are legislated or if they are less than what the insurer currently pays. Any insurer that does not likely will be at a competitive disadvantage.

The H.R. 3626 cost containment provisions are still too nebulous to justify any estimated reduction in costs at this time.

7 Provisions Not Quantified

The number and complexity of health insurance market reform proposals have outstripped the available data, and H.R. 3626 is no exception. Consequently, it is impossible to quantify certain provisions in the bill. In some cases more data and analysis are needed. In others data are not available to estimate credibly the impact of certain reforms on the market.

Some of the provisions not specifically quantified in this study are the minimum plan period, the notice of renewal, the index rate variation between blocks, the types of family enrollment, the transfers among blocks, the 5 percent limit on rate increases above trend, the geographic factors limited to MSAs, the self-insurance prohibition, the uniform claims forms, and the uniform reporting standards.

14 As defined by the United States Census Bureau, MSA means a metropolitan statistical area, e.g., Hartford, Connecticut.
Although the effect of H.R. 3626 on employees purchasing single coverage versus employees purchasing family coverage is not analyzed in this study, an independent study by an HIAA member company shows H.R. 3626 can be expected to increase rates for single coverage more than for family or single parent coverages. (Increases for singles are estimated to be five times greater.)

Some covariant effects cannot be analyzed with the data available and are beyond the scope of this study. For example, how geographic factors may change in the absence of other risk classification factors (such as industry or full age/gender rating) is not examined. As the scope of this study is limited to the effects of H.R. 3626 on the small employer group health insurance market, the impact of portability requirements on employers other than small employers is not analyzed. Similarly, the impact of H.R. 3626 on association groups and employer-provided individual health insurance is also beyond the scope of this study.

No specific attempt is made in this study to measure H.R. 3626's effect on the solvency of employers and insurers. But the magnitude of rate increases for some employers and the likelihood that certain insurers will get a disproportionate share of high risk insureds will have an impact on their solvency. Also, it is not possible to include the impact of state regulations already promulgated. For example, some states have passed laws similar to the rating restrictions and other provisions in this bill. In these states, to the extent that premiums and the market already reflect these changes, H.R. 3626 will have less impact.

8 Summary and Conclusions

H.R. 3626 tries to marry the social goals of guaranteed availability, community rating, and generous standard benefits. It doesn’t consider sufficiently the realities of price-sensitive small employers and individual employees acting in their own best interest in a highly competitive, voluntary market.

While improving availability and affordability of health insurance for a minority of small employers, H.R. 3626’s rating restrictions increase premiums disproportionately for the majority of small employers. Employers with younger, lower income employees will be forced to subsidize employers with older, higher income employees. Smaller small employers will subsidize larger small employers. Premiums no longer will reflect expected claims, except in the aggregate, exacerbating the tendency in small employer markets to be uninsured due to cost.
Changes in the insured small employer population as a result of H.R. 3626 will increase the average premium per capita of all small employer groups 8 to 24 percent, largely as a result of the severe rating restrictions. The premium per capita for almost every small employer group either will increase or decrease, and the distribution of premiums per capita for insured employer groups will change, generally worsening. In effect, H.R. 3626 proposes a solution that affects 100 percent of insured small employers, most of them negatively, in order to address a problem that afflicts less than 15 percent of small employers.

Some employers will respond to the H.R. 3626 rate increases by dropping their coverage altogether. Based on my experience with selling coverage to small employers, it seems far more likely that small employers who currently have coverage will do what they have always done when faced with significant rate increases. They will seek less costly alternatives such as reducing benefits to the minimum allowable (if their benefits are currently more generous), increasing employee contributions (employee share of the premium), self-insuring (if feasible), or utilizing the individual health insurance market.

While the full impact is not yet clear, the impact of the community rating law for small employers in New York State seems consistent with this conclusion. Young and healthy lives have dropped out of the system, claims costs have risen, and, at least anecdotally, small employers and individuals are choosing less generous benefit plans. (New York does not mandate a minimum or standard benefit plan.) Mitigating any negative impact of reforms in New York State is the implementation of a risk adjustment mechanism for risk pooling across the individual and small group markets. If H.R. 3626 had contained such a provision, the impact on rates and the market would be less.

Employees experiencing large rate increases also will seek lower cost alternatives. Employees could choose to drop their coverage or reduce their contribution toward premiums by dropping family coverage in favor of single coverage on the employee only.

H.R. 3626 will increase the risk to insurers of providing small employer coverage. Coupled with a hostile regulatory environment wherein rate increases often are reduced or denied, insurers will find it increasingly difficult to charge premiums that are adequate to protect existing policyholders. In response, insurers staying in the market may try to strengthen and apply participation requirements more strictly, increase risk margins, expand self-insurance products to small employers, reduce rates below an actuarially sound level (in an attempt to achieve or maintain a standard mix of risks), or develop more innovative responses that will protect the insurer from insolvency.
In a highly competitive, voluntary insurance market, the actuarial process of rating, the underwriting process of risk selection, and the competitive market in which they operate are symbiotic. Actuarially sound rates are established to ensure the solvency of the insurer in order to protect its policyholders. If these rates are too high, some persons will not purchase insurance. If rates are too low, there will not be sufficient reserves to pay policyholder claims. If the insurer screens too many risks, there will not be sufficient policyholders to cover the costs of operating the business. If the insurer screens too few or does not assign the appropriate rate to high risk policyholders, it will not have sufficient reserves to pay policyholder claims. There is always a decision to be made regarding costs versus benefits whenever considering changes to any of these processes—changing one affects all.

H.R. 3626 fails this litmus test of cost/benefit analysis. It does so, in large part, because of its severe rating restrictions. In the current market where health care costs are such a large proportion of nonsalary employee expenses, employers are looking to reduce this expense and are unwilling to subsidize actuarially higher risk insureds of another employer. If their employees are actuarially low risk, they demand low premiums. Otherwise, they do not purchase insurance. Consequently, forcing insurers in a free market to charge premiums that do not reflect the expected claims of insureds (thereby forcing large rate increases on most small employers) in order to satisfy a social goal will not produce the intended result.

This study shows that it is not the guaranteed issue/availability provisions of H.R. 3626 that lead to most of the small employer premium increases; rather it is the bill's rating restrictions. Other small group reform proposals with less severe rating restrictions will provide the benefits of guaranteed availability without the onerous rate increases precipitated by H.R. 3626.

In closing, although H.R. 3626 will improve availability of coverage for small employers and portability of coverage for all employees, the severe rating restrictions will lead to more persons being uninsured. It will force many small employers to pay a high price to make coverage more affordable for a few small employers. In short, the costs of this bill will far exceed its benefits.

Table A1
Summary of the Basic Benefit Provisions of H.R. 3626

<table>
<thead>
<tr>
<th>Provision</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Size</td>
<td>Two to 50 employees (portability provisions apply to all group health plans);</td>
</tr>
<tr>
<td>Transitional Period</td>
<td>Various, but up to three years for some provisions;</td>
</tr>
<tr>
<td>Availability</td>
<td>Guaranteed issue (year round; uniform waiting periods and minimum participation requirements allowed);</td>
</tr>
<tr>
<td>Individual Policies</td>
<td>Not applicable to individual policies (unless provided by employer);</td>
</tr>
<tr>
<td>Case Characteristics</td>
<td>Age, gender, and geography (no smaller than MSA);</td>
</tr>
<tr>
<td>Rating Restrictions</td>
<td>Community rating such that variations between blocks of business shall not exceed 20 percent. Age and sex adjustments may be used, but only up to ±25 percent and only if applied to all small employers;</td>
</tr>
<tr>
<td>Renewal Rating</td>
<td>May not exceed the sum of the percentage change in the base premium rate plus 5 percentage points;</td>
</tr>
<tr>
<td>Renewability</td>
<td>• Guaranteed renewable except for nonpayment of premiums, fraud or misrepresentation, and failure to maintain minimum participation rates;</td>
</tr>
<tr>
<td></td>
<td>• Must give notice 60 days prior to renewal date; terms of renewal must be same as at issue except for premiums and administrative changes;</td>
</tr>
<tr>
<td>Whole Groups</td>
<td>Coverage must be offered to any eligible employee and dependent;</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>Not included;</td>
</tr>
<tr>
<td>Reinsurance Price</td>
<td>Not applicable;</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>Not applicable;</td>
</tr>
<tr>
<td>Assessments</td>
<td>Not applicable;</td>
</tr>
</tbody>
</table>

*MSA = Metropolitan statistical area.
<table>
<thead>
<tr>
<th>Provision</th>
<th>Brief Description</th>
</tr>
</thead>
</table>
| Portability | These provisions apply to all group health plans:  
| | • Excise tax for failure to provide all of these portability benefits (25 percent of gross premiums);  
| | • Prohibition against denying, limiting, or conditioning coverage (or benefits) on health status;  
| | • Maximum six month preexisting condition limitation (except for newborns);  
| | • Continuity of coverage provision that mandates credit for prior coverage if no more than a three month break in coverage;  
| Other | • Self-employed deduction increased to 100 percent;  
| | • Applies to employees working at least 17.5 hours per week;  
| | • Deductible standard benefit package with preventive benefits;  
| | • Preemption of state mandates beyond standard benefit package;  
| | • Percent excise tax on self-insured;  
| | • Any payor may choose to use DRG\(^\dagger\) and RBRVS\(^\dagger\) schedules;  
| | • Must offer single, couple, single parent, and family rates  
| Effective Date | Various: depends on provision (some on January 1, 1992).  

\(^\dagger\)DRG = Diagnosis-related group.  
\(^\dagger\)RBRVS = Resource-based relative value scale.
Appendix B: H.R. 3626, Summary of Provisions Affecting Rating

H.R. 3626 has provisions that apply to small groups (defined as employer groups of two to 50 employees) and all employer groups, including self-insured plans. An employee is defined as any worker who normally works at least 17.5 hours per week.

**Self-employed deduction:** The amount of deduction for self-employed individuals is extended indefinitely, starting in 1993. The deduction increases from 25 percent to 50 percent in 1993, 75 percent in 1994, and 100 percent in 1995 and subsequent years.

**Preemption of state-mandated benefits:** States cannot mandate benefits beyond those in the standard benefit package, but they can establish more stringent requirements in other areas.

**Guaranteed eligibility:** Insurer cannot exclude any eligible employee or dependent to whom the employer offers coverage.

**Guaranteed issue:** Insurers offering a plan to small employers in a community must offer it to all employers in the area year round. Waiting periods are allowed if applied to all employees.

**Minimum plan period:** Rating basis applies for 12 months.

**Guaranteed renewability:** Insurers only can nonrenew and cancel for nonpayment of premiums, fraud, misrepresentation, or failure to maintain minimum participation rates.

**Notice of renewal (expiration):** Insurers must give notice 60 days prior to the renewal date. Terms of renewal must be the same as at issue except for premiums and administrative changes.

**Discrimination based on health status:** Insurers cannot deny, limit, or condition coverage or benefits based on an individual's "health status, claims experience, receipt of medical care, medical history or lack of evidence of insurability." An exception is made to this provision to allow for the preexisting condition exclusion.

**Index rate variation between blocks:** This must be less than 20 percent unless the block is one that always has provided open enrollment, the insurer never has transferred groups into the block involuntarily, and the block is currently available for purchase when an exception to the 20 percent rule is sought.
Community rating: Must be used within a block.

Age and sex adjustments: This may be used if applied consistently to all small employers. Maximum variation is ±25 percent.

Definition of community: Not smaller than an MSA.

Types of family enrollment: Insurers must have separate rates for single adults, childless couples, single parents, and families.

Transfers among blocks: Insurer cannot force an employer to transfer among blocks and may not transfer an employer unless the transfer is offered to all small employer plans and unless it is not based on demographics, experience, or date of issue.

Limits on rate increases: Increase may not exceed the percentage change in the base premium rate plus 5 percent (500 basis points).

Definitions:

1. A block (of business) consists of the small employer plans issued by an insurer. Distinct groups can be treated as separate blocks based on whether the group is marketed through direct response, has been acquired from another insurer, or is provided via an association of at least 25 small employers.

2. The reference premium rate is the lowest rate charged or available to any actuarial class.

3. The index rate is 133 1/3 percent of the reference premium rate.

4. The base premium rate, though not specifically defined, can be defined to be the index rate.

Standard benefit package:

1. In general, same as Parts A and B of Medicare.

2. Unlimited inpatient hospital coverage for children without coinsurance. (The deductible is not excluded.)

3. Maternity (including prenatal, inpatient labor and delivery, postnatal, and postnatal family planning).

4. The $250/500 deductible is indexed for future inflation.

5. The individual out-of-pocket limit of $2500/3000 is indexed for inflation in future years.
6. Preventive services must be provided without deductible or coinsurance. These services include: maternity, well-child care (including dental), screening mammography, screening pap smear, colorectal screening, and certain immunizations. Others may be added at a later date. There are limitations on what providers may charge for these. Effective 1/1/92.

Self-insurance prohibition: Small employers (two to 50 employees, including self-employed) may not self insure. This is enforced through a 25 percent excise tax on health care expenditures by self-insured plans.

Preexisting condition limitation (PCL) for all groups: Limits pre-existing condition exclusion to six months with a further proviso that prior coverage must be credited toward the six months as long as there isn't more than a three month lapse in coverage. PCL cannot be applied to newborns and is defined as a condition diagnosed or treated during the three months prior to issue. This applies to all employers. Effective 1/1/93.

Other portability provisions: In addition to the PCL, the portability provisions are an excise tax for failure to provide all of these portability benefits (25 percent of gross premium for plan); a prohibition against denying, limiting, or conditioning coverage (or benefits) on health status; and a continuity of coverage provision that mandates credit for prior coverage if no more than a three month break in coverage has occurred. All of the portability provisions apply to all group health plans, regardless of size, including self-insured plans.

Cost containment: This includes optional rates (prices) for hospitals, physicians and other medical providers, DRGs, and RBRVS. Any health care purchaser, including individuals, can choose to use promulgated rates. Providers must accept these rates as payment in full.

Uniform claims forms: Effective 1/1/94.

Uniform reporting standards: For development of rates (prices) to be used in cost containment efforts. Effective 1/1/93.
Appendix C: H.R. 3626: The Impact of Migration

Table C1

Assumptions for Migration Modeling Under the Optimistic, Best Estimate, and Pessimistic Scenarios

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Optimistic</th>
<th>Best Estimate</th>
<th>Pessimistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Market</td>
<td>45,000,000</td>
<td>50,000,000</td>
<td>55,000,000</td>
</tr>
</tbody>
</table>

Distribution (before reforms):

A. Employer-sponsored 55% 51.36% 50.0%
B. Individually-insured 20% 22.31% 22.5%
C. Uninsured 25% 26.33% 27.5%

Morbidity of Population as a Percentage of Employer-Sponsored Net Claims Cost (before migration):

A. Employer-sponsored 100.00% 100.00% 100%
B. Individually-insured 100.00% 100.00% 120%
C. Uninsured 75.04% 80.62% 102%

Employer-Sponsored Insureds Withdrawing From Small Employer Market:

A. % withdrawing 5% 10% 15%
B. Morbidity 24% 32% 40%

Individually Insureds Withdrawing From Small Employer Market:

A. % withdrawing 5% 5% 5%
B. Morbidity 100% 120% 120%
Table C1 (continued)

Assumptions for Migration Modeling Under the Optimistic, Best Estimate and Pessimistic Scenarios

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Optimistic</th>
<th>Best Estimate</th>
<th>Pessimistic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additions of Uninsureds to Small Employer Market:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Percentage of uninsureds who are medically uninsurable</td>
<td>7%</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>B. Percentage of medically uninsurables purchasing coverage after reforms</td>
<td>25%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>C. Percentage of all uninsureds purchasing coverage after reforms</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>D. Morbidity of medically uninsurables</td>
<td>248.08%</td>
<td>248.08%</td>
<td>300%</td>
</tr>
<tr>
<td>E. Morbidity of uninsureds who are not medically uninsurable</td>
<td>62.02%</td>
<td>62.02%</td>
<td>75.00%</td>
</tr>
</tbody>
</table>

*Note: Total Market = Population (employees and dependents) in small employer market before any changes*
Table C2
Basic Set of Assumptions

<table>
<thead>
<tr>
<th>Total Market (before migration):</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ER-sponsored Insureds</td>
<td>25,680,000</td>
<td>51.36%</td>
<td>100.00%</td>
<td>$1,470.74</td>
<td>1.95</td>
</tr>
<tr>
<td>B. Individually insured</td>
<td>11,155,000</td>
<td>22.31%</td>
<td>100.00%</td>
<td>$1,470.74</td>
<td>1.95</td>
</tr>
<tr>
<td>C. Uninsured</td>
<td>13,165,000</td>
<td>26.33%</td>
<td>80.62%</td>
<td>$1,185.71</td>
<td>1.45</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50,000,000</td>
<td>100.00%</td>
<td>94.90%</td>
<td>$1,395.69</td>
<td>1.79</td>
</tr>
</tbody>
</table>

Impact of Migration on:

<table>
<thead>
<tr>
<th>ER-Sponsored Insureds:</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Withdraw from market</td>
<td>2,568,000</td>
<td>10.0%</td>
<td>32.00%</td>
<td>$470.64</td>
<td>1.95</td>
</tr>
<tr>
<td>B. Remain in market</td>
<td>23,112,000</td>
<td>90.0%</td>
<td>107.56%</td>
<td>$1,581.86</td>
<td>1.95</td>
</tr>
<tr>
<td>Subtotal</td>
<td>25,680,000</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individually Insureds:</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Migrate to SGM</td>
<td>557,750</td>
<td>5.0%</td>
<td>120.00%</td>
<td>$1,764.89</td>
<td>1.95</td>
</tr>
<tr>
<td>B. Remain individually insured</td>
<td>10,597,250</td>
<td>95.0%</td>
<td>98.95%</td>
<td>$1,455.26</td>
<td>1.95</td>
</tr>
<tr>
<td>Subtotal</td>
<td>11,155,000</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Uninsureds (UIs):

A. MUIs migrating to SGM
   - Insurables entering SGM

B. Uninsureds who remain

Subtotal

<table>
<thead>
<tr>
<th></th>
<th>Number of Covered Lives</th>
<th>Percent</th>
<th>Ratio of Net Claim Costs to Market Cost</th>
<th>Cost Per Covered Life</th>
<th>Average Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ER-sponsored insureds</td>
<td>658,250</td>
<td>5.0%</td>
<td>248.08%</td>
<td>$3,648.61</td>
<td>1.45</td>
</tr>
<tr>
<td>B. Individually insured</td>
<td>658,250</td>
<td>5.0%</td>
<td>62.02%</td>
<td>$912.15</td>
<td>1.45</td>
</tr>
<tr>
<td>C. Uninsured</td>
<td>11,848,500</td>
<td>90.0%</td>
<td>72.35%</td>
<td>$1,064.08</td>
<td>1.45</td>
</tr>
<tr>
<td>Subtotal</td>
<td>13,165,000</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Market (after migration):

A. ER-sponsored insureds
   B. Individually insured
   C. Uninsured

TOTAL

<table>
<thead>
<tr>
<th></th>
<th>Number of Covered Lives</th>
<th>Percent</th>
<th>Ratio of Net Claim Costs to Market Cost</th>
<th>Cost Per Covered Life</th>
<th>Average Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ER-sponsored insureds</td>
<td>24,986,250</td>
<td>49.97%</td>
<td>110.34%</td>
<td>$1,622.75</td>
<td>1.92</td>
</tr>
<tr>
<td>B. Individually insured</td>
<td>10,597,250</td>
<td>21.19%</td>
<td>98.95%</td>
<td>$1,455.26</td>
<td>1.95</td>
</tr>
<tr>
<td>C. Uninsured</td>
<td>14,416,500</td>
<td>28.83%</td>
<td>65.16%</td>
<td>$958.37</td>
<td>1.52</td>
</tr>
<tr>
<td>TOTAL</td>
<td>50,000,000</td>
<td>100.00%</td>
<td>94.90%</td>
<td>$1,395.69</td>
<td>1.79</td>
</tr>
</tbody>
</table>

Note: Column headings are as follows: (1) Number of Covered Lives; (2) Percent of subtotal or total in column (1); (3) Ratio of Net claim Costs to Market Cost (Market Cost = $1470.74); (4) Cost Per Covered Life; and (5) Average Family Size. Data in columns (2) to (5) are rounded to two decimal places.

ER = Employer.

These withdrawing employer-sponsored insureds are now considered as uninsured.

SGM = Small group market.

MUI = Medically uninsured.
Table C3
Calculations Using Data From Table C2

<table>
<thead>
<tr>
<th></th>
<th>(6)</th>
<th>(7)</th>
<th>(8)</th>
<th>(9)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Market (before migration):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Employer-sponsored insureds</td>
<td>37,768,603,200</td>
<td>13,169,231</td>
<td>$2,867.94</td>
<td>$239.00</td>
</tr>
<tr>
<td>B. Individually insured</td>
<td>16,406,104,700</td>
<td>5,720,513</td>
<td>$2,867.94</td>
<td>$239.00</td>
</tr>
<tr>
<td>C. Uninsured</td>
<td>15,609,879,891</td>
<td>9,079,310</td>
<td>$1,719.28</td>
<td>$143.27</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>69,784,587,791</td>
<td>27,969,054</td>
<td>$2,495.06</td>
<td>$207.92</td>
</tr>
</tbody>
</table>

**Impact of Migration on:**

Employer-Sponsored Insureds:

<table>
<thead>
<tr>
<th></th>
<th>(6)</th>
<th>(7)</th>
<th>(8)</th>
<th>(9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Withdraw from market</td>
<td>1,208,595,302</td>
<td>1,316,923</td>
<td>$917.74</td>
<td>$76.48</td>
</tr>
<tr>
<td>B. Remain in market</td>
<td>36,560,007,898</td>
<td>11,852,308</td>
<td>$3,084.63</td>
<td>$257.05</td>
</tr>
</tbody>
</table>

Individually Insured:

<table>
<thead>
<tr>
<th></th>
<th>(6)</th>
<th>(7)</th>
<th>(8)</th>
<th>(9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Migrate to small group market</td>
<td>984,366,282</td>
<td>286,026</td>
<td>$3,441.53</td>
<td>$286.79</td>
</tr>
<tr>
<td>B. Remain individually insured</td>
<td>15,421,738,418</td>
<td>5,434,487</td>
<td>$2,837.75</td>
<td>$236.48</td>
</tr>
</tbody>
</table>

Uninsured:

<table>
<thead>
<tr>
<th></th>
<th>(6)</th>
<th>(7)</th>
<th>(8)</th>
<th>(9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uninsured MUs' migrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurable migrants</td>
<td>600,424,678</td>
<td>453,966</td>
<td>$1,322.62</td>
<td>$110.21</td>
</tr>
<tr>
<td>Subtotal migrating</td>
<td>3,002,123,390</td>
<td>907,931</td>
<td>$3,306.55</td>
<td>$275.55</td>
</tr>
<tr>
<td>B. Uninsureds who remain</td>
<td>12,607,756,501</td>
<td>8,171,379</td>
<td>$1,542.92</td>
<td>$128.57</td>
</tr>
</tbody>
</table>
### Total Market (after migration):

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Covered Employees</th>
<th>Annual Cost Per Employee</th>
<th>Monthly Cost Per Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Employer-sponsored insureds</td>
<td>40,546,497,570</td>
<td>$3,107.90</td>
<td>$258.99</td>
</tr>
<tr>
<td>B. Individually insured</td>
<td>15,421,738,418</td>
<td>$2,837.75</td>
<td>$236.48</td>
</tr>
<tr>
<td>C. Uninsured</td>
<td>13,816,351,803</td>
<td>$1,456.15</td>
<td>$121.35</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>69,784,587,791</td>
<td><strong>$2,495.06</strong></td>
<td><strong>$207.92</strong></td>
</tr>
</tbody>
</table>

Note: Column headings are as follows: (6) Total Cost; (7) Number of Covered Employees; (8) Annual Cost Per Employee; (9) Monthly Cost Per Employee.

'MUls = Medically uninsured.

Data in columns (8) and (9) are rounded to two decimal places.
Table C4
Best Estimate of Financial Impact of H.R. 3626 Small Group Reforms: Increase in Employer-Sponsored Insured Small Group Net Claim Cost due to Guarantees and Other Benefits After Reforms (Calculations Using Data From Tables C2 and C3)

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guarantees¹</td>
<td>10.3%</td>
<td>$152.01</td>
<td>$2,777,894,370</td>
<td>$239.96</td>
<td>$20.00</td>
</tr>
<tr>
<td>Other Benefits²</td>
<td>4.0%</td>
<td>$58.83</td>
<td>$1,469,931,093</td>
<td>$112.67</td>
<td>$9.39</td>
</tr>
<tr>
<td>TOTAL</td>
<td>14.3%</td>
<td>$210.84</td>
<td>$4,247,825,463</td>
<td>$352.63</td>
<td>$29.39</td>
</tr>
</tbody>
</table>

Percentage Change 14.3% 11.2% 12.3% 12.3%

Note: Column headings are as follows: (1) Increase in the Ratio of Net Claim Costs to Market Cost; (2) Increase in the Cost Per Covered Life; (3) Increase in the Total Cost; (4) Increase in the Annual Cost Per Employee; and (5) Increase in the Monthly Cost Per Employee.

¹These include guaranteed issue, eligibility, and renewability; community rating; and rating restrictions.
²These include preexisting condition limits, self-employment deduction, preventive services, elimination of mandates, cost containment, and the standard benefit package.

Column (1): 10.3% is taken from 110.34% in Table C2, column; and 4.0% is based on information in Section 5.

Column (2) = Column (1) x 1470.74.

Column (3): 2,777,894,370 = 40,546,497,570 - 37,768,603,200; and 1,469,931,093 = 58.83 x 24,986,250.
Table C5
Best Estimate of Financial Impact of H.R. 3626 Small Group Reforms:
ER-Sponsored Net Claim Cost After Reforms (Migrations, Guarantees, and Limits Included)
Calculations Using Data From Tables C2, C3, and C4

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
<th>(7)</th>
<th>(8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ER*-Sponsored (Before Reforms)</td>
<td>25,680,000</td>
<td>100.00%</td>
<td>$1,470.74</td>
<td>$37,768,603,200</td>
<td>1.95</td>
<td>13,169,231</td>
<td>$2,867.94</td>
</tr>
<tr>
<td>Increases due to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current insureds</td>
<td>-2,568,000</td>
<td>14.34%</td>
<td>$1,096,120,368</td>
<td>1,316,924</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrations</td>
<td>1,874,250</td>
<td>14.34%</td>
<td>$3,151,705,095</td>
<td>1,193,957</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>-693,750</td>
<td>14.34%</td>
<td>$4,247,825,463</td>
<td>13,046,264</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total ER-Sponsored (After Reforms)</td>
<td>24,986,250</td>
<td>97.30%</td>
<td>114.34%</td>
<td>$1,681.58</td>
<td>$42,016,428,663</td>
<td>1.92</td>
<td>13,046,264</td>
</tr>
</tbody>
</table>

*ER = Employer.

Note: Column headings are as follows: (1) Number of Covered Lives; (2) Percentage of Total Number of Employer-Sponsored Insureds; (3) Ratio of Net Claim Costs to Market Cost (Market Cost = $1470.74); (4) Cost Per Covered Life; (5) Total Cost; (6) Average Family Size; (7) Number of Covered Employees; and (8) Annual Cost Per Employee.