

**MERCER**

Risk, Finance & Insurance Consulting

**Impact of Association Health Plan Legislation on  
Premiums and Coverage for Small Employers**

**Prepared for:**

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## Executive Summary

National Small Business United (NSBU) engaged Mercer Risk, Finance & Insurance (Mercer) to analyze the “Small Business Health Fairness Act of 2003” (H.R. 660 and S. 545). This legislation would encourage the formation of federally certified Association Health Plans (AHPs) by exempting these plans from various state laws that govern health insurance sold to small employers today.

Proponents of H.R. 660 and S. 545 argue that federally certified AHPs would expand access to affordable health insurance for small employers and reduce the number of uninsured. Opponents believe the legislation would have the exact opposite effect – that is, it would cause premiums to rise and the number of uninsured to increase.

Mercer developed an actuarial model to assess how this legislation would affect premiums for small firms that purchase state-regulated coverage and firms that enroll in AHPs over a four year period as well as the impact on the number of uninsured.

The analysis concludes that federal AHP legislation would not alleviate the health insurance cost pressures faced by small employers. Rather, the proposed AHP legislation would have a detrimental impact on small employer premiums, especially for firms with high-cost workers, and would cause a significant number of small employers to drop coverage, thereby increasing the nation’s uninsured population.

In brief, we found that once federal AHP legislation was fully implemented:

- **Health insurance costs would increase significantly for small businesses in the state-regulated insurance market.** Health insurance premiums would increase by 23% for small employers that continued to purchase state-regulated coverage. This increase would result from AHPs’ ability to attract healthier-than-average firms out of the state-regulated market. AHPs’ exemption from mandated benefits would allow them to tailor products attractive to healthier populations. Moreover, exemption from state limits on premiums and marketing standards would allow AHPs to enroll healthier-than-average groups and encourage firms with high cost workers to switch back to the state-regulated market.

As AHPs attract small employers whose perceived health status is good, firms with greater expected health care utilization would remain in the state-regulated market, where they have the protection of mandated benefits and other requirements. The resulting outflow of low-cost groups from the state-regulated market and the remaining concentration of high-cost groups would start an adverse selection spiral that would accelerate premium increases for employers in the state-regulated market.

- **AHP legislation would increase, not decrease, the number of uninsured.** The number of uninsured would increase by over 1 million as a result of coverage losses among workers in small firms and their dependents. As premiums for small employers in the state-regulated market increased, some firms would drop coverage and not switch to an AHP. Coverage declines would also result when

groups covered by AHPs drop their coverage when their rates increase because someone in the group gets sick. While some of these groups would switch back to the state-regulated market, others would drop coverage entirely.

- **Federal AHPs would gain a pricing advantage through risk-selection, not greater administrative efficiency.** The modeling predicts that after four years premiums for AHPs would average 10% below that of the existing small group market. However, we expect these price reductions to result from favorable risk selection and exclusion of benefits rather than improved purchasing efficiency or lower administrative costs. AHPs could use a variety of techniques to select healthier-than-average firms – techniques available to AHPs because the legislation preempts key provisions of state law designed to prevent risk selection.

Specifically, under HR. 660 and S. 545 AHPs could: charge firms with high-cost workers much higher premiums than permitted under state law; experience rate each association based on the risk of only their members; and offer pared-down products without benefits that would be needed or desired by higher-risk small employers. Together, these strategies would allow AHPs to offer the most attractive rates to healthy groups and avoid the cross-subsidies that state small employer health insurance reforms require.

- **Federal AHPs would insure the healthiest small employers.** The modeling estimates that the average morbidity (a measure of whether a firm is “sick” or “healthy”) of firms enrolling in AHPs would be 21% lower than the average morbidity of small employers in the market today. Further, as higher-cost small employers dropped coverage in response to rate increases resulting from the movement of healthy employers out of the state-regulated market, the average morbidity of the uninsured population would increase by 12.3%. AHPs would appeal most to firms with younger workers given the close correlation between age and health status.
- **Small employers would face higher premiums overall.** Average small employer premiums (considering both cost increases for the state-regulated market and premium reductions for AHPs) would increase by 6%. Average premiums would increase because the size of the average premium increase for the population remaining in the state-regulated market (23%) would outweigh the smaller average premium decrease for those covered by AHPs (10%).

These results indicate that AHP legislation is not a solution to rising health care costs for small employers. While some firms obtaining coverage through AHPs may see lower premiums, firms with higher-cost employees would see their premiums increase. Overall, small employers would pay higher premiums and the uninsured population would increase if this legislation were enacted.

## **Introduction**

National Small Business United (NSBU) engaged Mercer Risk, Finance & Insurance (Mercer) to analyze the impact of the proposed "Small Business Health Fairness Act of 2003" (H.R. 660 and S. 545) on the cost of health insurance coverage for small employers and on the number of uninsured.

### ***Background: Small Employers and the Small Group Insurance Market***

Nearly half of all uninsured workers are either self-employed or work for firms with fewer than 25 employees; another 14% are in firms with 25-99 workers.<sup>1</sup> Differences in health coverage depending on the size and type of businesses have existed for years. In 2000, 47.2% of employers with fewer than 50 workers offered health insurance, compared to 96.8% of larger firms.<sup>2</sup>

Small firms choose not to provide health benefits for many different reasons, but the paramount reason today is cost. Prior to the passage of state small group reform legislation in the 1980s, other barriers existed as well. High-risk small employers could be turned away from coverage altogether or be quoted rates that were unaffordable. In addition, as groups aged or became ill, insurers could increase their rates to the point that the groups were forced to drop coverage.

State reforms and passage of the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996 addressed most of these problems. State laws and HIPAA ensure that small employers cannot be denied coverage because of health status. The vast majority of states have passed laws that include additional protections not addressed in HIPAA. Most important, these laws require insurers to spread risk broadly, allowing only limited, and in some cases, no variation in premiums based on health risk and other factors.<sup>3</sup>

Chambers of Commerce, Farm Bureaus and other business associations sponsor health insurance for their members today. However, these arrangements are typically offered through health insurance plans that are subject to state small employer health insurance reforms, including state rating requirements and consumer protections, and are subject to oversight by state insurance commissioners.

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<sup>1</sup> Fronstin, Paul, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey," EBRI Issue Brief Number 252, December 2002.

<sup>2</sup> Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2000 Medical Expenditure Panel Survey - Insurance Component: Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2000; [http://www.meps.ahrq.gov/MEPSDATA/ic/2000/Tables\\_II/TIIA2.pdf](http://www.meps.ahrq.gov/MEPSDATA/ic/2000/Tables_II/TIIA2.pdf) Table II.A.2 (2000)

<sup>3</sup> All states have adopted rating limits for health plans serving small employers, although four states apply these limitations only to specific products or health plans. See National Association of Health Underwriters: State Level Health Insurance Reforms, August, 2001.

Today, the problem is not a lack of opportunity to buy coverage. Small employers across the country have access to a choice of guaranteed issue health insurance

products.<sup>4</sup> The final, and perhaps largest, barrier to coverage that remains is cost, for employers and their workers. Premiums for both small and large employers have risen dramatically over the last several years in response to increases in underlying medical costs, such as costs for prescription drugs and hospital services, advances in technology, consumer demand and other factors.

### ***Why are federal AHPs being considered?***

With healthcare costs, insurance premiums, and the number of uninsured Americans on the rise, policymakers are searching for ways to address the cost barrier for small employers. One proposal, the “Small Business Health Fairness Act of 2003” (H.R. 660 and S. 545), attempts to do so by encouraging the formation of federally certified AHPs through preemption of state insurance laws.

The proposed legislation would dramatically alter the existing state-based framework for regulating small employer health insurance in the United States. The legislation would allow bona fide national business, trade and professional associations to sponsor health insurance arrangements for their members without complying with insurance laws in each state in which they offer coverage.

The proposed legislation would create two types of federally certified AHPs neither of which would have to provide the protections required by state laws and regulations.

**Self-funded AHPs:** Associations that have at least 1,000 members and meet the sponsorship requirements in the legislation may apply to the Secretary of Labor for certification of a self-funded AHP.<sup>5</sup> Once certified, self-funded AHPs would be exempt from state insurance regulation and oversight similar to a self-funded health plan offered by a single large employer today.

Associations that self-fund benefits would, either directly or through a third-party administrator hired by the association, market coverage to members of the association, collect premiums and pay claims. Self-funded AHPs would

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<sup>4</sup> The median number of licensed carriers in the small group market per state was 28 in 2002, according to a survey by the General Accounting Office. See: “Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market,” U.S. General Accounting Office, March 2002.

<sup>5</sup> HR 660/S. 545 requires that the plan be sponsored by a bona fide association that has been in existence for three years and exists for substantial purposes other than sponsoring health insurance. In order to sponsor a self-funded plan, the association must also be a broad membership organization, an industry association that serves one of 23 specified industries or another association approved by the Secretary of Labor.

assume risk much like insurance companies. HR 660 and S. 545 specify limited solvency standards that require self-funded AHPs set aside funds to pay future claims that are certified by an actuary retained by the plan.<sup>6</sup>

Under the proposed legislation, self-funded AHPs would be regulated by the U.S. Department of Labor (DOL) under a limited set of standards. The bill largely relies on self-policing by AHPs for oversight (e.g., self-reporting of financial condition).

**Insured AHPs:** Associations that meet the sponsorship requirements of the legislation may sponsor insured AHPs.<sup>7</sup> The legislation would encourage the development of insured AHPs by exempting them from state laws, such as benefit mandates, and allowing them to price products based on the claims experience of only their membership.

The legislation would preempt any and all state laws that preclude the offering of health insurance coverage through a certified AHP.<sup>8</sup> Additional preemption provisions in the legislation would allow insured AHPs to obtain approval for a product in one state and offer that product on a national basis without complying with the laws and regulations of other states.<sup>9</sup>

The legislation would allow AHPs to get a policy approved in a state with few rules and market that policy nationwide. While the legislation is clear that the state of “domicile” could regulate the AHP’s coverage in that state, insurance commissioners in other states may not be able to enforce standards for AHPs. A commissioner, for example, could not prohibit an AHP from selling a policy that violates local laws as a result of the bill’s broad preemption language.

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<sup>6</sup> Although not the focus of this report, the American Academy of Actuaries found that these standards are inadequate to protect participants in AHPs. Of particular concern to the Academy is the provision of the legislation that would limit the size of the surplus to no more \$2 million regardless of the size of the plan, which creates an insolvency risk for self-funded AHPs. See [http://www.actuary.org/pdf/health/ahp\\_042803.pdf](http://www.actuary.org/pdf/health/ahp_042803.pdf).

<sup>7</sup> The legislation would require DOL to establish a class certification procedure to facilitate certification of insured AHPs.

<sup>8</sup> Sec. 812(b) provides a broad exemption from state laws for insurers offering coverage through an AHP. The bill would “supercede any and all state laws insofar as they may preclude, or have the effect of precluding, a health insurance issuer from offering coverage in connection with an AHP.

<sup>9</sup> Sec. 812(b) also would “supercede any and all laws of any other state” that may preclude offering a policy type approved in another state. However, the bill reported by the Subcommittee on Employer-Employee relations of the House Committee on Education and the Workforce included language that clarified that state solvency regulation would not be preempted with regard to insurance coverage offered through associations.

### **Proponents' and Opponents' Major Points**

Supporters of this legislation, predominantly national business associations, have stated that the legislation would reduce health insurance premiums for small employers and reduce the number of uninsured.

Proponents of AHP legislation have said that AHPs would lower the cost of insurance coverage for small employers by 15 – 30% and help as many as 8.5 million uninsured gain coverage.<sup>10</sup> AHPs, they believe, would increase small businesses' bargaining power with health care providers, give them freedom from costly state-mandated benefits, and lower their overhead costs by as much as 30%.

Opponents of this legislation include a number of business organizations (including NSBU), state officials (including state attorneys general and state insurance regulators), and various insurance, consumer and health care provider groups.

These opponents argue that exempting health coverage sold by business associations from state laws and regulations will make things worse, not better, for small businesses by increasing premiums for the majority of small employers and their families. They cite a Congressional Budget Office estimate that 80% of small employers would face higher premiums as a result of AHP legislation.<sup>11</sup>

Opponents also object to exempting AHPs from existing state small employer health insurance reforms and the loss of other key health protections millions of Americans have today. And opponents cite the potential for fraud and health plan failure that would result from exempting AHPs from state oversight and solvency standards.

### **Prior Research on AHPs**

Previous analyses have addressed the impact of AHP legislation on small employer health coverage. These studies tend to predict that association health plan legislation would increase premiums for most small employers, but give mixed results with regard to whether AHPs would help the uninsured.

- *Congressional Budget Office (2000)*. A 2000 Congressional Budget Office (CBO) report on the impact of proposed federal association health plan and HealthMart<sup>12</sup> legislation predicted that AHPs and HealthMarts together would enroll 4.6 million people, accounting for about 20% of small group market enrollment. However, overall enrollment in the small group market would increase by only 330,000 people because most small firms purchasing coverage through AHPs and HealthMarts would be switching from state-regulated insurance products.

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<sup>10</sup> [www.nfib.com](http://www.nfib.com)

<sup>11</sup> Congressional Budget Office: "Increasing Small-Firm Health Insurance Through Association Health Plans and HealthMarts," January 2000.

<sup>12</sup> The HealthMart provisions of HR 2990 in the 106<sup>th</sup> Congress, would have established purchasing cooperatives for small employers that would be exempt from state mandated benefits and certain other standards.

CBO predicted that premiums for AHPs and HealthMarts would be 13% lower than coverage in the state-regulated market. The savings for AHPs and HealthMarts reflected 5% savings from the avoidance of state benefit mandates and 8% savings from attracting a healthier population of small employers and avoiding state premium compression laws. CBO assumed that AHPs and HealthMarts would not achieve administrative savings relative to other health insurance arrangements.

CBO further predicted that the 80% of firms that continued to purchase traditional plans would see premiums increase as a result of the shift of some low-cost firms to AHPs and HealthMarts. The CBO model estimated that 10,000 high-cost individuals would lose coverage as a result of the proposed legislation because they would not be able to afford the increased premiums.

- *Urban Institute (1999)*. A 1999 report prepared by the Urban Institute for the U.S. Department of Labor predicted that AHP and HealthMart legislation would increase health insurance premiums and increase the number of uninsured.<sup>13</sup> The Urban Institute report predicted that AHPs and HealthMarts would reduce overall levels of coverage by less than 1% of all workers. Assuming that there are about 25 million workers insured in the small employer market, this estimate would translate into as many as 250,000 workers losing coverage under AHPs and HealthMarts.

The study predicted that net coverage would decline because the commercial insurance markets lose some of their best risks to the AHPs. Because of this risk-pool deterioration, the study predicted that some firms would drop coverage rather than pay the new higher prices that go with this deteriorating risk pool.

- *Actuarial Research Consulting (1996)*. A 1996 study by Actuarial Research Consulting (ARC) performed for the Blue Cross and Blue Shield Association predicted that premiums for small employers would increase by up to 16.2% for the state-regulated markets under similar legislation exempting Multiple Employer Welfare Arrangements (MEWAs) from state law.<sup>14</sup> The analysis also predicted that premiums for the individual health insurance market would increase by up to 29.8%.
- *CONSAD Research Corporation (1998)*. CONSAD Research Corporation prepared a report on behalf of the National Federation of Independent Business (NFIB) that examined how AHPs might affect the uninsured given a range of hypothetical premium reductions.<sup>15</sup> This report predicted that coverage would

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<sup>13</sup> Linda J. Blumberg, Len M. Nichols, and David Liska, Choosing Employment-Based Health Insurance Arrangements: An Application of the Health Insurance Reform Simulation Model. Final Report 0657-001-00, Department of Labor, Pension and Welfare Benefits Administration, March 1999. <http://www.urban.org/TESTIMON/nichols6-16-99.html>

<sup>14</sup> Actuarial Research Corporation: "Cost Impacts of the MEWA Provisions of the Health Coverage and Affordability Act of 1996," 1996.

<sup>15</sup> CONSAD Research Corporation: "Projected Impacts of The Expanded Portability and Health Insurance Coverage Act," July 10, 1998, (<http://www.consad.com/projects/9800001s.htm>)

likely increase by 4.5 million people. Unlike the other studies mentioned above, however, the CONSAD report did not examine the impact that AHPs would have on the state-regulated small employer market. Therefore the report did not cover the loss of enrollment in the state-regulated market, so in turn it did not address selection issues and premium rate increases in the state-regulated market.

- *Actuarial Research Corporation (2003)*. A study conducted by ARC for the U.S. Small Business Administration predicted that “AHPs could also offer small employers health insurance that did not involve indirect subsidies to higher cost small employers, especially those involved in requiring guaranteed issue and the same premium rates for very small “baby” groups (e.g., with 1-4 employees), which cost much more to insure due to the potential for anti-selection, fraud and abuse and disproportionate administrative expenses”.<sup>16</sup> According to the report, AHPs located in states with less stringent state laws and could offer coverage to the lower-cost groups that are now forced to cross-subsidize higher cost groups in states that require community rating or narrow rate bands.

Our evaluation expands on these previous analyses by examining the impact of AHP legislation over time, taking into account the cumulative impact of adverse selection. This analysis is more dynamic because it looks at the cumulative effect of the legislation on the small group market over a four-year period.

## **Assumptions**

The following section describes the key assumptions employed in our modeling of the insurance market once AHPs are introduced. We also describe where assumptions differ from the 2000 Congressional Budget Office report. While the CBO report is highly credible, we believe that the CBO model underestimates the impact of AHP legislation on the state-regulated market.

**Savings from Avoiding State Regulation:** AHPs could obtain savings from exemption from state mandated benefits as well as other state requirements. Self-funded AHPs would generally be exempt from all state laws under ERISA. In addition to mandated benefits, other state laws that AHPs could avoid include a range of state consumer protections, state solvency requirements, state continuation of coverage requirements (e.g., Mini-COBRA laws), provider prompt pay laws and state assessments to fund programs for uninsurable individuals (e.g., state high risk pools). Insured AHPs could select a state with the fewest restrictions and market that coverage in all other states, thereby avoiding more costly state standards.

A 1996 analysis by the U.S. General Accounting Office found that the cost of mandated benefits varies considerably by state. The cost of mandated coverage ranged from 5.4% of total claims in Iowa to 22% of total claims in Maryland. Although the cost of mandates may be considerable in some states, small employers will likely demand coverage of some portion of the benefits covered under state mandates.

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<sup>16</sup> Actuarial Research Corporation: “Study of the Administrative Costs and Actuarial Values of Small Health Plans,” 2003, pp 24-25. Prepared for the Small Business Administration Office of Advocacy. See <http://www.sba.gov/advo/research/rs224tot.pdf>

The Congressional Budget Office analysis assumed that AHPs would save 5% by avoiding state mandated benefits. While this assumption is reasonable with regard to savings from state mandated benefits, the potential savings that AHPs could realize from avoiding other types of restrictions would cause total savings to exceed 5%.

Additional sources of savings for AHPs could include avoiding assessments for state high-risk pools, which are typically 1% of premiums. Savings from avoiding participation in state guarantee funds and other solvency requirements could exceed 1%. Avoidance of other state laws, such as state external review laws in the case of self-funded plans, may also be significant. Moreover, AHPs could avoid compliance costs associated with regulation by state insurance departments, which can be a significant expense in the state-regulated market.

As a result of our review of state requirements, we assumed that AHPs would achieve a 7.5% reduction in premium associated with the exemption from mandated benefits and avoidance of other state requirements.

**Administrative Savings:** The CBO analysis assumed that federal AHPs would not achieve lower administrative costs than existing health insurance carriers. We agree with CBO's assumption as well as the American Academy of Actuaries letter<sup>17</sup> that federal AHPs would not achieve administrative savings.

Associations that sponsor AHPs can adopt a number of models for administering their health insurance programs. Some will simply endorse health plans offered by an insurance carrier, others will outsource administration to a third-party administrator that will contract with insurers or facilitate a self-funded plan, and others, although likely a minority, will attempt to administer the plan themselves.

Regardless of the model employed, the basic administrative functions that health insurers currently perform will also be required for AHPs. AHPs cannot achieve administrative costs that approach those of large employers because they will be selling to thousands of independent small employers. As a result, they will incur costs related to sales, underwriting, and customer service for each individual employer.

Proponents of the AHP legislation state that this bill will allow small employer groups to have the same advantages that large employer groups receive and that a key source of the savings will come from reductions in the administrative costs. However as testified by Len Nichols of the Center for Studying Health System Change the analogy between the AHPs and General Motors "fails for a simple but powerful reason: General Motors self-insures all of its workers, it does not allow workers in California to select one self-insured pool and workers in Flint to select another ... whereas an AHP by construction would be a set of very small employers, any of whom could bolt or join at open enrollment time or at will if another insurer was willing to take or free them."<sup>18</sup>

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<sup>17</sup> American Academy of Actuaries Letter to The Honorable John A. Boehner, dated April 28, 2003; American Academy of Actuaries website, [http://www.actuary.org/pdf/health/ahp\\_042803.pdf](http://www.actuary.org/pdf/health/ahp_042803.pdf)

<sup>18</sup> Len Nichols, Center on Studying Health System Change Testimony; <http://sbc.senate.gov/hearing/020503nichols.html>

A previous analysis of administrative costs by Mercer predicted that administrative costs for AHPs would not reduce small employer costs in light of additional costs that may be incurred for health insurers selling through associations, such as royalties or other service fees charged by associations.<sup>19</sup> For the purpose of this analysis, we assumed that administrative costs would be comparable, regardless of whether a small employer purchases coverage through an association.

**Price Responsiveness:** Our model is designed to explain how small employers will migrate between the regulated market, AHPs and the uninsured over time. In order to determine the migration between these market segments, we needed to make assumptions regarding the price responsiveness for different types of firms (typically referred to in the economic literature as “elasticity of demand”).

Elasticity determines the number of groups that will add or drop insurance due to changes in premiums, as well as the number of groups that will switch coverage between a state-regulated insurer and an AHP (and vice versa in later years).

We assumed small employers would be more likely to switch insurance coverage than they would be likely to add or drop insurance coverage. We used an average elasticity of demand of  $-1.5$  for firms that switch from state-regulated insurance to AHPs, or, once enrolled in an AHP, switch back to the regulated market in response to price changes. In other words, if premiums were 10% lower in an AHP, 15% of small employers would be expected to switch from the state-regulated market to AHPs. The average elasticity used in this analysis appears comparable to that used in the CBO report.

We also assumed that small employers would need to have a 5% reduction in cost before switching coverage. This assumption is consistent with our experience that small employers will tend to stay with their current health plan, unless premiums are noticeably lower in an alternative health plan.

We assumed that firms would drop health insurance in response to price increases, but at a lower rate than they would switch coverage. We used an average elasticity of  $-1.1$  to estimate the number of firms that would drop coverage in response to price increases. In other words, we assumed that 11% of small employers would drop coverage in response to a 10% price increase. CBO used the same elasticity.

We assumed that the costs associated with the decision to offer insurance differ from those associated with the decision to continue to offer insurance. New purchasers will have to acquire information about health plans, undergo underwriting and establish plan administrative functions. These entry costs imply that non-offering firms will have to perceive larger premium reductions prior to actively seeking to offer health insurance. We assumed an elasticity of  $-.75$  for uninsured firms to offer coverage (which we call the “add” elasticity). Use of this assumption may overstate the number of uninsured firms that take up coverage with AHPs. A recent analysis by researchers at the Center on Studying Health System Change, which included a

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<sup>19</sup> Mercer Risk, Finance and Insurance: “Association Health Plan Legislation: Impact on Administrative Costs for Small Businesses.” March, 1999. Performed for the Blue Cross and Blue Shield Association.

review of prior research on small firm price responsiveness, predicted an elasticity  $-.54$ , indicating that small employers would be less likely to take up coverage than we assumed for our model.<sup>20</sup>

In addition, the actual elasticity any specific group was subjected to depends on the group's size and morbidity. We assume the very smallest groups are more sensitive to price changes and therefore exhibit a higher elasticity than the larger "small" groups. We also assume that groups with a low average morbidity (i.e., "healthy groups") are more likely to move. Varying the assumed elasticity according to morbidity reflects the notion that the demand for health insurance is greater for firms with sicker insured populations, who would be willing to incur larger premium increases than healthier populations before deciding to drop coverage.

The AHP market will be similar to the small group health insurance market prior to reforms in the '90s. We can look to this experience to determine the impact AHPs could have on the market. In 1983, an analysis performed showed that small employer programs had a lapse rate of approximately 3% to 4% per month or about one-third to one-half of all employers leave each year. This study found that employers terminating coverage tend to be the healthier groups.<sup>21,22</sup>

**Premium Variation:** Our model assumes that AHPs would be able to charge higher cost groups more than would be permitted under state law as a result of the preemption of state rating limitations.

There is a significant variation among regulations adopted by individual states. Some states require pure community rating (where age/gender, morbidity and other case characteristics are not allowed); some require community rating by class (where case characteristics may be used, but rates cannot vary by health status or experience); and some have adopted the National Association of Insurance Commissioners (NAIC) model (which allows variation in premiums due to health status or experience of  $\pm 25\%$  variation around a midpoint range plus a  $\pm 10\%$  range for various classes of business) or similar rating structure.

The data obtained from our review of the state regulations and information regarding the number of members in the small group market within each state provided the average range of the variation around the midpoint for the current insurance environment. We expect that the average range that insurers could charge small employers across all states would be  $\pm 20$  or  $.80$  to  $1.20$ . This represents a total range of rates for groups with similar case characteristics of  $1.5:1$ . With the amount of flexibility that AHPs would have in rating coverage, we expect them to rate within  $\pm 60\%$  band or  $.40$  to  $1.60$ , which is a total range of  $4:1$ .

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<sup>20</sup> Hadley, J. and Reschovsky, J. "Small Firms' Demand for Health Insurance: The Decision to Offer Insurance," *Inquiry* 39:118-137, 2002.

<sup>21</sup> David M. Cutler and Richard J. Zeckhauser, "Adverse Selection in Health Insurance", NBER Working Paper Series, Working Paper 6107, July 1997

<sup>22</sup> Howard Bolnick, "Why Small Group Programs Fail", *Best's Review*, Volume 84, No. 8, 1983

Our model follows the actuarial principle of cumulative anti-selection to capture what happens to an insurance pool that is subject to a selection spiral. In other words, as costs increase, healthy firms are more likely to switch to AHPs or let their coverage lapse than sicker firms. The AHPs have a price advantage of 7.5% immediately. The higher elasticity for healthy groups mean they are more sensitive to costs and will be more willing to change to the AHP market, resulting in a higher percentage of sicker groups remaining in the state-regulated market. The resulting concentration of sicker firms causes prices to increase for the remaining pool, thereby leading more firms to leave the original pool. This spiral takes several years to develop. This phenomenon has been observed in various public and private health insurance programs.<sup>23,24,25</sup>

**Aggregate Morbidity:** We assume that the aggregate morbidity of the small group population is stable over the four years of the model. In other words, the small group population as a whole does not get sicker or healthier over the time period of the modeling. This would include members in the insurance market and the uninsured.

**Health Care Cost Inflation:** The study does not consider health inflation. The purpose of this study was to examine what, if any, impact AHPs will have on the regulated market and what, if any, impact AHPs will have on the number of uninsured. Thus, we froze premiums at 2000 levels. The changes in premiums predicted by this model will be in addition to underlying health cost inflation.

We believe these assumptions are reasonable based on our review of existing literature and our knowledge of the health care marketplace and actuarial principles. As with any model, however, the results are sensitive to the assumptions used. Analyses using different assumptions will generate different results.

## Methodology

**Establishment of Baseline Population:** We created a baseline population to simulate the characteristics of the current small employer health insurance market. Data from the Employee Benefit Research Institute (EBRI) was used to estimate the number of members in the small group market within each state.<sup>26</sup> The corresponding premium for small groups for each state was estimated from the 2000 Medical Expenditure Panel Survey (MEPS).<sup>27</sup>

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<sup>23</sup> *ibid*

<sup>24</sup> David M. Cutler and Richard J. Zeckhauser, "Adverse Selection in Health Insurance", NBER Working Paper Series, Working Paper 6107, July 1997

<sup>25</sup> Roger Feldman and Harry Sutton, "Premium Death Spirals: Theory and Empirical Evidence", Society of Actuary's Record, Volume 28, No. 3, October 2002; <http://www.soa.org/library/record/2000-09/rsa02v28n398pp.pdf>

<sup>26</sup> Employee Benefit Research Institute tabulations of data from the March 2001 Current Population Survey

<sup>27</sup> Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2000 Medical Expenditure Panel Survey - Insurance Component.

The “baseline” market represents the actual market as of 2000 and includes both insured and uninsured. We estimate that there were about 24.8 million members (workers and dependents) insured in the small group market, representing \$51.7 billion in premium in 2000. The average premium per worker for these groups was about \$4,000 in 2000 (Table 1). The simulated baseline population is comparable to the population used in the CBO model. CBO’s report estimated the premium for this market to be \$50.4 billion, in 1999 dollars, and enrollment to be 24.5 million members.

<b>Table 1: Baseline Insured Small Group Population</b>	
Premium	\$ 51,702,891,556
# Groups	1,843,749
# Employees	12,906,244
# members	24,779,988
Premium Per Employee	\$ 4,006.04

We estimate that there are another 11.7 million people in families headed by someone who works for a small employer who are uninsured in the baseline market. CBO estimated that 13 million such people were uninsured in 1997.

**Simulation of Market Changes:** We used small group data from some insurers in states that had not adopted any limitations in rates or had adopted the initial NAIC model or a variation of that model which provided for a wider range of rating flexibility. This sample data represented about one million members. The information included an average age/gender factor, a morbidity factor, premiums and claims for an entire year. The morbidity factors for each company and state were indexed so they all represented a percentage of an index rate (midpoint rate).

Some of the data received was from states with some type of rating restrictions, albeit, more liberal rating restrictions. Even liberal rating restrictions have an impact on the decision of some employers to purchase insurance or become uninsured. As such, modifications were made to the data received to account for the impact of the rating restrictions. Distributions from states without rating restrictions were used to perform the modifications.

The next step was to develop unregulated premium (which includes the assumed 7.5% savings AHPs obtain from exemption from state regulation) which serves as a simulation of the premium to be charged by the average AHP. The state-regulated premium is also developed, which is reflective of the aggregate rating band resulting from our weighted average of all states and serves as the estimated premium charged by the average insurer subject to state regulations.

The model simulates the movement of groups within the market, entering the market and leaving the market. The movement in and out of the insurance market as well as movement between the different market segments is determined by the elasticities previously described in this report and a comparison of the state-regulated premium and the simulated AHP premium. For example, movement to the AHP from the uninsured in the first year is driven by a combination of the “add elasticity” and a comparison of what the state-regulated premium would be for this group to the AHP premium.

At the end of the first year, estimates are made regarding the overall change in the premiums for the state-regulated market versus the unregulated market. Changes in the premiums are determined by comparing the change in morbidity and age/gender. Premiums in each market are adjusted accordingly.

A random variable representing material changes in morbidity is applied to the entire population to simulate significant changes occurring at the group level. This also simulates “re-underwriting” in the aggregate. The rate increase due to change in morbidity is limited to 15% in the regulated market, which is consistent with the majority of the state laws. No such limitation was imposed on the AHP market. Therefore, if a group’s morbidity increased by 30%, the AHP would be able to rate for the entire change where the state-regulated insurer would be limited to 15%. State-regulated premiums and AHP premiums are estimated for each group.

In the second and subsequent years, all insured groups receiving an increase in premium are subjected to the “drop elasticity” in addition to the “cross elasticity”. The change in premium is determined by comparing the group’s premium during the previous year to the premium the group will be charged first in the market they were in the previous year (i.e., state-regulated or AHP) and then the premium for the market they are not in. Groups can switch between the state-regulated market and the AHP based upon comparisons of these premiums and the corresponding elasticities. Uninsured groups cannot become insured in subsequent years unless there is a premium that is less than the state-regulated premium that this group would have paid (if they had been insured) during the baseline.

This process is replicated through four renewal periods. As the groups stratify by morbidity, the premium rates for the state-regulated market continue to increase at a higher rate than the AHP premium rates. This results in more of the residual “better risk” moving to the AHP. The end result is cumulative anti-selection.

**Normalization:** The results for each year are then normalized to the total population. This captures the impact on the insured, AHP and uninsured population on a nationwide basis.

## **Results**

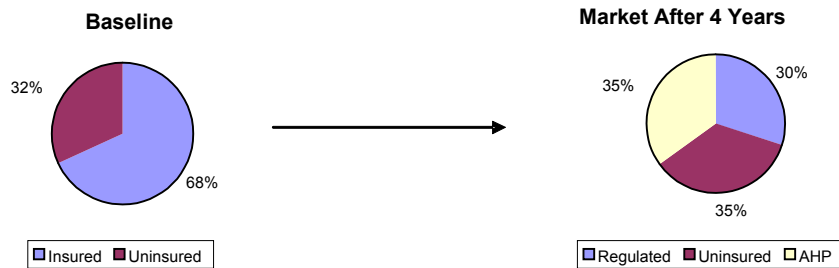
### ***Overall Findings***

Our analysis concludes that, rather than being a solution to the health insurance cost pressures faced by small employers, the proposed AHP legislation would have a detrimental impact on small employer premiums, especially for firms with high-cost

workers, and would cause more small employers to drop coverage, thereby increasing the nation's uninsured population.

The charts below provide a snapshot of the study results, illustrating how the current small group insurance market would be affected by AHP legislation, including movement out of the state-regulated market and an increase in the uninsured population.

**Figure 1: Summary Impact of AHP Legislation on Enrollment in the Small Employer Marketplace**



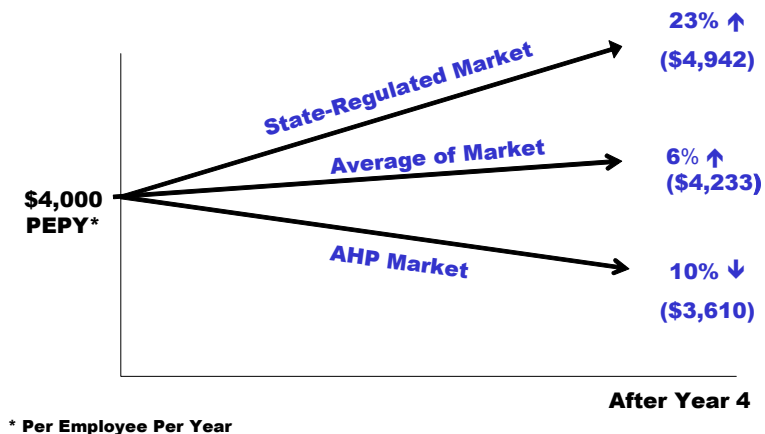
Enrollment in state-regulated plans would decline from 24.8 million members in the baseline to 11 million after 4 years. AHP enrollment would total 12.8 million members after 4 years. As described below, the total number of the small employer market would decline from 24.8 million members in the baseline to 23.8 million after 4 years as a result of firms dropping coverage in response to the introduction of AHPs.

### **Specific Results**

#### **Impact on the Cost of Health Insurance for Small Employers**

- **Health insurance costs would increase significantly for small businesses in the state-regulated insurance market.** Health insurance premiums would increase by 23% for small employers that continued to purchase state-regulated coverage. This increase is directly attributable to AHPs' ability to attract healthier-than-average firms from the insured market. AHPs' exemption from mandated benefits, rating limitations and marketing standards would allow them to tailor products attractive to healthier populations.

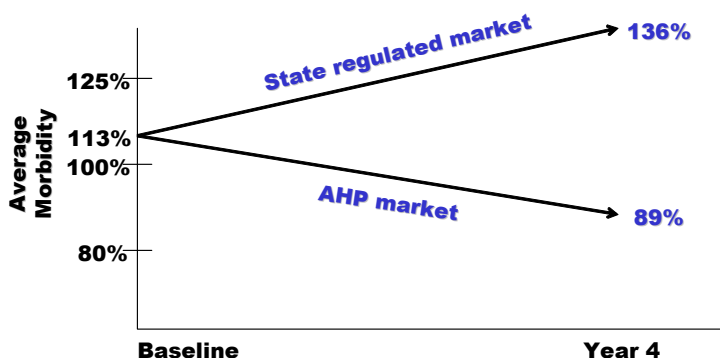
**Figure 2: Premiums Increase in the Regulated Market, While Dropping in AHP Market**



As AHPs attract small employers whose perceived health status is good, employers with greater expected health care utilization would remain in the state-regulated market, where they have the full protection of mandated benefits and rating restrictions. The resulting outflow of low-cost groups from the state-regulated market and the remaining concentration of high-cost groups would start an adverse selection spiral that would accelerate premium increases for employers in the state-regulated market.

This adverse selection spiral is illustrated in Figure 3, which shows how morbidity – a measure of the extent to which a population uses health care services (with higher percentages representing sicker populations and vice-versa) -- worsens by nearly twenty percentage points for the state-regulated market, but improves by nearly the same amount in the AHP market.

**Figure 3: Health Status Worsens in Regulated Market but Improves in AHP Market**



AHPs will not attract groups with sicker members because AHPs, unlike the regulated market, do not have the same level of restriction in how much they can vary premiums. Thus, the regulated population will attract an increasingly higher share of the unhealthy members.

- Federal AHPs would gain a pricing advantage through risk-selection, not greater administrative efficiency.** The modeling predicts that AHPs could offer coverage at average prices 10% below current premiums. However, the research concludes that these price reductions would result from favorable risk selection and avoidance of state mandates rather than improved purchasing efficiency or lower administrative costs. The research notes a variety of techniques AHPs could use to select healthier-than-average firms – techniques available to AHPs because the legislation preempts key provisions of state law.

Specifically, under HR. 660 and S. 545 AHPs could: charge firms with high-cost workers much higher premiums than permitted under state law; fragment their members into multiple rating pools that separate higher-cost groups from lower-cost groups; and offer pared-down products without benefits that would be needed or desired by higher-risk small employers. Together, these strategies would allow AHPs to offer the most attractive rates to healthy groups and avoid the cross-subsidies that state reforms require.

Interestingly, these advantages could permit AHPs to lower premiums well below the 10% decline estimated by our modeling. Of this 10%, 7.5% is attributed to exemption from state benefit and provider mandates as well as other state laws and regulations, including state external review laws, prompt pay requirements and “patients’ rights” standards (e.g., access to emergency care). The remaining 2.5% of the reduction is attributed to attracting better risks resulting in a decrease in the average premium.

However, we believe that this latter estimate understates the degree to which cherry picking would provide a cost advantage to AHPs, because health insurers marketing coverage through AHP market are likely to “shadow price” coverage in the state regulated market in order to maximize profits. In other words, these insurers are likely to price their coverage just far enough below that of the state-regulated market to induce healthy small groups to switch coverage while maintaining a healthy margin for profit.

In terms of the actual premiums paid by small employers, we would expect those firms that remain in the state regulated market to pay approximately \$950 more per covered worker than they would in the absence of AHP legislation. This premium increase would be in addition to any increase in underlying medical cost inflation. Firms enrolling in AHPs would pay approximately \$400 less per covered worker than they would otherwise pay without the introduction of the AHPs.

- **Small employers would face higher premiums overall.** Average small employer premiums (considering both cost increases for the state-regulated market and cost reductions for AHPs) would increase by 6%. Average premiums would increase because the size of the average premium increase for the population remaining in the state-regulated market (23%) would outweigh the smaller premium decrease for those covered by AHPs (10%).

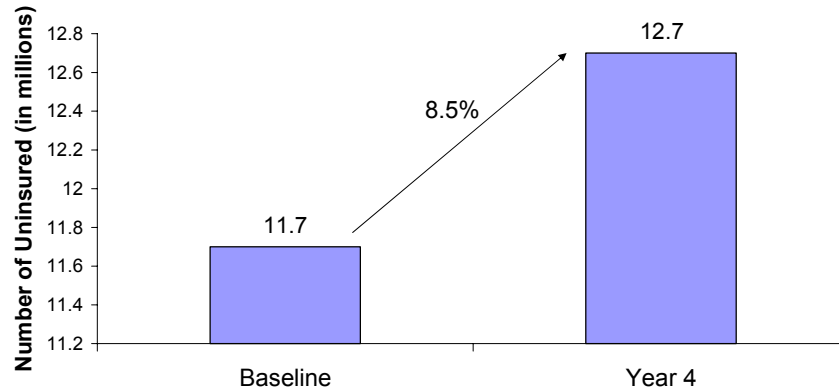
<u>Market Segment</u>	<u>Average Premium after Four Years</u>		<u>Employees in Four Years</u>		<u>Premium Dollars after Four Years</u>
State-regulated	\$4,942	x	5.8 million	=	\$28.7 billion
AHP	3,610	x	6.6 million	=	23.8 billion
Total Insured			12.4 million		\$52.5 billion

Average Premium after Year 4 = \$52.5 billion / 12.4 million employees = \$4,233.03

Overall Increase: \$4,233.03 / \$4,000 = 6% (Premium after Year Four / Baseline)

- **National AHPs would insure the healthiest small employers.** The modeling estimates that the average health care costs of firms enrolling in AHPs would be 21% lower than the average health care costs of small employers in the market today. Further, as higher-cost small employers drop coverage in response to rate increases resulting from the movement of healthy employers out of the state-regulated market, the average health care costs of the uninsured population would increase by 12.3% (see Figure 4). This is a direct result of the increase in average morbidity for the uninsured.

**Figure 4: Number of Uninsured in Small Group Market Increases by Over 8%**

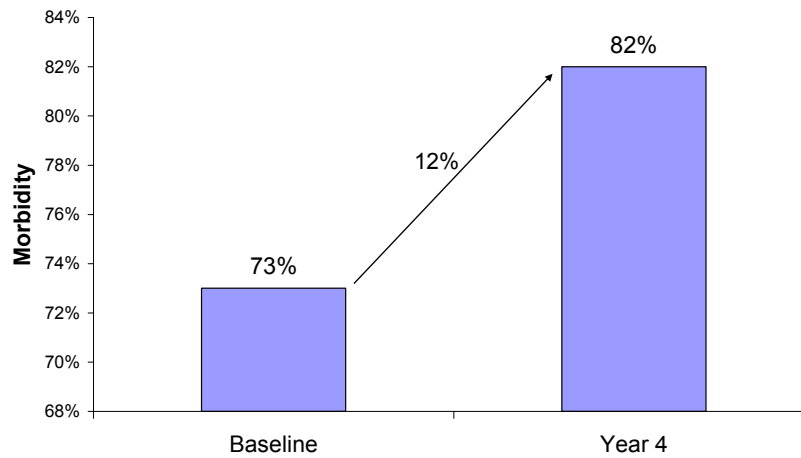


- **National AHPs would appeal more to younger individuals.** Given the close correlation between age and health status (generally, the younger an employee population, the lower its health care costs, and vice-versa), AHPs are also likely to appeal to groups made up of younger workers. In contrast, groups with older employees are more likely to remain in the state-regulated market, because state rating laws require insurers to pool costs of older and younger, healthier and sicker employees, to ensure maximum cross-subsidization.

### **Impact on the Uninsured**

- **AHP legislation would increase, not decrease, the number of uninsured.** The number of uninsured would increase by over 1 million as a result of coverage losses among workers in small firms and their dependents. As premiums for small employers in the state-regulated market increased, more small employers would drop coverage than would be added by premium reductions for AHPs. In addition, coverage declines also are attributable to the loss of coverage when once-healthy groups covered by AHPs drop their coverage when their rates are increased because someone in their group becomes sick.

**Figure 5: Health Status of Uninsured Worsens by 12%**



The model predicts that the 10% reduction in AHP premiums compared to the regulated market would not be sufficient to attract the uninsured population. In fact, the model shows that as the regulated market premiums increase (because of the worsening risk profile in this market, as healthier groups move to AHP coverage), more groups actually drop coverage, and the health status of the uninsured population worsens.

These results indicate that AHP legislation is not, in fact, a solution to rising health care costs for small employers. While some firms obtaining coverage through AHPs may see lower premiums, those firms with higher-cost employees would see their premiums increase. Overall, the study concludes that small employers would pay higher premiums, and the uninsured population would increase if this legislation were enacted.