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Small Business Health Plans

Taking Care of Small Business Owners and Their Employees

Executive Summary

- Recent increases in health care premiums have far outpaced the rate of inflation and the increase in employee wages. Since 2000, premiums for family coverage have increased by 73 percent, while inflation has increased by 14 percent and wages by 15 percent.
- As a likely response to the explosive growth in health insurance premiums, the percentage of all employers offering health insurance to their employees during the last five years has dropped from 69 to just 60 percent.
- In 1950, health benefits accounted for 8.8 percent of all benefit spending; yet, by 2004, health benefits accounted for 43.2 percent of all benefit spending.
- The situation is more dire for small businesses. All cost increases hit small businesses particularly hard, but, for health care costs, this is compounded by the fact that it costs small businesses more than their larger counterparts to provide health benefits to their employees.
- S. 1955 is a market-driven, fiscally responsible, and workable solution for making affordable, quality health care coverage more accessible to small businesses.
- The Congressional Budget Office (CBO) estimates that enacting S. 1955 would increase federal revenues from payroll and income taxes by $1 billion over the 2007-2011 period and by $3.3 billion over the 2007-2016 period.
- By contrast, an alternative bill (S. 2510) would create within the federal government a huge new program that would cost taxpayers billions and expose insurers to a complex regulatory framework.
- Small businesses employ nearly two-thirds of the working uninsured population, and so it makes the most sense for Congress to enact S. 1955 to create a more competitive marketplace so these owners and their employees can secure the health care coverage they deserve.

Introduction

In May 2006, the Senate considered legislation that is estimated to reduce the cost of health insurance for small business owners and their employees by approximately 12 percent, or about $1,000 per employee.[1] The Health Insurance Marketplace Modernization and Affordability Act of 2005 (S. 1955 or HIMMA) also would make coverage more affordable for nearly one million working Americans who do not currently have any health insurance.[2] However, efforts to enact the bill stalled when, by a vote of 55 to 43, the Senate failed to invoke cloture on the bill.[3] Despite this setback, interest in enacting legislation to provide health care coverage to small businesses remains strong. This paper will discuss the growing need for this type of legislation and will discuss the provisions of S. 1955 and an alternative, the Small Employers Health Benefits Program Act of 2006 (S. 2510), to illustrate how each would impact the problem, concluding that S. 1955 is the better bill and should be enacted promptly.

The Effects of Rising Health Care Costs

According to the Kaiser Family Foundation and the Health Research and Educational Trust, premiums for employer-sponsored health insurance (for large and small employers) rose by 9.2 percent between spring 2004 and spring 2005.[4] At 9.2 percent, the increase in premiums far outpaces the rate of inflation (reported at 3.5 percent) and the increase in employee wages (reported at 2.7 percent).[5] Looking at the last five years, the numbers are even more challenging. Since 2000, premiums for family coverage have increased by 73 percent, while inflation has increased by 14 percent and wages by 15 percent.[6]

The factors fueling rising health care costs are complicated and are often misportrayed, but one serious recent study by PricewaterhouseCoopers, a firm providing health care consulting services, offers some insight. It identified several factors as having a significant impact on cost increases, including a shift to broader-access provider networks (resulting in decreased competition); increased utilization of health care services (due in part to an aging population); lifestyle changes (including obesity, smoking, drug abuse, and physical inactivity); introduction of new, higher-priced technologies; increased practice of defensive medicine (related to concerns about medical liability); and increased consumer demand for "lifestyle" drugs (like those for treatment of erectile dysfunction) that did not formerly enjoy widespread use.[7] Some of these

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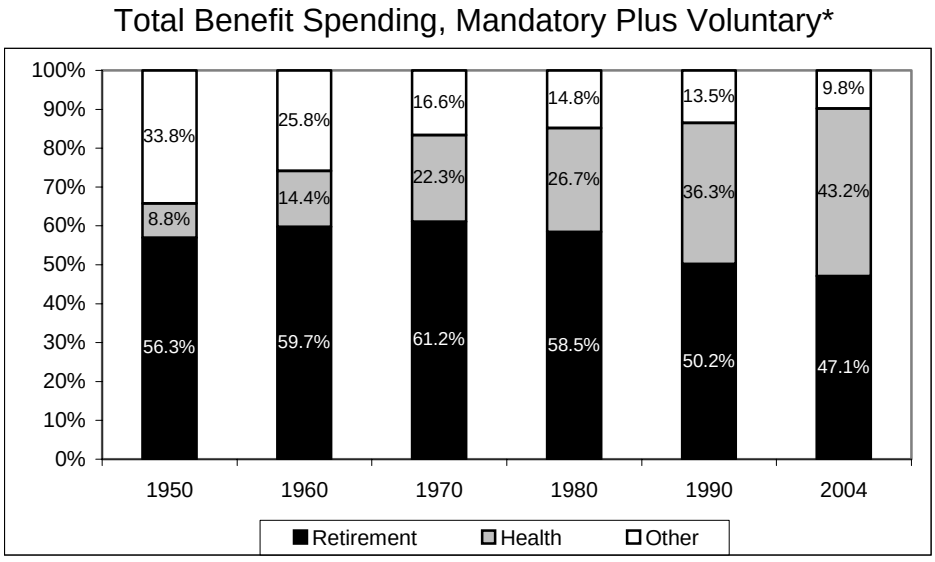
[1] Mercer Oliver Wyman (actuarial firm) letter to Todd McCracken, President of the National Small Business Association, March 7, 2006, available at http://nsba.biz/docs/2006_mercer_report.pdf.
[2] *Id*.
[3] S. 1955 was the third of three health care-related bills considered the Senate's "Health Week." Republicans filed cloture on all three bills, which would require 60 affirmative votes in each instance to move forward with consideration of the legislation. See Roll Call Vote 119, 109th Congress, 2nd Session, May 11, 2006. See also Roll Call Vote 117, cloture on the motion to proceed, agreed to 96-2, May 9, 2006.
[4] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005 Annual Survey," September 14, 2005, available at http://www.kff.org/insurance/7315/upload/7315.pdf.
[5] *Id.*
[6] *Id.*
[7] PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006," January 2006.

factors do not lend themselves to legislative remedies, but Congress clearly has a legitimate role to play in assuring greater competition in the marketplace.

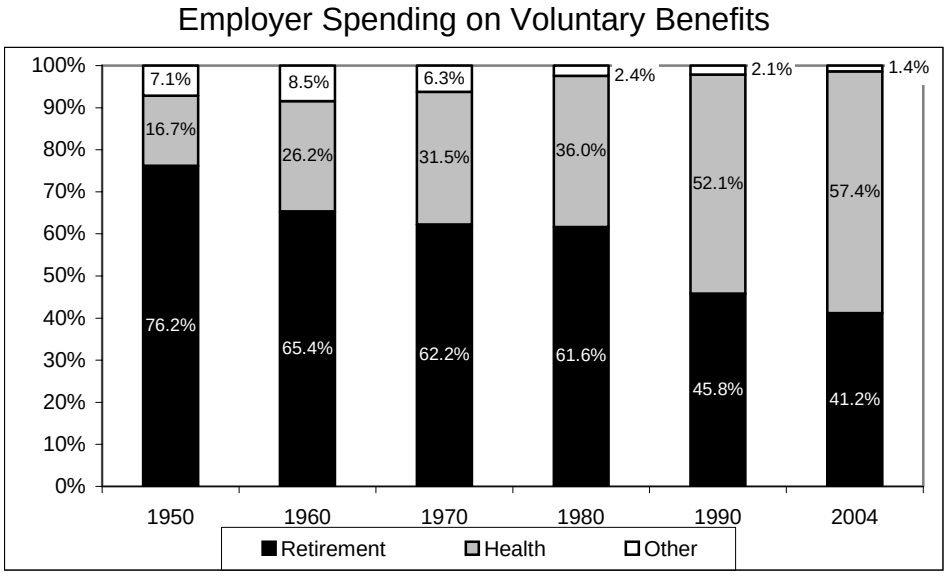
A Troublesome Trend for Health Care Benefits

In response to the explosive growth in health insurance premiums, the percentage of all employers offering health insurance to their employees during the last five years has dropped from 69 percent to just 60 percent.[8] Worse, it looks like the trend will continue – the Employee Benefit Research Institute (EBRI) reports that, "While total retirement benefits currently constitute the largest single share of employer spending on benefits, health costs are growing fast, and are on a course that could soon make them the largest portion of benefits expense."[9] According to EBRI, "of the three major employee benefit categories, health benefits increased the most as a percentage of benefit spending, and if current trends continue will displace retirement costs as the largest sector in benefit costs. In 1950, health benefits accounted for 8.8 percent of all benefit spending" yet, "by 2004, health benefits accounted for 43.2 percent of all benefit spending."[10] (See Figure 1 for a graphical depiction of employer spending on health care benefits.[11])

Figure 1
The Changing Share of Employer Spending on Benefits, 1950–2004



[8] *Id.*
[9] Employee Benefits Research Institute, "Finances of Employee Benefits: Health Costs Driving Changing Trends," EBRI NOTES, December 2005.
[10] *Id.*
[11] *Id.*



Source: Employee Benefit Research Institute tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, www.bea.gov/bea/dn/nipaweb/index.asp

*Mandatory spending is benefit spending required by law and includes employer contributions to Medicare, Social Security, and workers' compensation. Voluntary spending includes health insurance and retirement health benefits. These charts represent benefit spending by both public-sector and private-sector employers.

Rising Health Care Costs Especially Hurt Small Business Owners

The situation is more dire for small business owners and their employees. All cost increases hit small business owners particularly hard, due in part to their smaller profit margins. For health care costs, this is compounded by the fact that it costs small business owners more than their counterparts in larger companies to provide health benefits to their employees, due to economies of scale. In January 2003, the federal Small Business Administration's Office of Advocacy reported that administrative expenses for insurers of small health plans account for as much as 33 to 37 percent of claims.[12] For large companies' insurers, administrative expenses comprise only about 5 to 11 percent of claims.

Meanwhile, according to the Small Business Administration, small businesses represent 99.7 percent of all employers in the United States and employ half of all private-sector employees.[13] Small businesses have generated between 60 and 80 percent of net new jobs annually over the last decade.[14] With small businesses having such a strong presence in the marketplace, it would make sense for Congress to work toward providing small business owners relief from this growing problem.

[12] Actuarial Research Corporation (for the Small Business Administration Office of Advocacy), "Study of the Administrative Costs and Actuarial Values of Small Health Plans," January 2003.
[13] Small Business Administration Office of Advocacy, "Frequently Asked Questions," June 2006. Note that the Small Business Administration defines a small business as one having fewer than 500 employees.
[14] *Id.*

The National Federation of Independent Business (NFIB), a small business advocacy group, reports that 27 million working people are uninsured, and that 63 percent of them are either self-employed or work for a small business.[15] If health care costs continue to rise, more small business owners may need to discontinue health benefits, and more small business employees may find themselves among the ranks of the uninsured. In October 2005, the National Small Business Association (NSBA), another small business advocate, conducted a study of its members on the health care benefits they provide for their employees. The results were telling: 51 percent of NSBA's members reported that they are considering making changes to their employee health benefits plans in the upcoming year, and 66 percent of those members are considering decreasing employee benefits or increasing the employee share of premiums.[16]

Senate Bills Use Different Means to Ease the Burden on Small Businesses

The Senate debate about small business health plans in May 2006 included discussion of two major proposals. HIMMA (S. 1955), introduced by Senators Enzi, Burns, and Nelson (NE), would give small business owners the power to band together through their trade or industry associations to insure their employees using what would be called small business health plans (SBHPs). This pooling of small business groups is designed to afford the groups the power to negotiate for more affordable health care benefits. The other proposal (S. 2510), sponsored by Senators Durbin and Lincoln, takes a starkly different approach. It would create within the federal Office of Personnel Management a new health insurance program for non-federal employees of small businesses and the self-employed – that is, government-administered health insurance.

HIMMA (S. 1955)

S. 1955, or HIMMA, would make three changes in the health care market: introduction of small business health plans, modernization of the health insurance market, and better harmonization of states' health insurance standards. The bill's sponsors say that, taken together, the three steps would reduce the high cost of health care coverage for small businesses.

Creation of, and Rules Governing, Small Business Health Plans

The Employee Retirement Income Security Act of 1974 (ERISA) sets minimum standards that govern the operation of most private health insurance plans.[17] ERISA is intended to protect consumers participating in these plans. S. 1955 creates a new "Part 8" under ERISA to create SBHPs and to delineate the rules governing them. The section defines an SBHP as a fully insured group health plan sponsored by a bona fide trade or industry association that does not

[15] Press Release, "Rising Cost of Health Insurance is Top Priority for Small Business," National Federation of Independent Business, April 13, 2006.
[16] Todd McCracken, President, National Small Business Association (NSBA), in testimony before the Senate Committee on Finance, April 6, 2006, available at http://finance.senate.gov/hearings/testimony/2005test/040606tmtest.pdf.
[17] ERISA is P.L. 93-406, 88 Stat. 829, September 2, 1974.

condition membership on health status or minimum group size. In addition, the new rules direct the Secretary of Labor to establish a process for certification of SBHPs.

Among the rules are these: the plan sponsor must meet or exceed the sponsorship standards for at least three years before applying for certification (e.g., a group cannot form for the sole purpose of providing its members health care coverage under this bill); the employers participating in an SBHP must be members of the plan's sponsoring organization; and the individuals covered by the SBHP must be owners or employees of the plan sponsor (or dependents of an owner or employee). Plan sponsors must furnish information about coverage options to all eligible employers. Furthermore, SBHP sponsors must adhere to the portability, guaranteed issue, and guaranteed renewability requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[18]

The bill also sets forth rules governing SBHP documentation, contribution rates, and benefit options. The rules prohibit variation in contribution rates from participating employers based on the health status of their employees or the type of business in which they are engaged; however, the rules permit the use of claims experience as a factor in varying contribution rates, with specified limitations. Furthermore, SBHP sponsors may offer coverage to self-employed members of an association, with some restrictions. SBHP sponsors are given some discretion to design their own benefit options (but subject to requirements set forth in the bill).

Market Relief Provisions Aim to Make it Easier for Insurers to Operate Across State Lines

S. 1955 creates a new provision of law dedicated to "Health Care Insurance Marketplace Modernization," which would apply primarily to the small group market. (In general, state governments bear the responsibility for regulating insurance carriers. As such, state governments regulate premium rating, benefit mandates, and other activities in which insurance carriers engage.) Under the new provision, the Secretary of Health and Human Services (HHS) would promulgate regulations implementing the Model Small Group Rating Rules (adopted by the National Association of Insurance Commissioners in 1993 and outlined in the bill). These rating rules limit the extent to which insurers can vary the premiums they offer in that market. Each state has its own rating rules, similar to the model rules, although state rules may vary in how flexible or restrictive they are. The bill gives the Secretary of HHS discretion to provide for a graduated transition to the Model Rules so as to minimize market disruption.

If a state chooses not to adopt the Model Small Group rating Rules, that state will be designated a "non-adopting state." Insurance carriers in non-adopting states that meet certain criteria will be permitted to sell insurance in that state using the federal Model Rules instead of the applicable state rules. In order to qualify for preemption, the insurer must provide proper notification to HHS and the state insurance commissioner and must incorporate the terms of the Model Rules into its insurance contracts. One of the bill's safeguards is a provision requiring the Secretary of HHS to review the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market and to make recommendations to Congress.

[18] P.L. 104-191, 110 Stat. 1998, August 21, 1996.

The bill provides health insurance issuers wishing to sponsor SBHPs some flexibility in their benefit choice standards. This is a key provision for keeping premiums affordable. It provides that the health insurance issuer may offer a plan that does not comply with one or more of that state's mandates regarding covered benefits, services, or categories of providers in a given state, provided that the insurer also offers to would-be purchasers in that state an alternate "high-option" plan that includes the same covered benefits, services, and categories of providers as are mandated by a state employee coverage plan in one of the five most populous states (currently, these states are California, Florida, Illinois, New York, and Texas). This means that employees of small businesses will not be forced to enroll in a "no frills" health plan that doesn't adequately meet their health care needs. It seems logical to assume that, since small business owners and their families would be covered under the same plans as their employees, they would want to provide the best possible coverage that they can afford. Presumably, employers will want to plan for future medical needs as well and will want to secure coverage that anticipates those needs. The bill is intended to ensure that at least one comprehensive policy is offered to every employee participating in a SBHP while ensuring that more basic, affordable policies are available as well.

Harmonization of Health Insurance Standards

The standards harmonization provisions in S. 1955 are designed to eliminate inconsistencies in certain categories of insurance law among the 50 states. The bill establishes a process intended to create greater uniformity in the administrative and process requirements in current state health insurance regulation. Reducing the patchwork of inconsistent laws will ease plan administration and, ultimately, reduce costs.

Durbin-Lincoln Alternative (S. 2510)

Unlike S. 1955, S. 2510 relies on the federal government, rather than the market, to administer health plans for small businesses. The sponsors say their program, the Small Employers Health Benefits Program (SEHBP) is modeled after the Federal Employees Health Benefits Program. Others would argue that the program's similarities to the federal employees' program are limited to the fact that both would be administered by the federal Office of Personnel Management (OPM). One key distinction is that this plan includes incentives that both skew the marketplace and that put taxpayers at risk.[19]

SEHBP Fundamentals

S. 2510 requires that OPM maintain a risk pool for SEHBP participants that is separate from the one maintained for federal employees and their dependents. Contract requirements for SEHBP participating plans include the mandate that such plans offer coverage for individuals only, individuals with one or more children, married individuals without children, and married individuals with one or more children. Further, SEHBP plans must, at a minimum, comport with benefit mandates applicable to the federal employees' program; if, however, a plan participating in SEHBP intends to offer a particular health plan nationwide, that plan must comply with *all* 50 states' benefit mandates.

[19] See the National Association of Health Underwriters' critique of these incentives on pages 9-10.

In general, the SEHBP plans would be held to the same standards as the federal employees' plans (but plan sponsors in the federal employees' program would not be required to participate in SEHBP). For example, SEHBP plan enrollees would be subject to a preexisting-condition exclusion and premium rating adjusted for geographic location, family composition and size, and age. S. 2510 prohibits rating adjustments made on the basis of health-status related factors, gender, class of business, or claims experience, although plan sponsors may develop separate rates for Medicare-eligible individuals for whom Medicare is the primary payor. The rating provisions in S. 2510 are intended to supersede state rating rules, except where a rating variance with respect to age is less than the federal limit or where state law provides for community rating.

Incentives for Plan Participation

Rather than relying on marketplace incentives, S. 2510 employs a variety of alternative methods to entice insurers into participating in SEHBP. Although the bill's sponsors point to the federal employees' program as a model, none of these methods (as formulated in the bill) is used by the federal employees' program.[20]

One incentive the bill uses to encourage insurers to participate in the SEHBP is employing what are known as "risk corridors." Risk corridors allow plans to offset gains and losses above a specified percentage; usually this risk would be shared with the plans' enrollees; however, in this case, unlike in the marketplace, this risk is shared with OPM (i.e., the taxpayers). The risk corridor in S. 2510 is +/- 3 percent, and this is how it works: For plan years 2007 through 2009, in the year preceding a given plan year, the insurer will be required to report to OPM its expected premium receipts and administrative costs (the "target"). If it has actual premium receipts and administrative costs that total between 97 and 103 percent of its target, no adjustment is made. If its costs total between 103 and 108 percent of its target, OPM will reimburse the plan for 75 percent of its excess costs. Similarly, if a plan's costs are between 92 and 97 percent of its target, the plan will pay 75 percent of the difference between the actual and target costs into an existing contingency fund maintained by OPM. [21]

Further, if a plan's costs exceed 108 percent of the target, OPM will reimburse the plan for 3.75 percent of its target plus 90 percent of the excess costs up to 108 percent. If costs fall below 92 percent of a plan's target, the plan would pay into the existing OPM contingency fund an amount equal to 3.75 percent of the target plus 90 percent of the difference between the target and the amount equal to 92 percent of the target.

The bill outlines an additional incentive meant to bring plan sponsors into the SEHBP – a reinsurance fund for the purpose of reimbursing plans that experience one or more catastrophic claims in a plan year. To be eligible for payment from the fund, a plan would be required to submit an application certifying that it has paid one or more claims for covered benefits for an

[20] However, another federal benefits program, TRICARE, which provides health care coverage to the U.S. military, does employ risk corridors.

[21] The contingency fund was established by 5 U.S.C. §8909(b)(2). The fund is maintained to provide for any payments to plans that are authorized by law.

individual in excess of $50,000. The amount of reimbursement a plan would receive would be determined by OPM, but in no case would it exceed 80 percent of the catastrophic claim amount. Under the provisions of the bill, the reinsurance fund would terminate two years after the date of the first contract period becomes effective under the bill.

Finally, the bill establishes a new contingency reserve fund, beginning October 1, 2010, using any unobligated appropriations authorized for the creation of the SEHBP. The purpose of the fund is to provide financial assistance to SEHBP plan sponsors that experience unanticipated financial hardships (as determined by OPM).

Tax Credits for Participating Employers

Taxpayers would further subsidize this program with the bill's awarding of tax credits to employers participating in SEHBP as a means to reduce their cost of providing health care coverage to their low-income employees. To be eligible for this credit, an employer must agree to pay at least 60 percent of each employee's health insurance premium. If the employer contributes 60 percent or more toward the health insurance premium of a childless, unmarried employee making $25,000 or less, the employer would receive a 25 percent tax credit. The employer's tax credit would increase based on the number of individuals covered and the employer's level of contribution. The credit would increase to 30 percent for coverage of two adults or one adult and one or more children. In the case of family coverage, the employer would be eligible for a credit of up to 35 percent.

An employer would be eligible to receive a bonus tax credit if that employer contributes more than 60 percent of the covered individual's premium. For each additional 10 percent of premium covered (over the original 60 percent), the employer's tax credit would be increased by 5 percent. Employers enrolling in SEHBP in the program's first year would receive an additional 10-percent tax credit that year.

HIMMA Will Better Help Small Business Owners

S. 1955 is a market-driven, fiscally responsible, and workable solution for making affordable, quality health care coverage more accessible to small businesses. The Lincoln-Durbin bill is really not an alternative at all. S. 2510 shifts to the federal government the responsibility for administering a huge new program, rather than trusting small businesses and their advocates to do what they do best – work within the competitive marketplace. In addition, S. 2510 subjects insurers to a maze of burdensome (and often conflicting) state regulations. And, although the bill's sponsors say that their program will help make health care coverage more affordable, S. 2510 would increase the burden on taxpayers by billions of dollars over the next decade.

Two insurance industry groups have weighed in on the approaches embodied in HIMMA and the Lincoln-Durbin alternative. Both highlight their concerns with S. 2510.

The National Association of Health Underwriters (NAHU) lauded Senator Enzi for his approach, "modeled to produce a competitive market and a level playing field."[22] NAHU noted that it was "in particular pleased that [HIMMA] did not go in the direction of S. 2510," which "creates the worst kind of unlevel playing field by providing subsidies in the form of reinsurance and a risk corridor only to health plans offered in one purchasing vehicle within the small employer market."[23] NAHU explains that the payment of subsidies under S. 2510 would provide a competitive advantage to plans choosing to operate within the closed SEHBP pool. Thus, plans that cease to be able to afford to operate in the anti-competitive environment outside the pool would opt instead to offer coverage inside the pool, increasing the cost of the government subsidies. Once these limited-term subsidies expired, the cost of accessing health care would again increase. As a result, NAHU predicted that "the ultimate result [of S. 2510] would be an increased number of people being priced out of coverage and ultimately more, rather than fewer, people would be uninsured."[24]

The National Association of Insurance Commissioners (NAIC) also voiced its concerns with S. 2510. NAIC remarked that "S. 2510 creates an unlevel playing field by requiring plans sold through [SEHBP] to meet different rating standards than those required of plans not sold through SEHBP. By setting different rules for different carriers," NAIC notes that "S. 2510 could create an unworkable market in some states."[25]

In addition, over 190 trade associations and other organizations have expressed their strong support for HIMMA. The Bush Administration, in a May 9, 2006 Statement of Administration Policy, also supported passage of the bill. The Administration notes that "[S. 1955] would allow small businesses to offer health care coverage for their employees at discounts like those big companies get by benefiting from larger risk pools, increased negotiating clout, and administrative efficiencies currently enjoyed by large employers and labor unions purchasing health insurance."[26]

Unlike the alternative, S. 1955 is likely to save taxpayers money. The Congressional Budget Office (CBO) estimates that enacting S. 1955 would increase federal revenues from payroll and income taxes.[27] The increase in revenues would result from a reduction in the total amount spent on employer-sponsored health insurance; this assumption is based on the idea that, as the implementation of S. 1955 brings down employers' costs of providing non-taxable health care coverage to their employees, employers will pass the savings on to their employees in the form of higher wages and salaries (taxable income). As a result, the bill's provisions would reduce the share of compensation that is tax-advantaged (health insurance premiums) and would increase the share that is taxable (wages and salaries). According to CBO, this shift would

[22] National Association of Health Underwriters letter to Senator Michael Enzi, Chairman, Senate Committee on Health, Education, Labor, and Pensions, May 9, 2006.
[23] *Id*.
[24] *Id*.
[25] National Association of Insurance Commissioners letter to Senator Michael Enzi, Chairman, Senate Committee on Health, Education, Labor, and Pensions, May 9, 2006.
[26] Statement of Administration Policy for S. 1955, the Health Insurance Marketplace Modernization and Affordability Act, May 9, 2006.
[27] Congressional Budget Office, Cost Estimate for S. 1955, May 3, 2006.

increase federal revenues by $1 billion over the 2007-2011 period and by $3.3 billion over the 2007-2016 period.

CBO also estimates that S. 1955 would reduce direct spending for the federal share of Medicaid by $235 million over the 2007-2011 period and by $790 million over the 2007-2016 period. This decrease in federal spending would result from enrollment of individuals currently covered under the Medicaid program in new, employer-sponsored plans. CBO estimates that this shift in enrollment would result in Medicaid savings to states of $180 million over the 2007-2011 period and $600 million over the 2007-2016.

CBO has not made publicly available a cost estimate for S. 2510. Unofficial estimates have been circulating, and some observers believe that the bill could cost taxpayers as much as $50 billion to $73 billion over the first 10 years of the program.[28]

Conclusion

Small businesses are vital to our economy, but many of them continue to struggle to provide health care benefits to their employees in the face of rising health care costs. Small businesses employ nearly two-thirds of the working uninsured population, and so it makes the most sense for Congress to take action to create a more competitive health insurance marketplace so these owners and their employees can secure the health care coverage they deserve.

Experts agree that S. 1955 would go a long way toward meeting this goal. Congress should resolve to pass this legislation before adjournment this fall. Meanwhile, S. 2510 takes us in the wrong direction by exposing taxpayers to undue risk and by reducing, rather than increasing, competition in the marketplace.

[28] See, for example, "Senators Respond to Ad on Small Business Health Care," *Arkansas Democrat Gazette*, April 22, 2006.