Testimony before the U.S. Senate Committee on Health, Education, Labor, & Pensions

Increasing Health Costs Facing Small Business

November 3, 2009

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Introduction

Thank you for the opportunity to testify today on the potential impact of health reform legislation on the small business community.

I am testifying today on behalf of Oliver Wyman Actuarial Consulting. I am a credentialed actuary who has specialized in small employer health insurance issues for more than 35 years. My comments today are based on my experience in actually working for and advising health plans, state governments and other clients on the implications of proposed public policy changes at the state and federal level.

The focus of today's hearing – increasing health costs facing small business – underscores the need for reforms that expand coverage and improve affordability for small employers. With those goals in mind, my testimony today addresses the following issues:

- The challenges facing the small employer market, including a discussion of the factors that contribute to small employer premiums, and how those premiums are set;
- The need to "bend the cost curve" to make coverage more affordable for everyone; and
- A review of proposed policy changes that will impact small employers: specifically, insurance reforms, health insurance exchanges, and proposed taxes on insurance premiums.

I. Challenges Facing the Small Employer Health Insurance Market

Research has consistently shown that a significant percentage of uninsured workers are either self-employed or working for firms with fewer than 100 employees. To understand the challenges that small employers face when purchasing health insurance, it is important to understand how this market functions and how it is regulated.

Traditionally, small employers faced two major challenges in purchasing health insurance: access and affordability. The issue of access has been addressed as a result of a

combination of the enactment of state small employer health insurance reform laws in the 1990s and by HIPAA at the federal level. Today, state and federal law requires insurers to offer coverage to all small businesses (2-50 workers) regardless of their employees' health status. In all 50 states, small businesses cannot have their coverage turned down or cancelled if their employees become sick. Thus, small employers that can afford coverage are guaranteed access to coverage today.

The premiums that insurers charge small employers are now highly regulated. In all but three states (Hawaii, Pennsylvania and Virginia[1]), state laws limit the extent to which premiums can vary for individual small employers based on a variety of factors, including health status or claims experience. States typically prohibit health plans from charging premiums to small employers with high cost workers that are no more than 25% -35% higher than the midpoint rates. States also limit rate increases at renewal due to changes in morbidity to no more than 10-15% if one or more employees become seriously ill during the year. Furthermore, a minority of states do not allow health status to be used at all in setting initial or renewal rates.

These reforms spread the medical costs of all small employers more evenly to generate more affordable premiums for employers with less-healthy members by requiring that small group experience be pooled together. However, this results in higher premiums for the employers with healthier members than otherwise would be justified based on actuarially supported risk classifications. Conversely, the employers with members that consume greater health care resources are enjoying lower premiums than they would absent the existing rating regulations. These groups are being subsidized by the first group, those employers whose premiums are artificially higher due to reforms. In order for the small employer pool to stay

[1] In Pennsylvania, Blue Cross Blue Shield companies and health maintenance organizations are subject to strict rate limitations in the small group market. However, these regulations do not apply to other insurers. In Virginia, rating rules apply to certain standardized policies. However, most small employers purchase other policies not subject to these rules.

viable and generate sufficient premiums to fund claims and expenses, it is critical that enough of the lower-cost groups providing the subsidies remain. Otherwise, overall premiums for all participating employers increase.

These state rules are designed to improve access and fairness for small employers. This is an important objective, but these reforms may actually increase the average cost of health insurance. As an actuary with substantial experience in the small employer market, I have seen that some of the smallest employers make rational economic decisions about when to purchase insurance by taking advantage of these rules. The smallest firms make decisions much like individual purchasers. The National Association of Insurance Commissioners' (NAIC) rating manual states that "Individuals and small groups tend to select against an insurer when purchasing medical coverage. The purchaser generally knows the needs for insurance for each employee in very small groups and can select coverage in line with those individuals' needs."[2] This explains to some extent why small employer coverage can be more costly than coverage for other employers. In an environment where small employers can purchase any level of coverage at any time, there is an incentive to purchase the lowest level until such time they are aware of the need for medical services and then purchase increased coverage on a guaranteed issue basis.

Affordability is the central remaining challenge in the small employer market today. Since 1999, average health insurance premiums for family coverage for small employers have more than doubled from $5,683 to $13,375 in 2009, according to the 2009 Kaiser Family Foundation/HRET employer health benefits survey. As health care cost increases continue to outpace inflation, small firms have found it more and more difficult to provide or maintain coverage.

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[2] NAIC: *Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance*, 2003.

However, as the Kaiser Family Foundation report demonstrates, escalating premiums are not limited to small employers. In fact, average family premiums for covered workers in small have grown more slowly than those in large firms since 2004 (30% in small firms vs. 36% in large firms) and since 1999 (123% in small firms vs. 134% in large firms), according to the same survey. These premium increases are due to substantial growth in the underlying cost of medical care that impact premiums for all employers – large and small.

The causes for premium increases are due to many factors, including:

- *The price of medical services*. Price reflects the payment rates that health insurers negotiate with hospitals, physicians, pharmacies and other health care providers. Price also includes the increasing cost of purchasing prescription drugs, durable medical equipment, and other items. It is important to realize that insurers use their bargaining leverage to obtain the same price discounts for all of their customers - large employers, small employers, and individuals, so small employer and individuals do have access to the same provider reimbursement levels as large employers.

- *Utilization*. Utilization refers to the volume of medical goods and services that people use. Medical advances are continuously being introduced to improve care and outcomes. For example, a decade ago few people received a knee or hip replacement. Today, the procedures are commonplace. As new treatments are developed, manufacturers and providers advertise these new options, and consumers increasingly seek more care and have higher expectations regarding outcomes.

- *Intensity*. Intensity is when a treatment or procedure is replaced by a more expensive treatment. For example, magnetic resonance images (MRIs) are frequently used instead of less expensive X-rays, thereby increasing costs.

- *Aging of the population*: As we get older, we have greater health care needs and there is a greater demand for services. While this has the greatest impact on the Medicare program, it also impacts the under 65 population as well.

- *Government actions.* Many federal and state government actions also add to costs. These include mandated benefit levels, premium taxes, and regulatory requirements. Cost-shifting from government programs that provide below-cost reimbursement to providers also increase premiums for small employers. According to a recent report by Millman, Inc., annual health care spending for an average family of four is nearly $1,800 higher than it would be if Medicare and Medicaid paid hospitals and physicians rates that were comparable to those paid by private plans. Expansion of the number of people on Medicaid and reductions in Medicare reimbursement may exacerbate this cost-shifting. Cost-shifting from the uninsured is similarly problematic.

- *Personal behavior*. Health care costs are also influenced by personal behaviors such as poor diet and nutrition, lack of exercise, alcohol and substance abuse, smoking, avoidable injuries, and failure to obtain proper vaccines or follow prescribed medication regiments.

According to the Congressional Budget Office (CBO), the bulk of rising health care costs over the past four decades can be attributed to our nation's use of medical services made possible by technological advances (2008). In fact, CBO found that approximately one-half of all growth in health care spending during this time is associated with the emergence of new medical technologies and services and their adoption and widespread diffusion by the U.S. healthcare system.

II. Bending the Cost Curve

To address the fundamental reason why small employer health insurance cost have increased over the past decade – growth in medical expenses – we must find a way to "bend the cost curve" in our health care system. Policymakers, researchers, and industry experts alike have acknowledged that our current system includes misaligned incentives that drive increased health care costs, without regard to quality of care or outcomes. One result is unwarranted variation in medical practice that cannot be explained by patient demographics or severity of illness. This variation can be due to the underuse of tests and treatment known to be effective, the overuse of tests and treatments that may not have significant clinical value, and the misuse of tests and treatments that contribute to medical errors. The use of tests solely for the purpose of defending against the possibility of a lawsuit, commonly referred to as defensive medicine, also exerts upward pressure on health care costs.

To truly bend the cost curve, we must change processes and incentives in our current health care system to advance the best possible care, not just drive the use of more services. Properly aligned incentives can reinforce the adoption of evidence-based practice standards, which will facilitate the availability of transparent quality information for consumers to make informed choices about their care.

The bills before Congress do take steps to bend the cost curve over the long term. However, more emphasis must be put on changing the way that medical care is practiced to bring spending under control while improving quality for all. Insurance reform must be coupled with effective changes in how medical care is paid for, liability reform to reduce defensive medicine costs, and efforts to improve wellness and healthy lifestyles if we are to bend the cost curve in a substantial way.

III. Proposed Policy Changes that will Impact Small Employers

Insurance Reforms

The key health reform bills before Congress include significant reforms to health insurance industry practices in the small group market. Last month, Oliver Wyman released a report commissioned by the BlueCross BlueShield Association on the impact of the Senate Finance Committee's recently approved health reform legislation on the individual and small employer health insurance markets. While the report did not specifically address this Committee's reform legislation, its findings are still instructive. Our analysis concluded that under such reforms, small employers will face higher premiums, and that these higher premiums, coupled with a weak individual mandate will result in fewer small employers offering coverage.

All of the health care reform bills before Congress compress the rating factors that health insurers will be permitted to use in pricing products for small employers. The Senate Finance Committee bill would prohibit the use of health status in pricing products for small employers, limit the use of age to a 4:1 band, eliminate rating based on gender, restrict the use of group size as a rating factor, and limit use of family composition. Rate reform in the small employer market would be phased in over a five year period.

The rating reforms in the Senate Finance Committee bills will compress rates for firms with younger, healthier workers and firms with older, sicker workers. As a result, some younger and healthier firms will experience increases in premiums and older, sicker firms will experience rate decreases. The purchase of group insurance is a two-phase process. First, the employer must view the purchase as being of economical value and elect to offer insurance. The employer generally contributes a portion of the premium, requiring the employee to contribute the balance. So the second purchase is by the individual employee who must decide if his/her monetary contribution is of economic value. This is often referenced as the "take up rate."

As a result of the proposed premium compressions, groups with lower-than-average risks who today are enjoying lower than average premiums, may not perceive as much economic value in purchasing health insurance after reforms. The more restrictive the rating rules, the greater the subsidies required from the healthier groups, which means the higher the premium compared to current levels and the less attractive health insurance is for the exact market segment critical to creating a viable pool. While it is true that the higher cost groups will enjoy lower premiums, groups in the small employer market are not distributed equally between low cost and high cost entities. The distribution of employer groups by morbidity levels does not follow a bell-shaped curve. Rather, the distribution is skewed toward lower-cost groups, meaning that there are more employers that enjoy premium discounts than employers that pay higher rates. Therefore, the elimination of morbidity as a rating factor will cause a greater number of employers to experience premium increases than will enjoy premium reductions. Rate compression will cause some lower cost firms to drop health insurance coverage and/or cause some employees currently purchasing health insurance to no longer participate, causing the average morbidity to increase, and therefore raise costs for all firms that continue to provide insurance (and their participating employees). The absence of a strong individual mandate coupled with guaranteed issue with no pre-existing limitation will only exacerbate the incentive for individual employees who are lower cost to defer the purchase of insurance until they are aware of a health condition that will necessitate access to services that they can reasonably expect will cost more than the monthly premiums.

The Senate Finance Committee bill also includes certain minimum benefit requirements that apply to small employer coverage. The legislation would establish four defined levels of coverage, with the lowest level “Bronze” plan required to have an actuarial value of at least 65%. New coverage sold to small employers must provide certain minimum benefits, including some categories of services that are less commonly purchased among small employers today. New

coverage would include specified limits on out of pocket costs and no annual and lifetime caps. Based on a review of products commonly purchased by small employers today, we expect that coverage for small employers would be 3 percent more expensive as a result of the minimum actuarial value requirements on average. However, many small employers buy coverage that is significantly below the required actuarial value levels and would face much higher increases when they replace their current coverage.

We estimate that small employers purchasing new policies in the reformed market will experience premiums that are up to 19 percent higher five years after reforms become effective than they are today, not including the impact of medical inflation. While some smaller, low-wage firms will be eligible for tax credits that may offset the cost of these changes, the majority of firms that continue to provide health insurance will face higher premiums directly as a result of the proposed reforms. The government will also see its share of the costs for these reforms increase by having to provide higher subsidies per covered individual because of these higher premiums.

The legislation contains "grandfathering" provisions which allow currently insured small employers to keep the benefits they have today. Our model estimates that about 9.5 million small group employees (out of a total of 28 million small group employees) who have coverage today will stay covered under the "grandfathered" block in the initial post-reform years. These firms will avoid some of the cost increases as a result of reforms, but will face premium increases when the grandfathering phases-out. We can expect the firms whose grandfathered premiums are less than the post-reform premiums to remain under these plans until such time as these premiums are equal to or greater than the post-reform premiums due to the phase in, since groups whose premiums are higher will have economic incentives to purchase in the new post-reforms pools and take advantage of the lower rates.

The Senate Finance Committee bill will also create health insurance exchanges that will provide an alternative source of subsidized insurance coverage for employees of firms that chose to terminate health insurance coverage. The bill does not compel small employers to provide health benefits and exempts them from the "free rider" assessment that applies to larger firms that do not offer coverage. The combination of the exchange and new insurance rules that apply to the individual health insurance market may make it easier for small firms to drop coverage when faced with premium increases because they will know that their employees can obtain coverage – in some cases subsidized by the government – through the exchanges.

The absence of an effective individual mandate will also contribute to a reduction in the number of workers who obtain insurance in the small employer market. The individual mandate in the bill approved by the Senate Finance Committee was severely weakened. It does not include any penalty for individuals who do not purchase insurance in the first year of reform and then phases in nominal penalties that reach a maximum of only $750 per adult in 2017 – 15 percent of their expected premium. As a result, fewer low cost individuals are likely to opt into employer coverage than would otherwise have done so if a strong individual coverage requirement were included in the legislation. However, high cost individuals will have enhanced economic incentives to join, because their premiums may be significantly lower than current levels and/or benefits may be significantly richer. These are the individuals whose premiums do not totally fund claims. This combination of economic incentives – encouragement of higher cost individuals to join at premium levels less than sufficient to fund claims and the unintended economic encouragement of low cost individuals to defer coverage until services are required, exerts significant upward pressure on premiums in the post-reform individual market.

The bills before Congress should be commended for including tax credits to help small firms with low wage workers purchase health insurance. Small firms with low wage workers

have the lowest coverage rates of any segment of the employer sponsored health insurance market. While these tax credits may increase coverage among those firms that are eligible, many small employers will not see savings from premium tax credits and would face the full cost of the premium increases they are likely to experience as a result of health care reform.

Overall, the number of small employers offering coverage is likely decline after reform. We estimate that even accounting for small employer tax credits, premium increases in the small group market will result in 2.5 million fewer members being insured through small employer policies five years after reforms become effective. These losses would have been higher had the legislation not included small employer tax credits.

Exchanges

The key health bills under consideration would establish health insurance exchanges that would be open to both individuals and small employers. Some proponents of these exchanges believe that they could lower the cost of health insurance by reducing administrative costs, "pooling" small employers to gain economies of scale similar to larger employers, and spurring competition among health plans.

As the author of several reports on state purchasing cooperatives and other purchasing arrangements for small employers, I have studied health insurance cooperatives extensively, and have found little evidence that previous models have reduced premiums and have in fact identified some situations where their presence actually resulted in higher administrative costs. However, if properly structured, an exchange could potentially reduce distribution costs and increase competition by making it easier for consumers to compare products, although the savings would likely be limited by a number of factors I describe below.

While pooling of risks is an essential function of insurance, assembling many small groups or individuals into an exchange "pool" will not automatically reduce costs. While some

think that health insurance costs can be lowered if purchased in bulk, like commodities or consumer goods, the economic and actuarial realities affecting the cost of health insurance are fundamentally different.

There are significant differences between a pool of many small employer groups and a large employer pool. For example, a single employer with 999 employees is not the same as 333 groups with 3 employees each. Similarly, an exchange will not be one big pool, like a large employer, but rather a collection of many small firms that must each be serviced separately and each of which are making insurance decisions separately. Insurers participating in exchange will retain all of the health insurance risk of the groups they enroll; thus, the pooling of risk actually occurs at the insurer level, not at the level of the exchange. I have made these distinctions at several Capitol Hill briefings on behalf of the American Academy of Actuaries.

Exchanges will also have limited ability to reduce administrative costs. Many of the non-subsidy related functions they will perform will duplicate functions performed by the state insurance department, health plans, or insurance agents or brokers. When an exchange takes on enrollment functions, insurers must continue their own enrollment functions to assure appropriate services, claims payment, etc. Thus, while an exchange may assume certain administrative functions, it may not eliminate these functions or their related costs. While it has been argued that exchanges would save money by eliminating costs related to underwriting, any reduction in this area will be a function of changes in insurance rating and underwriting rules and not due to the exchange. Moreover, the costs attributed to underwriting are likely in the range of one percent of premiums in the small employer market.

One area where an exchange can provide value is in helping small employers shop for coverage and providing information on competing plans. Exchanges proposed by current health reform bills would provide small employers with information on prices and other important plan features on all health plans in the market.

New Taxes

The Finance Committee bill includes a number of fees and taxes on the health industry to help finance the proposal. These include a $6.7 billion annual assessment on insurers, as well as assessments on device and drug manufacturers that are likely to be included in the prices that insurers and their members pay. The bill also imposes an excise tax on high cost benefit plans offered in the employer marketplace.

Our recent analysis did not include the impact of these fees and taxes on cost and coverage in the individual and small employer markets. However, it is important to note that the $6.7 billion annual insurer fee is likely to disproportionately impact individuals and small employers. Insurers will have little choice but to pass these fees on to their customers in light of statutory reserve limits. Larger employers that self-fund their benefits are not subject to the insurer assessment. Thus, the design of the insurer fee provision is likely to cause more employers to self-fund, causing small employers and individuals to shoulder an increasing burden from these fees over time.

Few small employers may have benefit costs that exceed the threshold for the excise tax on high cost benefit plans today. However, because premiums have historically grown at a rate that exceeds the indexing formula in the bill (growth in CPI + 1 percent), more small employer plans are likely to become subject to the tax on high cost plans over time.

Some have argued that the high cost plan tax will cause small employers to purchase less expensive benefit plans to avoid the tax, thereby mitigating its impact. However, factors such as the worsening of the overall cost of the small employer pool after rating reforms, geographic cost differences (which may push plans in certain areas into the tax sooner than others), and the restrictions on benefit plan design in the bill may limit behavioral responses to avoid the tax.

Conclusion

Small employers are likely to judge the success of health care reform based on whether it improves affordability in the marketplace. While proposed insurance reforms may reduce costs for some firms, they will tend to increase costs in the aggregate by encouraging firms with low morbidity to exit the market in response to premium increases. The imposition of insurer fees and other assessments will also erode affordability.

As Congress considers health care reform proposals, it must carefully evaluate provisions of legislation that may have unintended impacts that result in increased premiums for small employers. Adequate rating flexibility will be important to assuring a balanced risk pool participates in the insurance pool to assure overall affordability. Congress should also consider the impact of assessments and fees that may disproportionately impact small employers and reduce affordability.

Thank you for the opportunity to testify today on the important subject of assuring affordable health insurance for small businesses.