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H.R. 3626
and
Its Effects on the Small-Employer Market

An Actuarial Study of
The Health Insurance Reform and Cost Control Act of 1991

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Executive Summary

If enacted, H.R. 3626, The Health Insurance Reform and Cost Control Act of 1991, would significantly change the small-employer (2 to 50 employees) market for health insurance.[1] It would:

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

But it would also:

- Make health insurance less affordable for the majority of small employers (more than three-quarters of small employers would receive rate increases of 10 percent or more--see Figure 1)[2];
- Increase small-employer premiums by 8 to 24 percent, on average, adding an estimated $3 to $9 billion to small-employer costs; and
- Increase the total number of uninsureds by 2 to 5 percent, adding an estimated 1 to 2 million persons to the total uninsured.

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

Furthermore, these rate increases are in addition to trend increases and are a direct result of the combination of the access, rating, and benefit provisions of H.R. 3626. (See Table 1 for a summary of these provisions.) H.R. 3626 would also lead to significant changes in who would be insured in the small-employer market.

Rating Restrictions: The Redistribution of Small-Employer Premiums. Under H.R. 3626 rating restrictions, the premium increase experienced by individual small employers would vary widely. Rating restrictions alone would increase rates significantly for two-thirds of the currently insured small employers and their employees. Younger, lower-income employers and employees would be forced to subsidize older, higher-income, employers and employees. Premiums would no longer reflect expected claims, except in the aggregate.

Rating restrictions also lead to more rate increases for the smallest of the small employers than for larger small employers: this probably reflects a tendency among the smallest of the small employers to purchase coverage only if they have a lower than average risk and, therefore, premium.

Changes in the Insured, Small-Employer Population. Combined, the H.R. 3626 rating, access, and benefit provisions would make health insurance more affordable and accessible for higher-risk groups and less affordable for average and lower-risk groups. This would create an environment of adverse selection, in which persons who know they are unhealthy would tend to purchase insurance and those who know they are healthy would tend not to do so. Lower-risk employers who don't want to drop their coverage entirely may also switch to other forms of coverage which may now be less costly than group insurance. In addition, the very tight rating bands of H.R. 3626 cause more adverse selection than proposals with less severe rating bands. Thus, H.R. 3626 leads to greater changes in the insured, small-employer population than other proposals might. Altogether, H.R. 3626 would lead to (1) an increase in the average premium for small employers and (2) fewer small employers and their employees being insured.

> **H.R. 3626 increases premiums 8 to 24 percent on average, resulting in an increase in cost for small employers of from $3 to $9 billion.** This increase in the average premium would be in addition to the rate increases most small employers would receive as a result of rating restrictions alone; some small employers would still receive decreases in rates.

> **H.R. 3626 increases the total number of uninsureds by 2 to 5 percent, increasing the total uninsured by about 1 to 2 million people rather than decreasing it.** This occurs in spite of the 1 to 2 million uninsureds who rejoin the market. These new additions are offset by the 1 to 4 million, mostly low-risk-employers and employees who leave the market. In addition, the tendency would be for these new uninsureds to be younger, to have lower-incomes, and to work for the smallest of the small employers. Many would be children.

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

H.R. 3626 increases the self-employment deduction for health insurance and adds four portability provisions that would apply to all group health plans, regardless of size, including self-insured plans. The portability requirements are (1) an excise tax for failure to provide all of these portability benefits (25 percent of gross premium for plan), (2) a prohibition against denying, limiting or conditioning coverage (or benefits) on health status, (3) a maximum 6-month preexisting condition limitation (except for newborns), and (4) a continuity of coverage provision that mandates credit for prior coverage if no more than a three-month break in coverage has occurred.

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

Cost Containment Provisions. H.R. 3626 calls for the establishment of a National Health Care Cost Containment Commission shortly after enactment of the bill. It also requires the Secretary of Health and Human Services to establish optional, maximum payment rates for hospitals, physicians, and other health services by October 1, 1994, and annually thereafter. The rates would be based on DRG (diagnosis-related group) and RBRVS (resource-based relative value scale) methodologies similar to what Medicare currently uses.

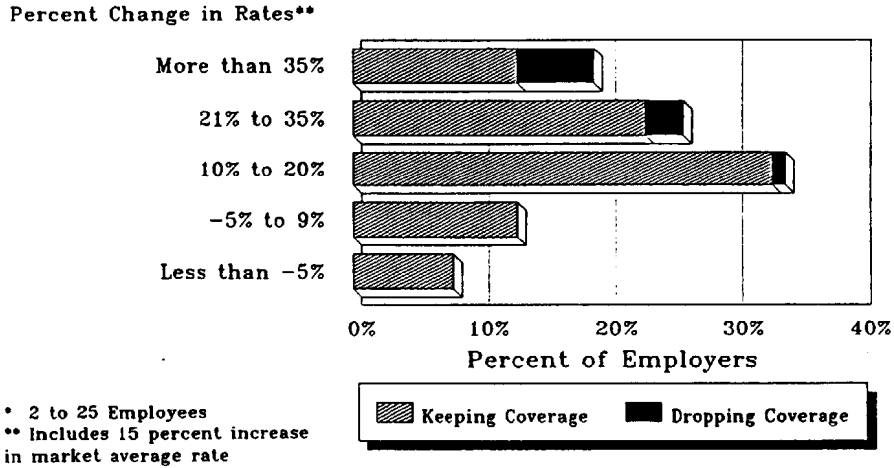
These cost containment provisions are too nebulous to justify any estimated reduction in costs at this time. While some studies have estimated significant savings from using current Medicare reimbursement maximums, it is by no means certain that the payment rates eventually approved would be so low.

However, to the extent that the optional DRG and RBRVS rates are used uniformly by health care payors, including government, some reductions in cost shifting may occur.

Conclusion. Although H.R. 3626 would improve availability of coverage for small employers and portability of coverage for all employees, the severe rating restrictions would lead to more people being uninsured than at present. It would force many small employers to pay a very high price to make coverage more affordable for a few small employers. In short, the costs of this bill would far exceed the benefits.

FIGURE 1

Distribution of Rate Changes for Currently Insured Small Employers* Under H.R. 3626



* 2 to 25 Employees
** Includes 15 percent increase in market average rate

Source: Health Insurance Association of America

For example, 19 percent of employers would receive an increase in rates of more than 35 percent: 13 percent would retain their coverage, and 6 percent would drop their coverage.

TABLE 1

	H.R. 3626 (Rostenkowski)
Group Size	2 to 50 employees (portability provisions apply to all group health plans)
Transitional Period	Various, but up to 3 years for some provisions
Availability	Guaranteed issue (year-round; uniform waiting periods and minimum participation requirements allowed)
Individual Policies	Not applicable to individual policies
Case Characteristics	Age, gender, and geography (no smaller than MSA)
Rating Restrictions	Community rating such that: variations between blocks of business shall not exceed 20 percent and age/sex adjustments may be used, but only up to +/- 25 percent and only if applied to all small employers
Renewal Rating	May not exceed the sum of the percentage change in the base premium rate plus 5 percentage points
Renewability	Guaranteed renewable except for non-payment of premiums, fraud or misrepresentation and failure to maintain minimum participation rates; must give notice 60 days prior to renewal date; terms of renewal must be same as at issue except for premiums and administrative changes.
Whole Groups	Coverage must be offered to any eligible employee and dependent
Portability	These provisions apply to all group health plans: -excise tax for failure to provide all of these portability benefits (25 percent of gross premiums) -prohibition against denying, limiting or conditioning coverage (or benefits) on health status -maximum 6-month preexisting condition limitation (except for newborns) -continuity of coverage provision that mandates credit for prior coverage if no more than a three-month break in coverage
Reinsurance	Not included
Reinsurance Price	Not applicable
Cost Sharing	Not applicable
Assessments	Not applicable
Other	-Self-employed deduction increased to 100 percent -Applies to employees working at least 17.5 hours/week -$250 deductible standard benefit package w/preventive benefits -Preemption of state mandates beyond standard benefit package -25 percent excise tax on self-insured -Any payor may use DRG and RBRVS schedules -Must offer Single, Couple, Single Parent, and Family rates
Effective Date	Various: depends on provision (some January 1, 1992)

ENDNOTES

1. This study only addresses the impact of H.R. 3626 on the small-employer market, but H.R. 3626 also sets forth portability requirements that apply to all group health plans--not just small employers.

2. Derived from an analysis of a random sample of actual small-employer group data from five different HIAA member companies. These data were run through an actuarial model that recalculated the premium each insurer would have to charge each of the 3,750 small employers in the sample using the H.R. 3626 rating restrictions.

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

   The sample included groups of 2 to 25 employees rather than the 2 to 50 employee definition used in H.R. 3626 because a credible database of 2 to 50 employees was not readily available whereas a 2 to 25 employee group database was. While the quantitative estimates contained in this report would slightly differ if data from the 2 to 50 employee groups were used, the direction and general order of magnitude would be similar. In addition, this difference does not materially affect the qualitative conclusions of this study.