

## Small Business Health Plans (S. 1955)

### A COSE Issue Paper

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#### *Executive Summary*

Senate Bill 1955:

- Allows the formation of cross state small business health plans (SBHPs).
- Is estimated to save \$600 million in Medicaid expenditure over the 2007-2016 period.
- Is expected to raise Government revenues by \$3.3 billion over the 2007-2016 period.
- Can enable 1 million previously uninsured Americans to attain/maintain health insurance.
- Is designed to reduce aggregate health insurance premiums for small businesses by 12%.

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#### **I. Status, content and purpose of Senate Bill 1955**

Small business health care reform was one of the top 10 items on President Bush's agenda during his 2004 reelection campaign. Amongst his health care agenda was the creation of Association Health Plans (AHPs) as formulated in Senate Bill 406. To address flaws in the proposed legislation, Senator Enzi [R-WY] drafted Senate Bill 1955, the "Health Insurance Marketplace Modernization and Affordability Act of 2006."

After reviewing S. 1955, the Committee on Health, Education, Labor, & Pension (HELP) returned a modified version of the bill to the entire Senate for consideration. On May 11 2006 the Senate debated the bill but failed to get cloture on it; since then S. 1955 has been on hold. If the bill is adopted at a later point, primary oversight of its implementation would lie at the state level, with federal rating benefits and rules enforced by state commissioners. States would be free to impose additional, but limited, benefit mandates for particular diseases as they see fit. SBHPs may be structured to include alternative offerings. They also have to offer at least one of five *enhanced option plans*. An enhanced option plan entails all benefits offered to state employees in one of the five most populous states (California, Florida, Illinois, New York or Texas). Licensure would be performed by the states. SBHPs would have to comply with the requirements of every state in which participating employers are located. To ease compliance with the various state requirements S. 1955 proposes to establish a *harmonization board* tasked with the development of uniform standards for insurance regulation.

A major problem with AHPs would have been their ability to selectively pick and chose what groups they would allow into their group. Favorable health risk groups would be welcome while high risk groups would be excluded. This adverse selection process is known as "cherry picking." COSE and other small business organizations strongly opposed AHPs due to the cherry picking potential (for more on this see section II).

To minimize the potential for cherry picking, SBHPs limit premium variations based on the previous insurer's variation over the span of coverage for the first year and 15% upon plan renewal. Further, SBHPs can only be established by organizations that operate in good faith as bona fide trade/industry/professional organizations/chambers of commerce and do not have health coverage as their primary purpose. SBHP organizations must be permanent entities

with active participation from the membership and may not condition membership or dues on factors related to health status of applicants.<sup>1</sup>

S. 1955 is designed to lower health care insurance premiums thus creating affordable solutions for many people who are currently without coverage. Conservative studies estimate that the potential cost reductions will be as great as 12%<sup>2</sup>. This becomes a very meaningful savings to small businesses who presently cannot afford today's high premium costs.

## II. Comparing SBHPs and AHPs

SBHPs are a significant improvement over previous attempts to reform and restructure the health insurance market and particularly over their predecessors referred to as AHPs. The U.S. House has passed legislation that would establish AHPs seven times to date; fortunately all of these proposals were rejected by the U.S. Senate. SBHPs differ from AHPs on a number of significant points: While with SBHPs oversight remains with the states, AHPs would delegate complete oversight to the U.S. Department of Labor, a move that has proven to be disastrous in the past, when Multiple Employer Welfare Agreements ("MEWAs") did the same.

Further, SBHPs, unlike AHPs, cannot be self-funded (i.e. operate independent of insurance providers). SBHPs must be licensed in all states in which they have participants while AHP licensure would be required only in those states in which 25% or more of participants and beneficiaries are located. The AHP proposal limits state mandated minimum benefits, though AHP providers would be required to abide by their home-state's coverage requirements for specific diseases.<sup>3</sup> This provision in the AHP bill would likely cause an upward distortion of prices, depending on a plans home state. The distortion would likely lead to market-destabilizations in the coverage industry due to insurers seeking more favorable home states.<sup>4</sup>

S. 1955's five state provision grants insurers a choice of benefits to offer and establishes uniform standards that can be implemented nationwide, thus avoiding the dangers of distortion and destabilization. Finally, the AHP proposal has no limitation on discrimination against gender, age, family composition or other factors that affect the insurance risk of a given individual, business or industry. This fundamental shortcoming in the AHP proposal would likely lead to cherry-picking and thus the subsequent exclusion of those who need health coverage the most (i.e. the elderly, the sick and the poor) or if coverage was made available to these people it would come with prohibiting high price tags.

COSE is pleased with the recognition it was given by Senator Enzi when he put forth his proposed legislation. Though S. 1955 still leaves unaddressed some of the concerns COSE had with AHP legislation, it is a major improvement. The AHP proposal was designed so that established state-wide policy groups such as COSE could not be grandfathered in and would have made them illegal. COSE currently provides health insurance coverage for more than 13,000 businesses and their 225,000 employees throughout Northeast Ohio via a total of 19 different plans. Along with health insurance plans, COSE provides a broad range of other insurance services from dental to life insurance to vision plans. Insurance provision has constituted an essential part of the services COSE provides to our members since its formation in 1973. Today, COSE members cherish this service as much as ever.

COSE's success and that of like organizations around the country, comes from the effective utilization of group purchasing power. It allows us to offer very competitive rates for small

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<sup>1</sup> Senate Bill 1955; "A bill to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace." Primary Sponsor: Senator Michael Enzy [R-Wy]

<sup>2</sup> Bender, Karen of Mercer Oliver Wyman; "Health Insurance Marketplace Modernization and Affordability Act of 2006"

<sup>3</sup> National Patient Advocate Foundation; "Small Business Health Plans: Bill Comparison [4/13/06]"

<sup>4</sup> The American Academy of Actuaries; "Issue Brief: FAQs on AHPs"

businesses in today's marketplace which attracts yet more subscribers which in turn further increases our bargaining power. Concentrating this purchasing power in numbers on a small locality or region increases leverage not only with insurance providers but with care providers as well. All of this would change in an instant if AHPs were enacted. Considering COSE alone, such change implies that 13,000 small business members and their and 225,000 employees would now have to find new ways to insure themselves, likely at much higher rates.

### **III. Impacts of SBHPs on small business**

The Employee Benefit Research Institute (EBRI) found that 63% of small employers (2-25 employees) regard high premium costs as a major reason not to offer health insurance to their workers. And, 43% consider their employees' inability to afford coverage a major reason.<sup>5</sup> Figure 1 gives a more comprehensive overview of why small business owners do not offer insurance to their employees. As you can see in figure 2 the proposed SBHP legislation would result in a 12% decrease of health insurance premiums for small employers. Therefore, a Mercer Oliver Wyman study asserts, the proposed SBHP legislation could potentially lower the number of uninsured small business employees by 1 million people (8.5%).<sup>2</sup> While this may seem to be a small number, any step toward reducing the uninsured population is a step in the right direction. The study suggests further that SBHP legislation would attract previously untapped low-risk individuals thus decreasing the aggregate morbidity of the insured market by 5%, which is likely to lead to further premium reductions over time.<sup>5</sup>

From the standpoint of the small business owner, all of these processes are highly desirable. The previously cited EBRI study suggests that 52% of small employers believe offering health coverage increases employee loyalty and 45% believe it helps employee attraction -- both of which are crucial to Ohio's small businesses, economic development and success.<sup>4</sup>

### **IV. SBHPs and Medicaid**

The Congressional Budget Office (CBO) estimates that S. 1955 would increase federal revenues from payroll and income taxes and simultaneously reduce federal spending on Medicaid. While the increase in revenue would be generated by a reduction of the total amount spent on employer sponsored health insurance (which is tax-advantaged) the reduction in Medicaid spending would result from an increased enrollment of individuals currently covered under Medicaid in alternative coverage plans. Figures 2 and 3 show how the reduction in tax advantages will be counteracted by decreasing per employee premiums faced by employers. The total increase in government revenues for the 2007-2016 period is estimated to be about \$3.3 billion at no real cost to taxpayers.

The CBO projects that approximately 135,000 people currently enrolled under Medicaid would enroll in private health coverage under S. 1955, while an estimated 17,000 people who currently have private coverage would be expected to switch to Medicaid or rely on it for wrap-around coverage. Such shifts toward Medicaid would be based mainly on private health insurers favoring lower-risk individuals in their policies making it more attractive for higher-risk clients to be covered under Medicaid. The increased cost on Medicaid imposed by new higher-risk clients however would easily be offset by other individuals switching to the private market, leaving the system with a surplus over previous years.<sup>6</sup>

### **VI. Conclusion**

S. 1955 has the potential to significantly increase the overall level of health coverage for both employers and employees in the small business segment. It addresses many of the shortcomings raised in objection to the previously proposed AHP legislation and should pass

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<sup>5</sup> Fronstin, Paul and Helman, Ruth; "Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey"

<sup>6</sup> Congressional Budget Office; "Cost Estimate: S. 1955 Health Insurance Marketplace Modernization and Affordability Act of 2006"

any well designed cost-benefit analysis. While COSE believes that a fundamental overhaul of the current system must occur to bring about comprehensive change to health care, COSE, the NSBA and other small business organizations are supportive of S. 1955 as an alternative to the past AHP legislation. For more information on COSE's position on health care, please go to, [www.cose.org/advocacy](http://www.cose.org/advocacy) to read COSE's 2006-2007 legislative agenda.

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<b>REASONS FOR NOT OFFERING A HEALTH PLAN, 2000 AND 2002</b>				
	Major Reason		Minor Reason	
	2000	2002	2000	2002
The business cannot afford it.	53%	63%	16%	16%
Revenue is too uncertain to commit to a plan.	40	45	16	23
Employees have coverage elsewhere.	43	40	18	21
Employees cannot afford it.	37	43	17	18
Large portion of workers are seasonal, part-time, or high turnover.	34	31	15	18
Employees prefer wages and/or other benefits.	30	28	20	21
Company does not need to offer a plan to recruit and retain good workers.	18	19	17	29
Owner has coverage elsewhere.	40	29	13	14
Setting up a plan is too complicated and time-consuming.	11	8	20	19
Employees are healthy and do not need it.	10	5	17	20
Do not know where to go for information on starting a plan.	8	4	21	18

Source: EBRI/CHEC/BCBSA 2000 and 2002 Small Employer Health Benefits Surveys.

**Figure 1<sup>4</sup>**

Premium Per Employee

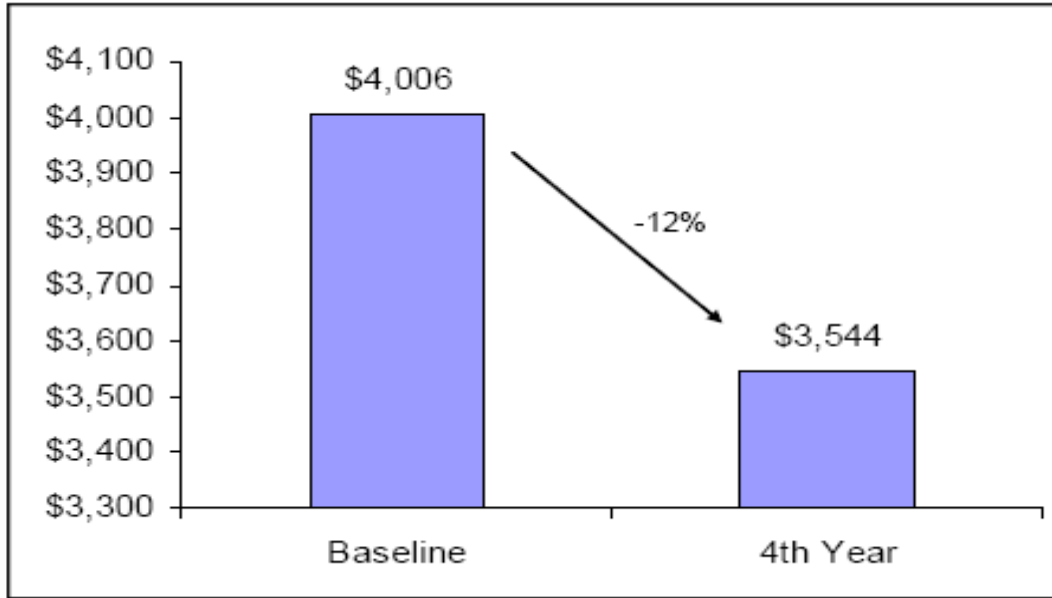


Figure 2<sup>5</sup>

	Premium per Employee		# of Employees Insured		Total Premium Dollars
Baseline	\$4,006	x	12.9 million	=	\$51.7 billion
After Year 4	3,544	x	13.4 million	=	47.5 billion
% change	-12%		4%		-8%

Figure 3<sup>5</sup>