TESTIMONY OF

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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on

Small Business Health Insurance:

Building a Gateway to Coverage

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Introduction

Good morning Mr. Chairman. My name is Joel Ario, the Acting Insurance Commissioner of Pennsylvania and Chair of the National Association of Insurance Commissioners (NAIC) Health Insurance and Managed Care Committee. I am testifying today on behalf of the NAIC, which represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I comment today generally on the small business healthcare crisis, and in particular on certain proposals currently being considered at both the state and federal levels.

To begin, I would like to emphasize the commissioners' recognition of how important it is to ensure that affordable health coverage is available to small business owners and their employees and I offer the full support of the NAIC in developing legislation that will reach this goal.

States led the way in requiring insurers to offer insurance to all small businesses in the early 1990s, and the federal government made guaranteed issue the law of the land in 1996[i] for all businesses with 2-50 employees. Federal law does not limit rating practices, but forty eight states have supplemented the guaranteed issue requirement with laws that limit rate variations between groups, cap rate increases, or impose other limitations on insurer rating practices. These rating laws vary significantly in response to local market conditions, but their common objective is to pool and spread small group risk across larger populations so that rates are more stable and no small group is vulnerable to a rate spike based on one or two expensive claims. In addition to requiring insurers to pool

their small group risk, many states have established various types of purchasing pools and licensed associations to provide state-approved insurance products to their members.

States continue to experiment with reinsurance, tax credits and subsidies, and programs to promote healthier lifestyles and manage diseases as they pursue the twin goals of controlling costs and expanding access. In Pennsylvania, for instance, new programs have been enacted to control costs by reducing hospital infections and enhancing chronic care management, and Governor Rendell has reforms pending on covering the uninsured and regulating insurance rates.

As always, states are the laboratories for innovative ideas. The federal government must work closely with their state partners, as well as with healthcare providers, insurers and consumers, to identify and implement reforms that will make insurance more affordable to small businesses.

It is in this spirit of cooperation and information-sharing that I was asked to testify before you today, and I appreciate this opportunity. Specifically, I was asked to comment on several reform concepts that are currently being considered at the federal level: multi-state purchasing pools; pooling for individuals and sole proprietors; and creating an affordable health coverage option. I will discuss each of these issues in turn and conclude with two brief observations on cost control and state innovation.

Multi-State Purchasing Pools

Small businesses in some states face limited choices when it comes to selecting a health insurance carrier. This can occur for a variety of reasons, including the fact that small businesses do not have the same market advantages that large businesses do. The

expectation of multi-state purchasing pools is that by pooling the purchasing power of many small businesses in multiple states they will be able to take advantage of the same economies of scale and negotiating power as large businesses.

While the multi-state pooling approach is untested, the experience of single-state purchasing pools created in the mid- and late-1990s suggests that adding more pooling options to the risk pooling that already exists in small group markets by virtue of state rate regulation may not add much value. While purchase pools did allow some employers to provide greater choice of plans to their employees, they unfortunately were not able to reduce costs and increase the number of small employers offering coverage to their employees.[ii] This was the result of several factors, which would also apply to multi-state pools.

First, grouping many small employers does not create the equivalent of a large employer any more than grouping three twelve-year-olds creates a thirty-six year old. The advantages that large employers have when purchasing coverage stem not only from their size, but also from their cohesiveness. The employees of a large employer are highly unlikely to reject the employer's choice of plan and purchase coverage on their own in the nongroup market due to the size of the employer's contribution to the cost of coverage. There is no similar incentive keeping small employers and their employees from purchasing outside the pool, however, and they will go wherever they can get the lowest premium for comparable coverage. So long as there is an outside market to compete against, a purchasing pool will not offer insurers the large, cohesive group that would give them the incentive to negotiate aggressively.

Second, the ability of pools to reduce administrative expenses through economies of scale has been less than expected. Early proponents of pooling initiatives expected that a purchasing pool would eliminate the need for participating plans to market as extensively and would help facilitate enrollment in the pool, reducing the substantial administrative costs in the small group market. Actual experience has shown, however, that small businesses continued to rely upon agents and brokers to assist them in selecting health insurance coverage for their employees, and without commissions comparable to those in the outside market, agents were not inclined to participate in marketing the pools.[iii] Furthermore, the reduction in administrative expenses that pools expected to realize by facilitating enrollment did not materialize to the extent that proponents had hoped.

In considering the creation of national, regional or multi-state pools, at least four key issues must be considered by policy makers:

- **Benefit Mandates** – For a plan to be effectively and efficiently marketed to the entire pool of small businesses, the package of benefits included in the policy cannot differ from state to state. This means state benefit and provider mandates would need to be preempted to a certain extent. However, as the current debate over mental health parity illustrates, the consumer, provider, and other interests that champion specific mandates at the state level tend to be very wary of federal efforts, however well-intentioned, that threaten to undermine their gains at the state level.
- **Rating Laws –** It is sometimes argued that multi-state pooling also requires the preemption of state rating laws. This is flat wrong, as evidenced by the current Medicare market, where benefit designs may be uniform across states but pricing varies based on local market conditions. As noted above, state rating laws vary significantly and it is absolutely critical that the rating laws in force for each

state's small group market continue to apply within the multi-state pool. If these rules differ, businesses will choose to purchase where the rules are most advantageous to them, resulting in adverse selection that will ultimately undermine either the multi-state pool or the state small group market. Applying state rating laws will not impede the creation of multi-state pools since geographic variations in the cost of health care services will necessitate different premiums state by state in any event.

- **Eligibility –** Eligibility rules can greatly impact the outcome of the pool. Including individuals and sole proprietors in the pool can provide additional options for these difficult-to-cover purchasers, but can also have implications for adverse selection, the stability of the pool, and the average cost of coverage. Requiring all small businesses coverage to be purchased through the pool can help reduce some adverse selection problems and create a more cohesive group to more effectively reduce rates, but also reduces the choice of plans available to employers.
- **Carrier Participation** – Like eligibility rules, the rules governing carrier participation can also have a profound impact on the success or failure of the pool. If all carriers are eligible to sell through the pool, participant choices will be maximized, but the pool's negotiating leverage will be reduced. Conversely, limiting the number of carriers that sell through the pool can provide greater leverage to reduce premiums, but also reduces participant choice.

There are many other issues to consider, such as how many states would constitute a pool, who would administer the pool, would there be risk adjustment among the participating carriers, and how would network adequacy be assured. However, the four key issues above must be hammered out first before these other matters are addressed.

Pooling for Individuals and Sole Proprietors

Massachusetts is experimenting with combining the individual and small group markets. The experiment merits close attention because the individual market is less regulated in most states than the small group market, leaving individuals vulnerable to exorbitant premiums if they are sick, limited coverage through a high risk pool, or even no access to coverage at all. Only a handful of states (including Massachusetts) have guaranteed issue in the individual market, and most states have more flexible rating laws in the individual market than in the small group market. This leads to better pricing for the best risks, but less protection for those most in need of health services. In this context, a federal mandate to combine the individual and small group markets – unless it were part of a comprehensive federal effort to achieve universal coverage—would cause major disruption.

A more practical first step could be the inclusion of self-employed individuals in small group markets. In most states, sole proprietors must purchase coverage in the nongroup market and thus cannot take advantage of the guaranteed issue and rating requirements in the small group market. However, twelve states have included these "groups-of-one" in their small group markets in an effort to reduce premiums and increase coverage for these sole proprietors.

While this is an effective tactic for helping these individuals purchase coverage, it can result in adverse selection problems if not done carefully. Groups-of-one generally tend to have higher health care costs than larger groups, as healthy individuals are more willing to go without health insurance than unhealthy individuals and can often get

cheaper coverage in the nongroup market where risks are not pooled as extensively as in the small group market.

For example, prior to the recent merger of the small-and non-group markets in Massachusetts, sole proprietors could purchase coverage in the small group market. In that state, groups of one had average claim costs of $296 per member per month, compared to average costs of $273 for groups of 2-5 employees and $250 for groups of 26-50 employees. To mitigate this risk of adverse selection, when the state merged the two markets, insurers were given more flexibility to take group size into account in their rating formulas.[iv]

Defining a Benefit Package

One of the most difficult issues in health insurance reform is how to define a basic benefit package that is both "adequate" to meet health needs and "affordable". The issue has become even more challenging in recent years with the advent of "consumer-driven health care" and the proliferation of new benefit designs to serve the preferences of targeted populations. The voices that decry any "one size fits all" solutions are getting louder, and they have their point about the diversity of health needs and preferences between, for example, a healthy 20-something and a 60 year old with a chronic condition. At the same time, other voices call for more standardization, and they have their point about how benefit design can be used as a discriminatory tool and how too many choices can lead to confusion rather than empowerment.

A successful approach will have to combine enough standardization to ensure adequate coverage and meaningful comparison of plans with enough flexibility to ensure

affordability and responsiveness to different needs and preferences. In practice, this means starting with a benchmark plan or a list of benefit categories and then making some hard decisions about how much flexibility to allow in modifying either the benefits or the cost-sharing to balance adequacy and affordability.

An example of the benchmark plan approach is to start with the basic FEHBP plan. The average total premium for coverage offered by the ten largest carriers under the FEHBP in 2007 is $415 for an individual and $942 for family coverage.v This would meet most adequacy tests, and flexibility could be added by allowing carriers to vary benefits as long as the variations achieved the same "actuarial value." Affordability could be achieved by allowing for higher cost-sharing versions, although it should be emphasized that any true measure of affordability must consider both premium costs and out-of-pocket costs.

An example of the benefit category approach is the NAIC's high risk pool model. That model defines what benefit categories must be covered by a state high risk pool plan, but allows flexibility in the specifics of the coverage based on state requirements and the needs of consumers. The model does not address cost-sharing requirements, which gives the states broad flexibility in that area, though I again emphasize that cost-sharing cannot be increased without considering all the ramifications, including the potential for some to go without needed services.

Finally, the most important point about benefit packages is that the devil is always in the details. As insurance regulators, we review the fine print of health insurance contracts on a daily basis and so we are quite knowledgeable about various benefit

configurations and how they impact the consumer. The NAIC would be happy to share that expertise at any point it would be helpful to your deliberations.

Conclusion

In conclusion, let me offer two brief observations on topics that should always be on the radar screen in discussions of health care reforms. The first observation concerns the growth in health care spending. Total spending on health care now makes up 16% of the gross domestic product, and spending continues to grow at 7% per year while our economy grows at less than 3% per year. This is not sustainable.

Health insurance reform will not solve this problem since insurance is primarily a method of financing health care costs. Nevertheless, insurers do have a vital role to play in reforms such as disease management, enhanced use of information technology, improved quality of care, wellness programs and prevention, and evidence-based medicine—all of which have shown promise in limiting the growth of health care spending. Whatever is done in insurance reform should be done in a manner that is consistent with sound cost control practices.

The second observation concerns the interplay between state and federal reform. States cannot solve the health care crisis alone; they need the help of the federal government. But neither can the federal government go it alone, at least until there is a much broader consensus for a specific plan to achieve universal coverage. In this context, the Congress should support efforts like S. 325, the Health Partnership Act, that provide funding for state initiatives and establish procedures for waiving federal requirements, such as certain ERISA provisions, that impede state innovation. Even

more important is to carefully consider the impact of any new federal reforms on the states' ability to be effective partners in solving our health care crisis.

The NAIC looks forward to working with the Members of this Committee and other policymakers to find real solutions for small businesses and individuals.

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[i] 42 U.S.C. 300gg-12.

[ii] Long, Stephen H. and Marquis, M. Susan, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001), pp. 154-163;
Long, Stephen H. and Marquis, M. Susan, "Pooled Purchasing: Who Are the Players?" *Health Affairs* 18:4 (July/August 1999), pp. 105-111; and
Wicks, Elliot K., "Health Insurance Purchasing Cooperatives" Commonwealth Fund, November 2002.

[iii] Wicks, p. 4.

[iv] Lischko, Amy, "Merging the Massachusetts Non-Group and Small Group Health Insurance Markets." January 25, 2007. <http://www.statecoverage.net/0107/lischko.ppt>

[v] John E. Dicken, United States Government Accountability Office, "Federal Employees Health Benefits Program: Premiums Continue to Rise, but Rate of Growth Has Recently Slowed," testimony before the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia, Committee on Homeland Security and Governmental Affairs, U.S. Senate, May 18, 2007, GA)-07-873T.