

BAD FOR BUSINESS, BAD FOR EMPLOYEES:
AN ANALYSIS OF S. 1955
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The United States Senate is currently considering legislation that would sweep aside many of the laws California has enacted to protect small employers and their employees in the health insurance marketplace. S. 1955, the Health Insurance Marketplace Modernization and Affordability Act of 2006, sponsored by Senator Enzi (R-WY), represents one of the most far-reaching changes in federal oversight of private insurance in recent history. With a stated purpose of increasing affordable coverage of the uninsured, S. 1955 is based on two basic premises: 1) the federal government should have greater control over insurance markets, including whether access to treatments and providers can be required; and 2) individual businesses should bear increased financial responsibility for insurance rates based on the health status of their own employees rather than sharing risk across the entire small business community.

In California, as in the rest of the country, large employers are able to purchase health insurance for their employees more easily than are small employers. Historically, small businesses have been considered more risky to insure. For this reason, insurers developed strategies to sort small businesses into higher and lower risk pools primarily dependent upon employee health status. Insurer profitability in such a system requires insurance companies to charge substantially higher rates to smaller firms and firms with older and sicker employees, or to avoid them altogether.

To help level the playing field, in the mid-1990s California and many other states developed laws that help small business owners purchase insurance for their employees. California's protections for small business owners and employees include rules that make premiums more predictable. These laws also assure that risk is spread more equitably among small employers to prevent insurers from "cherry picking" good risks and redlining older employees with health challenges. California has also enacted laws that ensure that health insurance will be of real value by guaranteeing access to certain medical treatments and providers.

S. 1955 would eliminate these protections. The bill permits the formation of new Small Business Health Plans (SBHPs) and drastically undermines California community rating laws. It is these laws that make health insurance premiums for small firms more predictable and stable. In addition, S. 1955 does away with state laws that have been enacted over decades to guarantee access to certain medical benefits, services and providers, and cripples the states' regulatory oversight over health insurance.

There is little analysis available on the likely impact of S. 1955. This brief report is an effort to fill this information gap. In an effort to explain accurately the effect of S. 1955 on California small businesses, this paper examines the impact of:

- Association Health Plans, Small Business Health Plans, and the Demise of Insurance Protections for Small Employers and their Employees
- S. 1955's Changes in Premium Rate Bands
- S. 1955's Changes to Laws requiring access to certain medical treatments, services and providers
- S. 1955's Overall Impact on the Health Insurance Marketplace



AHPs, SBHPs, AND THE DEMISE OF INSURANCE PROTECTIONS FOR SMALL EMPLOYERS AND THEIR EMPLOYEES

S. 1955 is a variation of Association Health Plan (AHP) legislation that has been introduced in Congress and failed many times over the last several years. S. 1955 differs from former AHP legislation in one important respect. Rather than allowing small business groups to form associations that could “self insure,” as is the case with AHP legislation, S. 1955 requires that Small Business Health Plans (SBHPs) deliver insurance by contracting with state licensed insurance companies. Obviously this change serves to remove opposition from large insurance companies who have in the past objected to AHP legislation. This modification also addresses opponents’ charges that the large scale formation of associations could result in insolvencies, since solvency oversight would remain under the regulation of states. Nevertheless, the legislation still suffers from all other shortcomings of AHPs.

As such, it makes sense to review the basics of AHP policy to fully appreciate S. 1955’s flaws. An understanding of AHP policy is also critical because H.R. 525 [Sam Johnson (R-TX)], an AHP bill with 235 co-authors, passed the U.S. House of Representatives 263 to 165 with significant Democratic support. If S. 1955 passes the Senate, it will go to a conference committee and face opposition from those who prefer the original AHP policy. The result would likely be compromise legislation more akin to AHPs than to S. 1955’s approach.

While some business organizations rally in support of association plans (a term used to describe both AHPs and SBHPs) as a means to expand access to health insurance, the reality is something very different. The following analysis shows that expansions of association plans will actually make it more difficult for many businesses to obtain needed coverage, increasing insurance rates for those who need insurance the most. The introduction of association plans will result in reduced health benefits, increased consumer risk and increased overall health care costs. Moreover, AHPs will do nothing to alleviate California’s ever-growing health care costs or the number of uninsured — and could well increase the number of uninsured in the long term.¹

Background

AHPs would permit unregulated insurance products to be sold by qualified business associations licensed by the U.S. Department of Labor. ***Such health plans would be exempt from state regulatory oversight and insurance standards.*** Association plans would be given broad discretion to design benefit packages and would not be required to follow state laws mandating the inclusion of specified benefits and services.

This approach stands in sharp contrast to California laws enforced by the California Department of Insurance. These state laws guarantee consumers access to adequate health coverage despite changes in their own or their coworkers’ health status, and without considerable financial risk. State laws not only protect consumers from insurance fraud and plan insolvency, but, over the last two decades, have improved availability of coverage for small businesses by outlawing “cherry picking” (only selling coverage to healthy people) and requiring portability, so employees with health problems can retain coverage when switching employers.²



Impact of Association Plans on Consumers

The stated rationale for AHPs and SBHPs is that government regulation has caused current difficulties in obtaining insurance. Proponents argue that deregulation and scaled back benefits will drive down health insurance costs, thereby allowing more small firms to enter the health insurance market. Therefore, AHP legislation is aimed at doing away with certain consumer protections. AHP legislation puts California consumers at risk by:

- *Eliminating critical health benefits.* To ensure that Californians have adequate coverage when it is needed, the Legislature has passed laws requiring that certain benefits be included in every health plan, such as maternity care and cancer testing. These requirements prevent insurers from offering skeletal health plans that have no real benefits. All current AHP legislation preempts state required benefit packages. (**Attachment A** highlights California and other state mandated benefits put at risk under AHP legislation. **Attachment B** provides a complete listing of California's mandated benefits and an explanation of each.)
- *Re-directing critical provider protections.* Making sure that Californians have access to specialist physicians is as important as offering comprehensive benefits. Prior to state reforms, health plans would intentionally exclude certain classes of providers from payment. If the patient discovered this exclusion after care was rendered, then the individual would be subject to full cost of the service. (**Attachment C** highlights the provider requirements in all states put at risk by AHP legislation.)
- *Discriminating against older and sicker employees.* Federal laws would preempt state laws that constrain rate hikes based on the health status of workers (community rating laws). Accordingly, association plans can be structured to weed out and avoid unhealthy persons by charging higher rates and eliminating benefits needed for chronic conditions. Such segmented markets discriminate against firms with older or sicker employees. The impact of the preemption of community rating laws is dealt with in detail in a later portion of this paper entitled, *Impact of Changes in Premium Rate Bands*

Impact of Association Plans on the Insurance Market

The proliferation of AHPs or SBHPs will not only weaken employee protections, it will also profoundly impact the health care marketplace by:

- *Increasing market confusion.* California's small businesses are already subject to federal and state rules. By creating either type of association plan, there will be an additional regulatory class of employer groups that are overseen by the U.S. Department of Labor. This federal oversight will add confusion to an already complex regulatory system as some small business health plans will remain subject to state oversight.
- *Increasing risk of plan insolvency.* AHPs will not be held to the same stringent solvency standards that California applies to HMOs and insurance companies, leaving healthcare consumers at personal financial risk e.g. Sunkist Growers, Inc.³ It should be noted that while this critical flaw remains in H.R. 525 and other AHP legislation, S. 1955 does require product delivery through state regulated carriers.



- *Adding cost pressure to the safety net and the insured.* Significantly limiting benefits shifts unsustainable liability for uncovered medical expenses to individuals. Thus, medically related personal bankruptcies will increase; hospitals and providers will charge the fully-insured more to cover unpaid (or underpaid) care; and the state will face increased costs as more people seek care from Medi-Cal and Healthy Families Program (S-CHIP).
- *Increasing risk of fraud.* The sale of illegal health plan products by otherwise legal trade associations has been a serious issue in all states. While the California Department of Insurance faces challenges in keeping ahead of these fraudulent schemes, it has shown that it can deal with health insurance fraud effectively. The Department of Labor (DOL) has limited experience in these matters and may be hard pressed to respond to them. It is also not clear if various versions of AHP legislation give the DOL the full authority and sufficient resources needed to control fraud.
- *Eroding the managed care marketplace.* AHP legislation would also harm California's HMO system that dominates the state's insurance market and helps keep costs down. This erosion of managed care will result in overall higher costs for employers and individuals. Under AHP legislation, HMOs will have a more difficult time adjusting to the new system than PPOs. It is unlikely that HMOs, which specialize in comprehensive, first dollar coverage, can compete successfully with PPOs under a system of stripped-down benefits and discriminatory rates. If HMOs survive at all they will become prohibitively expensive for most consumers, as they will be populated primarily with individuals whose health status forces them to seek more comprehensive benefits.

Many faults, few benefits

Given the significant risks inherent in deregulating the health care market, what benefits, if any, do AHPs offer?

Most analyses show that AHP legislation will not meaningfully reduce the number of uninsured.⁴ According to the Congressional Budget Office, a non-partisan arm of the U.S. Congress that evaluates the impact of legislation, two recent versions of AHP legislation will increase small business offering of health insurance by less than two percent.⁵ An analysis by the Urban Institute also found that the introduction of AHPs would result in a nominal, if any, net change in health insurance coverage and would increase premiums in the state-regulated markets by five percent.⁶

AHP legislation and S. 1955, at best, offer nominal savings in the small-group market for businesses with relatively healthy employees. Moreover, such savings occur only after the legislation significantly alters California's private-sector health insurance market and increases overall premiums.⁷ AHPs and S. 1955's SBHPs allow carriers to select only favorable risks. Healthier groups will gravitate toward less expensive association plans with slimmed down benefits and minimal regulation, while groups with less healthy and older members are left to rely exclusively on state-regulated plans.

More importantly, neither AHPs nor S. 1955 do anything to improve the fundamental functioning of the health care system. They do not improve quality nor contain costs.



IMPACT OF CHANGES IN PREMIUMS RATE BANDS

All AHP legislation and S. 1955 would eliminate the protections that California has created to mitigate large rate differences from employer to employer based on the health status of a firm's employees. California's rating rules allow the free market to operate while also protecting small employers. Insurance companies can charge rates that they deem appropriate while allowing for risk to be considered within reasonable ranges.

In California, insurance companies may set premium rates for employees based on only three risk factors: age, family composition, and geographic region. Using these factors, carriers establish a base rate (standard employee risk rate) which they can adjust based on the health status of the employer's workforce. Currently, such adjustments are limited to +/- 10 percent of the standard employee risk rate.

By narrowing the range of risk adjustments, all businesses must share in the risk of covering all employees. Insurance, therefore, becomes a shared responsibility in which firms with healthy employees help to offset the costs faced by those with less healthy employees. (**Attachment D**, Example 1 provides an example of how California's system works when applied to a carrier's actual rates.)

Other protections include:

- *Guaranteed Issue.* If an insurance carrier offers health insurance to a small business, it must offer coverage to all small businesses. Absent this protection, carriers could refuse to provide coverage to a high risk business.
- *Guaranteed Renewal.* Once a small business has insurance coverage, it has the right to renew coverage regardless of the health status of its employees.
- *Marketing Protections.* Insurance carriers must market and sell products to all businesses "fairly and affirmatively." These marketing requirements prevent brokers and carriers from steering businesses to certain products.

Rate rules under S. 1955 increase costs for many -- increase uncertainty for all

S. 1955 severely modifies state community rating laws by increasing permissible risk adjustments from 10 percent to 25 percent. As discussed in detail below, other provisions allow carriers to use additional variables to establish standard risk rates and to risk-adjust rates at renewal time.

Health insurance is fundamentally a mechanism for sharing the risk of illness or injury. Bills such as S. 1955 that support increased rate bands are antithetical to the concept of pooling risk through insurance. S. 1955 will create greater variability in premiums among small businesses.

- *New rules would put specific businesses at a disadvantage.* As noted above, California permits premiums to vary based on only three rating factors: age, family size, and geographic location. S. 1955 would expand this list to include: group size, participation in wellness programs, gender, and industry class.



These new rating factors disadvantage certain small businesses. The smallest businesses will automatically experience rate increases as a result of the group size factor. This will place insurance even further out of reach for small entrepreneurs. By adding industry class to the list, employers and employees in high risk jobs will also face premium increases. Similarly, businesses with a high proportion of women at child-bearing age will see rates go up as a result of the inclusion of gender.

- *Increase variability in premiums across businesses.* California premiums currently can be risk-adjusted by +/- 10 percent. Under S. 1955, risk adjustment will increase to +/- 25 percent. Additionally, contrary to California law, S. 1955 allows premiums to vary, based on up to nine different “classes of business,” a concept different from “industry” risk factor discussed above.

Examples 1 and 3 in **Attachment D**, demonstrate how S. 1955 would result in premium differentials between otherwise similar small employers as high as 100% based primarily upon differences in employee health status. Under current California law this differential cannot exceed 22 percent.

Chart 1: Impact of S. 1955 on a Small Business

	Low-End Premium	High End	Percent Difference from Low to High
Current Law	\$2,924	\$3,583	22%
S. 1955	\$2,437	\$4,873	100%

As the chart shows, S. 1955 creates financial uncertainty for all firms and allows high risk firms to be charged much more than current law.

- *Increased uncertainty at renewal time.* It is critical that businesses be able to predict their costs from year-to-year. To protect businesses in California carriers cannot increase the risk adjustment factor by more than 10 percent in any 12-month period up to the maximum 1.1 risk adjustment factor based on the actual claims experience of the employer. While prices can increase under any trend factor in California, the risk adjustment based on claims history is capped.⁸ However, S. 1955 would allow an adjustment of +/- 15 percent from year-to-year. In essence, this allows carriers to punish employers who need the most help -- those employers with higher claims.

IMPACT OF S. 1955 OVERALL

Taken as a whole, S. 1955 creates significant uncertainty and instability for California small businesses. In a recent report funded by the National Small Business Association (NSBA), the firm of Mercer Oliver Wyman suggested that S. 1955 could reduce the number of uninsured in the nation by about 2%.⁹ However, this conclusion is based on faulty assumptions and an overly narrow assessment of the impact that S. 1955 would have on the overall marketplace and government insurance programs. More specifically, the NSBA report contains the following analytical flaws.

- *Limited discussion of businesses that lose under S. 1955.* According to the NSBA report, under S. 1955 “in aggregate, small employers will experience a decrease in health insurance premium costs.”¹⁰ Given the elimination of benefit and provider mandates on small employers, and given the difficulty that the sick would have in obtaining coverage under SBHPs, it is certainly not surprising that some costs will go down.

However, the NSBA report fails to discuss who will pay more under S. 1955. Clearly, firms with healthy employees will pay less. But those with unhealthy employees will pay significantly more. Also, the NSBA report fails to acknowledge that those who are the least healthy—those who most need care—are likely to become uninsured in California because small businesses who now cover them would lack the protections needed to keep these individuals covered.

- *Underestimated small business resistance to purchasing coverage.* The NSBA report, assumes that the decisions of small firms to purchase insurance is relatively elastic at $-.75$.¹¹ This elasticity is much broader than the assumptions used by leading health care researchers. For example, a report by the Center for Studying Health System Change recently applied a far more inelastic assumption, $-.54$.¹² Similarly, a report by Susan Marquis of the Rand Corporation confirms these results.¹³ Marquis assumed a price elasticity of $-.14$ in her study, concluding that, “Even a 40 percent reduction in current prices would lead to only about a 3.1 percentage point increase in the likelihood of purchase among the employers with primarily low-wage workers, compared to about a 2.3 percentage point increase for other employers.”¹⁴

The elasticity assumption is critical to the results the NSBA analysis produced. By using a more generous assumption, the NSBA report greatly inflates the number of uninsured people that may be covered as a result of the provisions of S. 1955.

- *Limited Scope of Analysis.* According to the report, the scope of the analysis is “limited to small businesses as defined by HIPAA...” This is a critical limitation as it ignores the legislation’s impact on state budgets. As the sick are shut out of employer-sponsored insurance, they will inevitably migrate to state programs. Given that these individuals are disproportionately sick, such migration will place a severe financial burden on state programs.



- *Inaccurate Benefit Assumptions.* The NSBA report assumes that mandated benefits will be limited to those mandated benefits that are required in 45 states, as was the case in earlier versions of S. 1955. However, the current version of S. 1955 has changed this requirement, and it is not clear what the impact of the change will be on the number of those potentially covered.
- *Failure to consider the impact of health inflation.* The NSBA report assumes 0% growth in the increase in health care costs over time and is tied to average premiums used in 2000.

CONCLUSION

The best way to help California small businesses to purchase health insurance is by bringing down the overall cost of health care.

In 2005, the California Department of Insurance (CDI) issued a report entitled, “Priced Out: Health Care in California.” Through that 70+ page document, more than 40 recommendations are offered that will help expand coverage, improve quality, and contain health care costs. For example, recommendations are made on how to leverage technology to reduce bill costs, and how to help doctors better manage new information.

The number one reason small businesses do not offer coverage is the “high premiums” they would have to pay.¹⁵ S. 1955 does not address this concern for all firms, but it does increase prices for many firms and creates uncertainty in pricing for all. California truly needs policies that reduce overall costs through the use of technology and high quality care – such as those discussed in the CDI report.

California must have an insurance system that protects all of our citizens. In contrast, S. 1955 allows insurers to discriminate against unhealthy groups and erase prudent consumer protections. Federal legislation promoting AHPs eliminates protections that small businesses need. Exempting AHPs from state insurance laws is a backward step away from true health insurance reform. The legislation will not ease the burden of the State's 6.6 million uninsured residents, and neither will it significantly reduce costs to small business owners.

California small businesses and individuals need affordable health insurance, but that insurance should offer them peace of mind – not the prospect of financial failure.



Attachment A

California's Mandated Benefits as Compared with Other States

Select Benefits Only

The California Insurance Code requires that coverage for the following be offered by insurance companies. Sorted by total number of states with such a requirement.

Mandated Benefit	Citation	States With Related Requirements	
		Total Number	Other Specific States
Mental health services	§ 10144.5	44	AL, AR, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OK, OR, PA, RI, SC, SD, TN, TX, VT, VA, WA, WV, WI
Diabetic equipment, supplies and education classes	§ 10176.61	42	AK, AZ, AR, CO, CT, DC, DE, FL, GA, IA, IL, IN, KY, LA, ME, MI, MN, MS, MO, MT, NE, NV, NH, NM, NY, NC, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
Coverage for off-label drug use	§ 10123.195	32	AL, AZ, AR, CT, FL, GA, IL, IN, KS, LA, ME, MD, MA, MI, MN, MS, MO, NV, NH, NJ, NC, ND, OH, OR, RI, SC, SD, TN, TX, VA, WA
Metabolic disease care (PKU)	§ 10123.89	30	AK, AZ, AR, CO, CT, DC, FL, IN, KY, LA, ME, MD, MA, MN, MT, NV, NH, NJ, NM, NY, ND, OR, PA, SD, TN, TX, UT, VT, WA
Contraceptives approved by FDA	§ 10123.196	23	AZ, AR, CT, DE, GA, HI, IL, IA, ME, MD, MA, MO, NV, NH, NM, NY, NC, RI, TX, VT, VA, WV
Temporomandibular joint disorders	§ 10123.21	20	AR, CO, CT, FL, GA, HI, KY, MN, MS, NE, NV, NM, NC, ND, TX, UT, VT, VA, WA, WI, WV
All cancer tests, including mammography, pap smears, prostate cancer, etc.	§ 10123.8 § 10123.81 § 10123.83 § 10123.20	14	IL, KS, ME, MD, MO, NJ, NC, NY, OR, TX, VA, WV, WY
Coverage of pregnancy complications	§ 10123.2	14	CO, GA, IL, ME, MA, MN, MD, MT, NH, NJ, NY, VT, VA
Preventative care to age 16	§ 10123.5	8	AR, DE, DC, FL, NY, OK, RI
Osteoporosis	§ 10123.185	8	FL, GA, KS, LA, MD, TN, TX
Reconstructive Surgery	§ 10123.88	8	AR, AZ, CO, CT, DE, DC, FL
Long-term care for Alzheimer's	§ 10123.16	3	CO, MD

Sources: National Association of Insurance Commissioners, "Mandated Benefits," 2006.

California Department of Insurance, "Mandated Benefits," undated. All cites from CA Insurance Code.



Attachment B

Complete Listing and Explanation of California's Mandated Benefits and Mandated Offers

Unless otherwise noted, benefits apply to individual and group policies. Benefits are in order of citation in the California Insurance Code.

Mandated Benefit

1. IC Section 10119(b): Mandated benefit granting immediate accident and sickness coverage to each **newborn** infant and adoptive child.
2. IC Section 10119.5: Mandated benefit for involuntary **complications of pregnancy**, at regular policy benefits. Limited to those policies which provide maternity benefits.
3. IC Section 10119.7: Mandated benefit for **diethylstilbestrol (DES)** conditions or exposure.
4. IC Section 10119.9: Mandated benefit for **general anesthesia for dental procedures** performed in a hospital or surgery center on patients under age seven, the developmentally disabled and certain other patients.
5. IC Section 10123.21: Mandated benefit for surgical procedures for **jawbone conditions (TMJ)**.
6. IC Section 10123.5: Mandated benefits for comprehensive **preventive care for children** age 16 and under in accord with certain guidelines established by the American Academy of Pediatrics (applies to group policies only).
7. IC Section 10123.8: Mandated benefit for **breast cancer screening, diagnosis and treatment**, including prosthetic devices and reconstructive surgery.
8. IC Section 10123.81: Mandated benefits for **mammograms**.
9. IC Section 10123.82: Mandated benefits for prosthetic devices to restore a method of speaking incidental to a **laryngectomy**.
10. IC Section 10123.83: Mandated benefit for **prostate cancer screening/diagnosis**.
11. IC Section 10123.88. Mandated benefit for **reconstructive surgery**, as defined.
12. IC Section 10123.16: Mandated benefit requiring any policy providing coverage for long-term care facility services or home-based care to cover persons with certain degenerative illnesses, including **Alzheimer's disease** (except for preexisting conditions).



13. IC Section 10123.18: Mandated benefit for annual **cervical cancer screening test** if policy includes coverage for treatment/surgery of cervical cancer.
14. IC Section 10123.20: Mandated benefit for all generally medically accepted **cancer screening tests**.
15. IC Section 10123.68: Mandated benefit for **second opinion** when requested by insured or health professional treating an insured.
16. IC Section 10123.89: Mandated benefit for testing and treatment, including formulas and special food products, of **phenylketonuria (PKU)**.
17. IC Section 10123.184: Mandated benefit, in certain policies which provide maternity benefit, for participation in the **Expanded Alpha Feto Protein (AFP) prenatal testing program**.
18. IC Section 10123.185: Mandated benefit for services related to diagnosis, treatment, and appropriate management of **osteoporosis**.
19. IC Section 10123.195: Mandated benefit requiring any policy providing prescription drugs to cover **drugs** which are prescribed for a use that is different from the use for which the drug has been approved by the FDA.
20. IC Section 10123.196: Mandated benefit requiring any policy providing prescription drugs to cover a variety of FDA approved **prescription contraceptive methods**.
21. IC Section 10144.5: Mandated benefit for diagnosis/treatment of **severe mental illnesses (adults and children) and serious emotional disturbances of children**.
22. IC Section 10145.4: Mandated benefit for routine patient care costs related to **cancer clinical trials**.
23. IC Section 10176.61: Mandated benefit for equipment, supplies (including prescriptions if prescription coverage is included), and self-management training for the management and treatment of **diabetes**.

Mandated Benefit Offers

1. IC Section 10119.6: Mandated offer for coverage of **infertility treatment**.
2. IC Section 10119.8: Mandated offer for screening for **blood lead levels for children**.
3. IC Section 10121.7: Mandated offer for **domestic partner coverage** if dependent coverage is offered.



4. IC Section 10122.1: Mandated offer for group coverage to **physically handicapped** individual members of the group.
5. IC Section 10123.55: Mandated offer for comprehensive **preventive care of children** ages 17 and 18 in accord with certain guidelines established by the American Academy of Pediatrics.
6. IC Section 10123.6: Mandated offer for coverage for treatment of **alcoholism**.
7. IC Section 10123.7: Mandated offer for coverage for **orthotic and prosthetic devices**.
8. IC Section 10123.9: Mandated offer for coverage for **prenatal diagnosis of genetic disorders** if maternity coverage is present.
9. IC Section 10123.10: Mandated offer of coverage for **home health care**.
10. IC Section 10123.141: Mandated offer for **special footwear** related to foot disfigurement.
11. IC Section 10123.15: Mandated offer of coverage, in a policy which provides coverage for brain disorders, for certain specified biologically based **severe mental disorders**.
12. IC Section 10125: Mandated offer of coverage for **mental and nervous disorders**.
13. IC Section 10127.3: Mandated offer of coverage for **acupuncture**.
14. IC Section 10176.6: Mandated offer of coverage for **diabetic daycare self-management education programs**.



Attachment C

California's Mandated Providers as Compared to Other States

Provider Class	Citation	States With Similar Requirement	
		Total Number	Other Specific States
Optometrist	§ 10176	46	AL, AK, AZ, AR, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NH, NJ, NM, NY, NC, OH, OK, OR, PA, SC, SD, TN, TX, VT, VA, WA, WV, WI
Chiropractor	§ 10176	45	AL, AK, AZ, AR, CO, CT, DE, FL, GA, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, PA, RI, SC, SD, TN, TX, VA, VT, WA, WV, WI
Psychologist	§ 10176	41	AL, AZ, AR, CO, CT, DC, GA, HI, IL, IN, KS, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, VA, WA, WI, WY
Podiatrist	§ 10179	35	AL, AR, CO, CT, DE, FL, IN, IA, KS, KY, LA, MD, AL, AR, CO, CT, DE, FL, IN, IA, KS, NC, OH, OK, PA, RI, SC, SD, TN, TX, VA, WA, WV
Licensed clinical social worker	§ 10176	23	CO, CT, IL, KS, LA, ME, MD, MA, MS, MT, NV, NH, NM, NY, NC, ND, OR, SD, TN, TX, VA, WA
Psychiatric nurse, Advanced practice registered nurse, Clinical nurse specialist	§ 10176	18	AZ, CO, CT, HI, GA, IA, KS, ME, MD, MN, MT, NH, NM, NC, ND, PA, RI
Nurse midwife	§ 10354	17	AK, CT, DE, FL, ME, MD, MA, MI, MN, NJ, NM, NY, OH, PA, RI, WV
Marriage, family and child counselors	§ 10176	14	AK, CO, CT, ME, MD, MS, NV, MH, NC, RI, TX, VA, WA
Acupuncturist	§ 10176	10	AK, FL, HI, ME, MT, NV, NM, RI, TX
Speech-language pathologist, audiologist	§ 10176	8	AR, LA, NJ, NY, PA, TX, VA
Occupational therapist	§ 10176	4	AK, LA, TX

Source: National Association of Insurance Commissioners, 2006. All cites from CA Insurance Code.



Attachment D

Analysis of Rate Band Changes in S. 1955

Assumptions for All Examples

For each example below, there is a four-employee firm that meets the stated characteristics. The monthly premium estimate is taken from the 2006 Blue Shield Rate Book for the Access HMO Plan 15.

Employees	Monthly Premium
Single, 25, Region 2	\$234
Married, 35, Region 2	\$663
Married, 41, Region 1	\$844
Married with children, 55, Region 1	\$1,508
<i>Total Cost</i>	<i>\$3,249</i>

Example 1: Current California System

Once the monthly premium (technically referred to as the Monthly Standard Employee Risk Rate) is determined, carriers can adjust the rate by +/- 10 percent based on health status and claims history. This adjustment is called the Risk Adjustment Factor. This creates a range of monthly costs of:

- Low-Risk Firm: $\$3,249 * .9 = \$2,924$.
- High-Risk Firm: $\$3,249 * 1.1 = \$3,573$.

Mathematically, there is a 22% difference in the lowest and the highest cost plans. This is the range of prices that the carrier can charge based on the health and risk of the firm's employees.

Example 2: S. 1955 -- Risk-Adjusted within a Business Class

Based on the Enzi bill, carriers will be able to make additional adjustments.

Instead of a 10 percent range based on health status and claims history, S. 1955 allows a 25 percent range.

- Low-Risk Firm: $\$3,249 * .75 = \$2,437$
- High-Risk Firm: $\$3,249 * 1.25 = \$4,061$

This change in the risk adjustor creates a premium range of 67 percent from the lowest possible cost to the highest premium. Therefore, the insurance company can charge the firm between \$2,437 and \$4,061 based on the health and risk of the firm's employees.



Example 3: S. 1955 -- Risk-Adjusted within a Business Class and Across Business Classes

The bill also allows for a 20% cost increase based on the “class of business”. Business may be grouped into as many as nine different sections according to their claims history and the administrative cost.

Assuming that the base rate of \$3,249 was in the lowest possible group, that cost could be increased by 20% if the business was considered to be in the highest cost group, creating a base rate of: $\$3,249 * 1.2 = \$3,898$. This price point can be shifted again within a 25% range:

- Low-Risk Firm: $\$3,898 * .75 = \$2,924$ to
- High-Risk Firm: $\$3,898 * 1.25 = \$4,874$.

In this example, the lowest possible premium cost is \$2,437 and the highest is \$4,874 -- a 100% difference.

This is an analysis of the changes that can be quantified. As there are still other changes in premium rating specified in S. 1955, the 100 percent range in premiums should be considered a minimum. It is also worth noting that S. 1955 contains ambiguities in the language. These examples are based on the best understanding of the legislative language.

Example 4: Current California System at Renewal

There are no price controls in the California system. The base rate used in Example 1 (\$3,249) can increase by any trend rate as long as the increase applies consistently to all businesses based on the three categories of age, family composition, and region.

While the trend rate is uncapped, the adjustment for claims history is capped. The risk adjustment can be no more than +/- .1 of the risk adjustment factor.

Assuming no trend factor, and assuming a first year cost of \$3,249, the maximum amount that could be charged would be: $\$3,249 * 1.1 = \$3,579$ -- an increase of 10 percent.

Example 5: S. 1955 System at Renewal

As with the current system, there are no price controls, but there is a maximum shift of 15% from year-to-year under S. 1955 for risk. The current system only allows a 10% adjustment in the risk factor up to a maximum factor of 1.1. Even assuming no overall inflation in health premium costs, there is significant variability caused by this S. 1955 provision.

Looking at the maximum first year cost under Example 1, this amount (\$3573) cannot be increased based on risk at renewal because it is already at the maximum risk adjustment factor (remember, for simplicity, this example assumes no health care inflation, which carriers can increase uncapped for all similar situated businesses). Taking the maximum premium charge given in Example 3 from the new system, adjusted by the maximum risk charge of 15% means a much higher premium: $\$4061 * 1.15 = \$4,670$.



While the current system would permit no shift for risk and would protect the small employer, the new system would allow a maximum increase of \$609 in the renewal year for risk alone. For this business in the renewal year, the owner would pay a minimum of \$1,034 more than under the current California system ($\$4607 - \$3573 = \$1,034$) if the employer continued to be a bad risk in the renewal year.



Endnotes

¹ LJ Blumberg and Y Shen. 2004. *The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis*. Report prepared for the California HealthCare Foundation. www.chcf.org.

² In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).

³ Kofman, Mila and Karl Polzer. *What Would Association Health Plans Mean for California?*, Report prepared for the California HealthCare Foundation, January 2004. www.chcf.org.

⁴ LJ Blumberg and Y Shen. 2004. *The Effects of Introducing Federally Licensed Association Health Plans in California: A Quantitative Analysis*. Report prepared for the California HealthCare Foundation. www.chcf.org.

⁵ Increasing small-firm Health Insurance Coverage Through Association Health Plans and Healthmarts. Congressional Budget Office, January 2000. <http://www.cbo.gov/showdoc.cfm?index=1815&sequence=0>

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⁸ Roth, Debra, *Insurance Markets: Rules Governing California's Small Group Health Insurance Market*, California HealthCare Foundation, June 2003.

⁹ Letter to Todd McCracken, President, National Small Business Association from Mercer Oliver Wyman, March 7, 2006.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² Hadley, J. and Reschovsky, J. "Small Firms' Demand for Health Insurance: The Decision to Offer Insurance," *Inquiry* 39:118-137, 2002.

¹³ Marquis, S. and Long, S., "To Offer or Not to Offer: The role of price in Employers' Health Insurance Decisions," *Health Services Research*, October 2001.

¹⁴ *Ibid.*

¹⁵ California Health Employer Survey, California HealthCare Foundation, 2006.

