

# The Impact of the Health Insurance Marketplace Modernization and Affordability Act, S. 1955 on the Small Group Insurance Markets in Community Rated States

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*By:* **The Lewin Group** 

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#### Impact on Premiums in New York

- Premiums would change significantly for most small employers, depending upon the age and health status of their workers.
  - Ø 33 percent would see premiums increase by 10 percent or more.
    - One percent of workers in the small group market would see premium increases of about 130 percent, with an average premium increase of \$8,000 per worker.
    - Four percent of workers are in small firms where premiums would increase by 50 to 99 percent, with an average increase of \$4,900 per worker (*Figure ES-1*).
  - Ø 42 percent would see premiums drop by over 10 percent.

#### Impact on Coverage in New York

- Employer-Sponsored Insurance (ESI) would drop by 22,600 workers and dependents.
  - Ø About 183,400 people are in small firms that would drop coverage due to increased premiums (older and sicker).
  - Ø About 160,800 people would become covered in small firms that start to offer coverage due to a reduction in premiums (younger and healthier).
  - Ø ESI coverage would increase for younger workers but would be reduced for older workers (*Figure ES-2*).
- Medicaid spending would increase by \$22.6 million as older and sicker people losing ESI enroll in Medicaid. The state share for New York would be \$11.3 million.
- The number of uninsured in New York would increase by 28,200 people, resulting in a \$6.1 million increase in uncompensated care.





## I. THE ENZI BILL (S. 1955)

The Enzi legislation would permit carriers in the small group market to elect to be regulated under the 1993 Small Group Model Legislation developed by the National Association of Insurance Commissioners (NAIC). These rules permit insurers to vary premiums by age, gender, industry, firm size and health status, in addition to geography and family status. This differs from the community rating model now used in New York which permits premiums to vary only by family status and geography.

New York and Vermont use "pure" community rating in the small group market. This is where carriers are required to charge a single premium for a given product regardless of risk characteristics. Eight other states use "modified" community rating, where premiums are permitted to vary with age. Their common feature is that none of these states permits premiums to be varied with health status.

The Enzi legislation permits premiums to vary by: age, gender, firm size, industry (15 percent difference from highest to lowest), family status, geography and presence of a wellness program. In addition, it permits rates determined on the basis of these rating factors to be varied by +/-25 percent based upon health status or claims experience. The bill also permits variation in premiums by "class of business" not to exceed 20 percent from highest to lowest for a given index rate.

The Bill identifies three allowable classes of business including association plans, plans sold through differing marketing models and business acquired from another insurer. Carriers are permitted to have up to nine classes of business. It is unclear how important the class of business distinction will be in New York. Most of New York insurers do not currently have such distinctions.

A key element of the Enzi Bill is that it permits carriers to offer policies that are free of mandatory benefits requirements.<sup>1</sup> Many states include legislation that requires plans to cover certain services such as mental health, substance abuse, maternity and treatment of certain conditions such as infertility treatments, breast reconstructive surgery and preventive care. Mandates can also include a requirement that certain providers be covered such as chiropractors. In some cases these mandates take the form of a requirement that selected benefits be offered and others require that certain diseases or procedures be covered if a certain class of benefits is purchased. For example, if mental health coverage is purchased, the state may require that the policy cover schizophrenia or inpatient mental health care. The exemption from mandatory benefits is not part of the NAIC model.

Carriers who offer these plans must also offer a coverage option that is at least as comprehensive as one of the state employee health plans offered in the 5 most populous states. This provision is designed to guard against carriers entering a market for the purpose of "cherry picking" by attracting only healthy groups that are willing to purchase plans with

<sup>&</sup>lt;sup>1</sup> The mandated benefits exemption applies to the individual and large group markets as well. Thus, this provision could have effects in the individual and large group markets as well as small groups.

## **II. METHODOLOGY**

We simulated the impact of these rating reforms using the Lewin Group Health Benefits Simulation Model (HBSM). This includes a simulation of changes in premiums for firms under these reforms and the resulting changes in the number of employers taking-up coverage. We also estimate the impact of eliminating mandated benefits requirements on premiums and the resulting impact on coverage. In addition, the Model simulates changes in coverage in the individual market and under Medicaid. Throughout this analysis the term "Medicaid" includes the state's FHP, CHP-A and CHP-B programs, which are extensions of Medicaid and the State Children's Health Insurance Program (SCHIP). We also estimate the net change in the number of people without insurance.

The data and methods used in this analysis are summarized below. The methods used are illustrated in greater detail in *Attachment C*.<sup>2</sup>

#### A. Small Group Insurance Impacts

HBSM simulates premiums for a sample representation of small firms in New York and other states. For New York, we first calculated premiums for each individual firm under the current community rating laws and again under an alternative rating model such as the NAIC 1993/Enzi proposal. For each individual firm, the premium effect of the Enzi legislation is the difference between the premium under the Enzi rules and the premium under current law. These premium changes are tabulated across all firms in the data to show aggregate impacts across firms. The same approach is used to simulate the program's effect in other states using the rating rules that apply in each of these states.

For New York, the employer health insurance premium data under current law is based upon the New York sub-sample of the employer component of the Medicaid Expenditures Panel Survey (MEPS) data. Each firm in these data is matched through a statistical process with a sample of workers from the household component of the MEPS data that match the workforce characteristics reported by each employer (i.e., age, earnings, part-time/full-time status and family/single coverage). Premiums are adjusted to replicate premium and worker contribution amounts reported in the MEPS employer data. A similar approach is used to create a firm-level database for other states.

The MEPS data for workers provide detailed health expenditures and health status information for each worker employed in each firm. These data permit us to model rating practices that allow premiums to vary by age, gender, industry and firm size. The health spending and utilization data also permits us to simulate premiums based upon health status and prior year spending levels. We develop a "rating book", similar to those used in the industry that provided factors that allow us to rate by these factors.

<sup>&</sup>lt;sup>2</sup> For a detailed description of HBSM see: "Documentation to the Health Benefits Simulation Model (HBSM)," The Lewin Group, October 2000.



#### Figure 1 Summary Impact of the NAIC 1993/Enzi Bill on Health Insurance Coverage in New York <sup>a/</sup>

	NAIC 1993/Enzi		
	Without Exemption from Mandatory Benefits	With Exemption from Mandatory Benefits	
Impact on Small Group Cov	/erage		
Workers and dependents in insuring firms where ESI is discontinued	198,423	183,386	
Workers and dependents in non-insuring firms who take-up ESI	159,545	160,767	
Net change in employer coverage	(38,878)	(22,619)	
Average premium per worker- currently \$7,738	\$7,214	\$7,220	
Impact on Medicaid <sup>b/</sup>			
Increase in Medicaid enrollment for people losing ESI	22,441	19,274	
Reduction in Medicaid enrollment for people gaining ESI	23,918	23,919	
Net change in Medicaid enrollment	(1,477)	(4,645)	
Change in Medicaid spending (millions)	\$31.8	\$22.6	
Impact on Non-Group Cove	rage		
Increase in non-group coverage for people losing ESI	29,022	26,339	
Reduction in non-group coverage for people gaining ESI	18,226	18,236	
Reduction in non-group coverage due to premium increase <sup>c/</sup>	9,003	9,003	
Net change in non-group	1,793	(900)	
Change in Uninsured			
People with ESI who become uninsured	146,960	137,773	
People with non-group insurance who become uninsured <sup>c/</sup>	9,003	9,003	
Uninsured people who take ESI	117,402	118,612	
Net change in uninsured (currently 2.8 million)	38,561	28,164	
Other Effects			
Net change in uncompensated care (millions)	\$8.6	\$6.1	

a/ Estimates show changes in coverage resulting from premium changes with and without the premium effects of the exemption from mandatory benefits.

b/ Includes Medicaid, FHP, CHP-A and CHP-B.

c/ These proposals result in increased non-group enrollment for older people and reduced non-group enrollment of younger people resulting in an increase in non-group premiums averaging 4.5 percent in the NAIC 1993/Enzi Bill.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

When we include the effects of the exemption form mandatory benefits, we estimate an ESI coverage loss of 22,600 workers and dependents. Thus, the exemption from mandatory benefits reduces our coverage loss estimate from 38,900 people without the exemption by 16,300 people. Our estimate of the impact of the mandatory benefits exclusion reflects the low levels of enrollment in HNY, which already offers a product that is free of mandatory benefits for non-insuring firms with lower-wage workers (i.e., at least 30 percent of workers earning \$32,000 or less per year).

These changes in employer coverage reflect that the NAIC 1993/Enzi model increases premiums for older and sicker groups while reducing premiums for younger and healthier groups. Some firms facing increases in premiums would discontinue their coverage while some non-insuring firms would start offering coverage. For example, about 41,900 people age 55 to 64 would lose ESI coverage, while about 22,300 people under the age of 24 would become covered under ESI (*Figure 2*).

Figure 2	
Net-change in Workers and Dependents with ESI by Age under the NAIC 1993/	'Enzi Proposal

	Net Change in Workers and Dependents With Employer Coverage Under NAIC 1993/Enzi					
Age of Member	Without Mandatory Benefits Exemption	With Mandatory Benefits Exemption				
Age less than 25	21,122	22,315				
Age 25 to 34	16,742	19,504				
Age 35 to 44	2,063	8,465				
Age 45 to 54	(32,644)	(31,044)				
Age 55 to 64	(46,161)	(41,860)				
Total Net Change in Employer Coverage						
Net Change	(38,878)	(22,619)				

a/ Estimates show changes in coverage resulting from premium changes, including the effect of the exemption from mandatory benefits.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Average premiums in the small group market would drop from their current average of \$7,738 per worker to \$7,220 per worker due to the resulting shift towards younger and healthier enrollees. However, it is important to recognize



Based upon these estimated changes in coverage, we estimate that the number of uninsured in New York would increase by about 28,200 people. There would be an associated increase in uncompensated care costs of about \$6.1 million.

# B. Distributional impacts of the Enzi Bill in New York

The NAIC 1993/Enzi Bill would result in significant changes in premiums in the New York small group market due to the introduction of several risk rating factors. About 42 percent of workers and dependents in small firms offering insurance would see a premium reduction of 10 percent or more, while another 33 percent would see premiums increase by 10 percent or more (*Figure 3*). We estimate that no one would see a premium reduction greater than 50 percent. However, about 4 percent would see premiums increases by 50 percent to 99 percent and 1 percent would see premiums more than double (i.e., 100 percent increase).





a/ Estimates are based upon the change in the average premium per worker for each worker's employer. Estimates do not reflect changes in enrollment due to price changes.

Source: Lewin Group estimates using the Health Benefits Simulation Modes (HBSM).

The potential size of the change in premiums under the bill would often be dramatic. For example, for those who see a premium increase of 100 percent or more, the premium increase would on average be about \$8,000 per worker (*Figure 4*). For those seeing a premium reduction of 25 to 49 percent, premiums would drop by \$2,500 per worker.

As shown in *Figure 5*, the variability of premiums would be greatest for the smallest firms. This reflects the fact that per worker costs tend to regress to the population mean as group size increases, thus reducing the premium variation due to risk rating.



# IV. IMPACT OF THE ENZI BILL IN STATES USING COMMUNITY RATING IN THE SMALL GOUP MARKET

We estimated the impact of the NAIC 1993 small group rating model included in the Enzi legislation on other states that use pure or adjusted community rating in their small group market. In this analysis, community rating includes the single premium model where premiums for given products do not vary with risk factors, as in New York and Vermont. It also includes states where premiums are permitted to vary with age, but are not permitted to be varied by health status or claims experience (e.g., health pending in the prior year). We identified nine states other than New York that use community rating in the small group market.

#### A. States with Community Rating in the Small Group Market

Due to time constraints, we limited our analysis to the ten states using community rating in the small group market. These states and a summary of their rating rules include are:<sup>4</sup>

- *Connecticut:* Premium rates for small employers are based on a community rate adjusted to reflect one or more of the following classifications: age (age brackets of five years or more), gender, geography, industry (15 percent from highest to lowest), group size (1.25 to 1.0 ratio from highest to lowest) and family composition;
- *Maine*: Premium rates in the small group market can be adjusted by +/- 20 percent from the standard community rate for age, geography, occupation, and smoking status. Additional rate variation is permitted for group size, family status, smoker status and wellness program;
- *Maryland*: Small group health insurance premiums must be community rated with a maximum of +/- 40 percent variation for age and geography;
- *Massachusetts*: Small group health insurance premiums are community rated with adjustments for age, industry, group size (+/- 5 percent), geography (+/- 20 percent) family composition, participation rate and up to a 5 percent wellness discount; subject to an overall rating band of 2:1;
- *New Hampshire:* For small employers, rating factors are restricted to age (5.25 to 1), group size (1.32 to 1), and industry (1.2 to 1). These rates are subject to an overall rating band of 3.5:1. SB 125 was implemented beginning January 1, 2006 with a transition period from prior rating requirement. For illustrative purposes, we assume SB 125 is fully phased in for 2006;<sup>5</sup>
- *New Jersey*: For small employers, carriers may only consider the age, gender, family status and location of employer in determining the group premium. Carriers are



required to limit the range of premiums from highest to lowest risk group to a 2 to 1 ratio;

- *Oregon*: For groups of 2-25 employees, rating is based on a community rate adjusted for age, family mix and geography of the employer. Rates can have no more than a 43 percent difference from highest to lowest. For groups of 26-50 employees, community rates are adjusted for age, gender, family status and geography, but there are no age bands;
- *Vermont*: Used pure community rating by family status. The Commissioner is permitted to permit some groups to rate by age, but few of these exceptions have been approved.
- *Washington*: Small group premium rates must be based on a community rate with adjustments for age, geography and family composition. Rate variation is limited to 375 percent from highest to lowest.

HBSM is capable of modeling the effect of all of these rating restrictions except wellness programs, smoker status and geographic variation, which would probably change little under the Enzi bill.

Seven of these states also require community rating in the individual market. New Jersey, New York and Vermont use pure community rating in the non-group market. Modified community rating for non-group insurance is required in Massachusetts, Maine, Oregon and Washington (with some limits).<sup>6</sup> These states are likely to see a general increase in premiums as many older and sicker people losing employer coverage obtain coverage in the non-group market.

Also, in Michigan and Pennsylvania, the Blue Cross/Blue Shield carriers are required to use community rating in the small group market, while other carriers are permitted to vary premiums with risk factors. These states were not included in our list of community rated states because at least a portion of the small group market is already rated according to health status.

Other states use rating models that permit health status rating, subject to relatively tight limitations on premium variation. For example, California permits age rating and allows rates to vary with health status by +/-10 percent, which is substantially less than the health status rating band in the Enzi legislation (i.e., +/-25 percent).<sup>7</sup> These states also would be heavily impacted by the Enzi legislation. Due to time limitations, we focus here on only those states using community rating in the small group market.

# B. Impacts for States using Community Rating in the Small Group Market

For each state, we present estimates of the impact of adopting the NAIC 1993 rating model on coverage and costs for ESI, Medicaid and private non-group coverage. The methodology that we used is the same as that used to simulate the bill's impact on the New York small group

<sup>&</sup>lt;sup>6</sup> Congressional Budget Office (CBO), The Price Sensitivity of Demand for Non-group Health Insurance

<sup>&</sup>lt;sup>7</sup> Also permits rating by family composition and geography.

market. We did this by adjusting the firm data in HBSM to reflect detailed characteristics of workers and employers in the small group market in each individual state. We also used the employer component of the MEPS data to estimate average employer premium payments by firm size, including the share of the premium paid by the worker.

We then simulated the premiums paid for health insurance by small employers in these states under each state's current rating requirements and under the NAIC 1993 rating rules of the Enzi legislation. The change in the premium for each individual firm represents the bill's impact on the firm. We then modeled changes in sources of coverage in each state using the same price response methodologies described above for firms and individuals.

For each state, we developed these estimates with and without the exemption for mandatory benefits. Because mandatory benefits vary widely by state, we had to estimate the cost of mandatory benefits separately for each state based upon a similar analysis of the cost of key mandatory benefits in each state. These estimates were all adjusted to be in proportion to our assumption of 10.0 percent savings for New York. *Figure 9* presents our estimates of the cost of mandatory benefits as a percentage of premiums for each of the states with community rating.

The Enzi Bill (with mandatory benefits exemption) would result in a net reduction in the number of workers and dependents with ESI of about 199,000 people (*Figure 10*). Non-group coverage would increase by 8,700 people with Medicaid enrollment dropping by 3,100 people. The Enzi Bill would increase the number of uninsured by 193,400 people in community rated states.

States with Community or Modified Community Rating	Mandatory Benefits as a Percent of Premiums
Connecticut	2.5%
Maine	2.5%
Maryland	3.4%
Massachusetts	8.5%
New Hampshire	3.4%
New Jersey	0.9%
New York	10.0%
Oregon	1.7%
Vermont	8.5%
Washington	0.3%

#### Figure 9 Estimated Percentage of Premiums Attributable to Minimum Benefits Provisions in States using Community Rating

Source: Lewin Group analysis using National Association of Insurance Commissioners (NAIC) data on mandatory benefits by state.

One of the effects of the Enzi legislation would be to shift older and sicker people losing ESI into Medicaid, while drawing younger people out of Medicaid and into ESI. This shift in enrollment would increase Medicaid spending across the community rated states by about \$45.5 million



people (*Figure 11*). Provider uncompensated care costs would increase by \$42.1 million across the ten community rated states.



Figure 10 Changes in Coverage under the NAIC/Enzi Small Group Rating Model for Selected States

	Without I	Exemption fo	or Mandato	ry Benefits	With Exemption from Mandatory Benefits				
States with Community or Modified Community Rating	Change in ESI Coverage	Change in Medicaid Enrollment	Change in non- Group Coverage	Net Change in Number of Uninsured	Change in ESI Coverage	Change in Medicaid Enrollment	Change in non- Group Coverage	Net Change in Number of Uninsured	
Connecticut	(20,372)	318	(191)	20,245	(20,008)	318	(275)	19,965	
Maine	(5,192)	(452)	218	5,426	(4,872)	(452)	31	5,293	
Maryland	(26,608)	(21)	687	25,942	(26,094)	(46)	659	25,481	
Massachusetts	(36,643)	(708)	4,113	33,238	(34,645)	(712)	3,735	31,622	
New Hampshire	(10,626)	(225)	1,452	9,399	(10,220)	(225)	1,383	9,062	
New Jersey	(39,097)	(433)	4,746	34,783	(36,625)	(433)	4,329	32,729	
New York	(38,878)	(1,477)	1,793	38,561	(22,619)	(4,645)	(900)	28,164	
Oregon	(12,118)	(390)	1,861	10,647	(11,725)	(390)	1,815	10,300	
Vermont	(2,423)	(68)	(193)	2,684	(2,199)	(81)	(232)	2,512	
Washington	(30,446)	3,570	(1,722)	28,598	(30,034)	3,570	(1,791)	28,255	
Total	(222,403)	114	12,764	209,525	(199,041)	(3,096)	8,754	193,383	

#### Figure 11 Net Change in Medicaid Spending and Uncompensated Care Costs under the Enzi Bill for States Using Community Rating

States with Community or Modified Community Rating	Net Change In Medicaid Spending (millions)	Net Change in Uncompensated Care Costs (millions)
Connecticut	\$1.8	\$4.4
Maine	\$0.3	\$1.1
Maryland	\$0.8	\$5.6
Massachusetts	\$3.7	\$6.9
New Hampshire	(\$0.5)	\$2.0
New Jersey	\$2.4	\$7.1
New York	\$22.6	\$6.1
Oregon	\$1.1	\$2.2
Vermont	\$0.9	\$0.5
Washington	\$12.4	\$6.2
Total	\$45.5	\$42.1



*Figure 12* presents the distribution of workers and dependents by the amount of the change in the premium for their current coverage. New York would tend to see the greatest premium variation because they are currently using pure community rating (i.e., a single premium for each product). There is less variability for other states because they already permit some degree of premium variation by age.

Detailed analysis tables for these states are presented in *Attachment B*.



Figure 12 Percent Distribution of Workers and Dependents in the Small Group Market by Changes in Premium under the NAIC 1993/Enzi Bill in States with Community Rating or Modified Community Rating in 2006 <sup>a/</sup>

Percent Change in Premium under Alternative Rating Models	Connecticut	Maine	Maryland	Mass.	New Hampshire	New Jersey	New York	Oregon	Vermont	Washington
-50% to -100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
-25% to -49%	3%	17%	9%	17%	6%	16%	20%	17%	19%	7%
-10% to -24%	40%	24%	33%	24%	35%	27%	22%	25%	24%	37%
-10% to -1%	9%	14%	12%	13%	11%	12%	12%	13%	13%	9%
no chg +/- 1%	3%	2%	3%	2%	3%	2%	3%	2%	2%	3%
+1% to +10%	13%	13%	11%	17%	15%	12%	10%	12%	9%	11%
10% to 24%	16%	14%	17%	10%	13%	17%	15%	14%	15%	16%
25% to 49%	10%	11%	10%	11%	10%	11%	13%	12%	12%	11%
50% - 99%	7%	4%	5%	6%	6%	4%	4%	4%	5%	6%
100% to 200%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0%
over 200%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

# V. KEY ASSUMPTIONS AFFECTING ESTIMATES

Our analysis indicates that under the NAIC 1993/Enzi model, the number of people with ESI in New York would decline. This differs from other analyses of similar proposals that estimate a net increase in employer coverage. We believe that this difference has to do with differences in the way that coverage under other programs such as Medicaid and spousal ESI are modeled for affected people.

For example, under the NAIC 1993/Enzi model, we estimate a net reduction in the number of workers and dependents with ESI of about 22,600 people, if we do not account for the presence of Medicaid coverage for people in newly insuring firms. In fact, many of those who would be in newly insuring firms are covered under Medicaid. Most of these people can be expected to retain that coverage because, unlike most employer plans, Medicaid does not require a premium contribution or co-payments. When we account for this effect, we show a net reduction in the number of people with ESI, reflecting the fact that many Medicaid recipients in newly insuring firms would not shift to ESI (i.e., the number of people in newly insuring firms who take coverage is reduced by about 14,000 people).

#### Figure 12 Estimated Changes in Small Group Coverage Rating Scenarios for New York Under the NAIC 1993/Enzi Proposal in 2006, With and Without Accounting for Medicaid Enrollment Effects<sup>a/</sup>

	With Medicaid Effect <sup>b/</sup>	Without Medicaid Effect
Workers and dependents in insuring firms where ESI is discontinued	183,386	183,386
Workers and dependents in non-insuring firms who take-up ESI	160,767	174,900
Net change in employer coverage	(22,619)	(8,486)

a/ Assumes these rating models are implemented without the mandatory benefits exclusion.

b/ Estimates reflect worker decision to remain in Medicaid if enrolled when ESI is offered as in estimates presented above in *Figure 12*. Estimate based upon a Lewin Group multivariate analysis of Medicaid enrollment indicating that about 39 percent of Medicaid eligible people with access to employer health insurance will take Medicaid.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Another potential area of difference in our estimates is that we assume that workers in newly insuring firms who are already covered under a working spouse's employer plan as a dependent are assumed to retain this coverage and decline the newly offered coverage through their own employer. This reflects that many of those workers have better coverage through their spouse, many of whom work in larger firms where benefits are typically better. Also, premium contributions for family coverage on the spouse's employer plan are often less that what the worker premium contribution would be in the newly insuring firm. We also assume that people with Medicare or Tricare/CHAMPUS coverage do not take the employer coverage in newly insuring firms.

Accounting for Medicaid eligibility and spousal coverage alone does not explain the net reduction in ESI coverage that we have estimated for the NAIC 1993/Enzi proposal (22,619 people). Even when we do not adjust for people in newly insuring firms who remain with Medicaid, there is still a loss of ESI coverage of about 8,500 people. This net reduction in coverage occurs primarily because the NAIC 1993/Enzi Bill permits firm size rating. Due to the higher-cost of administering coverage in very small groups (i.e., 2 to 9 workers) firm size rating increases premiums for this group while reducing premiums for larger small groups.

This is crucial because econometric studies show that the firms with less than 10 workers are up to 4 times as likely to discontinue coverage in response to a price increase as are larger small firms. This causes a disproportionate share of the very smallest non-insuring firms to see premium increases causing them to discontinue coverage as well as discourage non-insuring firms from taking coverage.

It is important to recognize that under all these scenarios and assumptions, the estimated net change in ESI coverage is very small relative to the size of the covered population. For example, our estimated reduction in ESI coverage under the NAIC 1993/Enzi Bill without the mandatory benefits exclusion (38,900 people) is equal to about 1.5 percent of the total number of people now with ESI in the New York small group market. Consequently, the most significant impacts of these rating reforms would be the changes in premiums faced by people across risk categories as discussed above.

Attachment A Program Impacts for New York

Figure A-1 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill

Change in Premium											
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change				
Percentage Change in Premiums under Alternative Rating Models											
-50% to -99%				0%			0%				
-25% to -49%	287,430	234,704	522,134	20%	\$7,740.69	\$5,243.86	-32%				
-10% to -24%	311,518	247,390	558,909	22%	\$7,720.69	\$6,378.80	-17%				
-10% to -1%	166,407	137,563	303,969	12%	\$7,446.58	\$7,009.12	-6%				
no chg +/- 1%	35,600	33,612	69,212	3%	\$8,256.97	\$8,245.32	0%				
+1% to +10%	145,263	119,123	264,386	10%	\$7,682.23	\$8,081.37	5%				
10% to 24%	201,153	180,854	382,006	15%	\$7,986.64	\$9,347.43	17%				
25% to 49%	182,702	147,991	330,693	13%	\$7,838.20	\$10,541.89	34%				
50% - 99%	66,132	40,595	106,727	4%	\$7,527.75	\$12,438.21	65%				
100% to 200%	7,341	4,543	11,884	1%	\$6,187.73	\$14,154.39	129%				
over 200%				0%			0%				
Total	1,403,545	1,146,374	2,549,920	100%	\$7,738.21	\$7,738.21	0%				
	Firm Size										
2-9	669,409	498,811	1,168,219	46%	\$7,595.55	\$7,790.65	3%				
10-24	425,738	345,944	771,682	30%	\$7,476.86	\$7,199.84	-4%				
25-50	308,398	301,620	610,019	24%	\$8,408.67	\$8,367.60	0%				
Total	1,403,545	1,146,374	2,549,920	100%	\$7,738.21	\$7,738.21	0%				

#### Figure A-2 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -99%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	43,405	26%	\$7,740.69	\$5,243.86	-32%
-10% to -24%	33,987	20%	\$7,720.69	\$6,378.80	-17%
-10% to -1%	16,646	10%	\$7,446.58	\$7,009.12	-6%
no chg +/- 1%	3,134	2%	\$8,256.97	\$8,245.32	0%
+1% to +10%	14,275	9%	\$7,682.23	\$8,081.37	5%
10% to 24%	23,209	14%	\$7,986.64	\$9,347.43	17%
25% to 49%	20,540	12%	\$7,838.20	\$10,541.89	34%
50% - 99%	10,261	6%	\$7,527.75	\$12,438.21	65%
100% to 200%	1,219	1%	\$6,187.73	\$14,154.39	129%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	166,676	100%	\$7,738.21	\$7,738.21	0%

	Non Insuring Firms that Decide to Offer Coverage							
	Total In S Ma	mall Group arket	Number th Cove	at Take Up erage	Percent t Co	that Take Up verage		
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents		
		Fi	rm Size			•		
2-9 Workers	676,394	1,025,077	51,542	89,405	8%	9%		
10-24 Workers	231,012	328,159	38,435	55,967	17%	17%		
25-50 Workers	70,795	96,511	11,308	15,395	16%	16%		
-		Mer	nber Age					
Age < 25	156,351	184,423	27,260	31,167	17%	17%		
Age 25-34	226,739	350,121	34,818	55,920	15%	16%		
Age 35-44	242,466	418,131	25,588	49,824	11%	12%		
Age 45-54	154,224	230,526	9,122	18,692	6%	8%		
Age 55-64	198,420	266,545	4,496	5,165	2%	2%		
		C	Gender					
Male	596,386	879,306	70,079	106,866	12%	12%		
Female	381,815	570,440	31,206	53,901	8%	9%		
	Ν	lember Self-Re	eported Healt	h Status				
Excellent	719,037	1,050,131	77,549	124,928	11%	12%		
Good	206,869	315,762	19,372	29,555	9%	9%		
Fair	42,520	70,332	4,157	5,948	10%	8%		
Poor	9,775	13,522	207	335	2%	2%		
		Fam	ily income					
Less than \$10,000	140,355	196,869	13,169	18,261	9%	9%		
\$10,000-24,999	351,915	496,740	35,143	53,333	10%	11%		
\$25,000-49,999	273,314	422,970	32,447	55,629	12%	13%		
\$50,000-74,999	99,210	153,077	8,426	12,156	8%	8%		
\$75,000-99,999	48,199	78,079	4,147	6,277	9%	8%		
\$100,000-149,999	39,786	65,589	5,846	12,289	15%	19%		
\$150,000 & over	25,422	36,422	2,106	2,822	8%	8%		
Total	978,201	1,449,747	101,285	160,767	10%	11%		
Number who take up that were uninsured				118,612				

Figure A-3 People In Non-Insuring Firms Who Take-Up ESI under the NAIC 1993/Enzi Bill

Figure A-4 People in Insuring Firms that Discontinue ESI under the NAIC 1993/Enzi Bill

	Currently Insuring Firms that Decide to Drop Coverage							
	Total In Small Group Market		Number that Drop Coverage		Percent that Drop Coverage			
Work Workers Depe		Workers and Dependents	Workers and Workers and Dependents		Workers	Workers and Dependents		
Firm Size								
2-9 Workers	669,409	1,168,219	49,283	85,775	7%	7%		
10-24 Workers	425,738	771,682	22,272	39,512	5%	5%		
25-50 Workers	308,398	610,019	29,425	58,099	10%	10%		
Member Age								
Age < 25	141,091	164,515	8,248	8,852	6%	5%		
Age 25-34	309,515	528,629	19,210	36,415	6%	7%		
Age 35-44	354,150	802,562	17,283	41,359	5%	5%		
Age 45-54	334,826	654,474	25,694	49,735	8%	8%		
Age 55-64	263,963	399,740	30,546	47,025	12%	12%		
	•		Gender					
Male	894,679	1,741,716	57,691	112,997	6%	6%		
Female	508,867	808,204	43,290	70,389	9%	9%		
	•	Self-repor	ted Health St	tatus				
Excellent	1,122,028	2,060,305	74,316	142,234	7%	7%		
Good	237,319	408,302	21,984	35,015	9%	9%		
Fair	41,529	76,987	4,565	6,021	11%	8%		
Poor	2,669	4,325	116	116	4%	3%		
		Fan	nily Income					
Less than \$10,000	41,965	58,339	4,080	5,359	10%	9%		
\$10,000-24,999	175,421	251,344	12,325	18,831	7%	7%		
\$25,000-49,999	391,697	637,414	27,002	48,813	7%	8%		
\$50,000-74,999	258,063	500,883	18,637	32,281	7%	6%		
\$75,000-99,999	178,555	358,709	15,261	27,473	9%	8%		
\$100,000-149,999	196,535	387,648	12,758	27,026	6%	7%		
\$150,000 & over	161,310	355,583	10,918	23,603	7%	7%		
Total	1,403,545	2,549,920	100,981	183,386	7%	7%		
Number who go uninsured				137,773				

Figure A-5 Change in Number of People with ESI in the Small Group Market under the Enzi Bill

	Change in Number of People with Employer Coverage in Small Group Market							
	Number that Take Up Coverage		Number that Drop Coverage		Change in Employer Coverage			
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents		
Firm Size								
2-9 Workers	51,542	89,405	49,283	85,775	2,259	3,630		
10-24 Workers	38,435	55,967	22,272	39,512	16,162	16,455		
25-50 Workers	11,308	15,395	29,425	58,099	(18,117)	(42,704)		
	Member Age							
Age < 25	27,260	31,167	8,248	8,852	19,013	22,315		
Age 25-34	34,818	55,920	19,210	36,415	15,608	19,504		
Age 35-44	25,588	49,824	17,283	41,359	8,306	8,465		
Age 45-54	9,122	18,692	25,694	49,735	(16,571)	(31,044)		
Age 55-64	4,496	5,165	30,546	47,025	(26,051)	(41,860)		
		C	Gender					
Male	70,079	106,866	57,691	112,997	12,388	(6,132)		
Female	31,206	53,901	43,290	70,389	(12,084)	(16,488)		
		Self-report	ed Health Statu	JS				
Excellent	77,549	124,928	74,316	142,234	3,233	(17,306)		
Good	19,372	29,555	21,984	35,015	(2,612)	(5,460)		
Fair	4,157	5,948	4,565	6,021	(408)	(73)		
Poor	207	335	116	116	92	219		
Family Income								
Less than \$10,000	13,169	18,261	4,080	5,359	9,089	12,902		
\$10,000-24,999	35,143	53,333	12,325	18,831	22,818	34,502		
\$25,000-49,999	32,447	55,629	27,002	48,813	5,445	6,816		
\$50,000-74,999	8,426	12,156	18,637	32,281	(10,211)	(20,125)		
\$75,000-99,999	4,147	6,277	15,261	27,473	(11,113)	(21,195)		
\$100,000-149,999	5,846	12,289	12,758	27,026	(6,912)	(14,738)		
\$150,000 & over	2,106	2,822	10,918	23,603	(8,812)	(20,781)		
Total	101,285	160,767	100,981	183,386	304	(22,619)		

Figure A-6 Change in Premiums in the Small Group Market under the Enzi Bill

	Workers	Workers and Dependents	Premium Payments Per Worker
Current Law	1,403,545	2,549,920	\$7,738
NAIC 1993/Enzi Bill	1,403,849	2,527,301	\$7,220
Change from Current Law	304	(22,619)	-\$518



# Attachment B Program Impacts for Other Community Rated States

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#### Figure B-1 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for Connecticut in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits				
Impact on Small Group Coverage						
Workers and dependents in insuring firms where ESI is discontinued	37,438	37,101				
Workers and dependents in non-insuring firms who take-up ESI	17,066	17,093				
Net change in employer coverage	(20,372)	(20,008)				
Average premium per worker- currently \$7,752	\$7,443	\$7,445				
Impact on Medica	aid					
Increase in Medicaid enrollment for people losing ESI	1,454	1,454				
Reduction in Medicaid enrollment for people gaining ESI	1,136	1,136				
Net change in Medicaid enrollment	318	318				
Change in Medicaid spending (millions)	\$1.8	\$1.8				
Impact on Non-Group Coverage						
Increase in non-group coverage for people losing ESI	5,976	5,919				
Reduction in non-group coverage for people gaining ESI	6,167	6,194				
Reduction in non-group coverage due to premium increase <sup>a/</sup>						
Net change in non-group	(191)	(275)				
Change in Uninsured						
People with ESI who become uninsured	30,008	29,728				
People with Non-Group who become uninsured						
Uninsured people who take ESI	9,763	9,763				
Net change in uninsured	20,245	19,966				
Other Effects						
Net change in uncompensated care (millions)	\$4.4	\$4.4				

a/ Insurers are permitted to vary non-group premiums to reflect health status so there will be little change in premiums for those who now have coverage due to the migration of higher-cost people who lose ESI coverage to the non-group market.

Figure B-2 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill in Connecticut

Change in Premium								
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change	
	Percenta	ge Change in F	Premiums unde	er Alternat	ive Rating Mod	dels		
-50% to -100%	0	0	0	0%	\$0.00	\$0.00	0%	
-25% to -49%	7,068	7,704	14,772	3%	\$7,116.22	\$5,265.99	-26%	
-10% to -24%	116,085	78,419	194,504	40%	\$7,706.55	\$6,172.49	-20%	
-10% to -1%	25,756	16,299	42,055	9%	\$7,290.67	\$6,877.83	-6%	
no chg +/- 1%	8,602	6,649	15,252	3%	\$7,753.82	\$7,761.92	0%	
+1% to +10%	31,644	28,690	60,334	12%	\$8,234.58	\$8,710.47	6%	
10% to 24%	40,443	35,875	76,318	16%	\$7,825.35	\$8,992.61	15%	
25% to 49%	26,864	22,302	49,166	10%	\$6,859.84	\$9,294.10	35%	
50% - 99%	19,111	15,071	34,183	7%	\$7,164.62	\$11,553.94	61%	
100% to 200%	0	0	0	0%	\$0.00	\$0.00	0%	
over 200%	0	0	0	0%	\$0.00	\$0.00	0%	
Total	275,573	211,010	486,584	100%	\$7,752.00	\$7,752.00	0%	
Firm Size								
2-9	141,541	97,410	238,951	49%	\$7,914.37	\$7,785.32	-2%	
10-24	71,758	53,423	125,182	26%	\$7,260.08	\$7,171.46	-1%	
25-50	62,274	60,177	122,451	25%	\$7,949.81	\$8,345.23	5%	
Total	275,573	211,010	486,584	100%	\$7,752.00	\$7,752.00	0%	

Source: Lewin Group Estimates using the
## Figure B-3 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Connecticut

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	1,113	4%	\$7,116.22	\$5,265.99	-26%



# Figure B-4 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in Connecticut

	Change in Number of People with Employer Coverage in Small Group Market						
	Number th Cove	nat Take Up erage	Number t Cove	hat Drop rage	Change Co	Change in Employer Coverage	
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents	
		Fi	rm Size				
2-9 Workers	6,329	10,037	7,966	14,172	(1,637)	(4,136)	
10-24 Workers	3,562	5,173	4,509	8,014	(947)	(2,841)	
25-50 Workers	1,438	1,883	8,039	14,915	(6,601)	(13,032)	
		Ме	nber Age				
Age < 25	1,785	2,016	1,822	2,015	(37)	2	
Age 25-34	1,508	2,379	5,088	9,079	(3,581)	(6,700)	
Age 35-44	2,605	4,615	4,472	10,820	(1,867)	(6,205)	
Age 45-54	1,209	2,122	5,499	9,920	(4,290)	(7,798)	
Age 55-64	4,224	5,961	3,634	5,268	590	693	
		(	Gender				
Male	6,275	9,686	11,151	21,452	(4,876)	(11,766)	



## Figure B-5 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for Maine in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits
Impact on Small Group (	Coverage	
Workers and dependents in insuring firms where ESI is discontinued	12,841	12,682
Workers and dependents in non-insuring firms who take-up ESI	7,648	7,810
Net change in employer coverage	(5,192)	(4,872)
Average premium per worker- currently \$7,852	\$7,452	\$7,454
Impact on Medica	id	
Increase in Medicaid enrollment for people losing ESI	699	699
Reduction in Medicaid enrollment for people gaining ESI	1,150	1,150
Net change in Medicaid enrollment	(452)	(452)
Change in Medicaid spending (millions)	\$0.3	\$0.3
Impact on Non-Group C	overage	
Increase in non-group coverage for people losing ESI	2,001	1,976
Peduction in non-group coverage for poople		

Reduction in non-group coverage for people gaining ESI



Figure B-6 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill in Maine

Change in Premium									
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change		
	Percenta	ge Change in F	Premiums unde	er Alternat	ive Rating Mod	dels			
-50% to -100%	0	0	0	0%	\$0.00	\$0.00	0%		
-25% to -49%	16,493	13,686	30,178	17%	\$7,116.22	\$5,265.99	-26%		
-10% to -24%	25,907	17,019	42,926	24%	\$7,600.05	\$6,200.78	-18%		
-10% to -1%	14,489	11,031	25,520	14%	\$7,698.80	\$7,276.23	-5%		
no chg +/- 1%	2,017	1,389	3,406	2%	\$8,027.22	\$8,016.58	0%		
+1% to +10%	12,957	9,934	22,891	13%	\$8,166.50	\$8,633.94	6%		
10% to 24%	13,584	11,084	24,668	14%	\$8,150.06	\$9,515.96	17%		
25% to 49%	11,570	8,451	20,021	11%	\$7,791.89	\$10,575.50	36%		
50% - 99%	4,543	2,736	7,279	4%	\$7,395.55	\$12,090.37	63%		
100% to 200%	630	180	810	0%	\$6,616.83	\$14,441.14	118%		
over 200%	0	0	0	0%	\$0.00	\$0.00	0%		
Total	102,190	75,508	177,699	100%	\$7,851.81	\$7,851.81	0%		
			Firm Size						
2-9	50,732	32,977	83,709	47%	\$7,671.52	\$7,880.17	3%		
10-24	28,393	21,542	49,935	28%	\$7,564.52	\$7,286.10	-4%		
25-50	23,065	20,989	44,054	25%	\$8,601.99	\$8,485.79	-1%		
Total	102,190	75,508	177,699	100%	\$7,851.81	\$7,851.81	0%		

## Figure B-7 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Maine

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	1,955	18%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	2,691	25%	\$7,600.05	\$6,200.78	-18%
-10% to -1%	1,320	12%	\$7,698.80	\$7,276.23	-5%
no chg +/- 1%	180	2%	\$8,027.22	\$8,016.58	0%
+1% to +10%	1,116	10%	\$8,166.50	\$8,633.94	6%
10% to 24%	1,471	14%	\$8,150.06	\$9,515.96	17%
25% to 49%	1,249	12%	\$7,791.89	\$10,575.50	36%
50% - 99%	610	6%	\$7,395.55	\$12,090.37	63%
100% to 200%	102	1%	\$6,616.83	\$14,441.14	118%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	10,692	100%	\$7,851.81	\$7,851.81	0%



## Figure B-8 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in Maine

	Change in Number of People with Employer Coverage in Small Group Market						
	Number th Cove	nat Take Up erage	Number t Cove	hat Drop rage	Change in Employer Coverage		
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents	
	1	Fi	rm Size				
2-9 Workers	2,384	4,358	3,406	5,828	(1,022)	(1,470)	
10-24 Workers	1,797	2,578	1,774	3,039	23	(460)	
25-50 Workers	624	873	2,232	3,815	(1,608)	(2,942)	
		Mer	nber Age				
Age < 25	1,029	1,216	424	534	605	682	
Age 25-34	1,131	2,054	1,426	2,650	(295)	(595)	
Age 35-44	1,344	2,581	1,100	2,356	244	225	
Age 45-54	765	1,318	1,820	3,239	(1,055)	(1,921)	
Age 55-64	535	640	2,640	3,902	(2,105)	(3,262)	
		C	Gender				
Male	2,924	4,864	3,896	7,410	(972)	(2,546)	
Female	1,880	2,945	3,515	5,272	(1,635)	(2,326)	
		Self-report	ed Health Statu	ıs			
Excellent	3,706	6,190	5,155	8,905	(1,449)	(2,715)	
Good	985	1,397	1,921	3,296	(936)	(1,898)	
Fair	114	221	318	463	(204)	(243)	
Poor	1	1	18	18	(17)	(16)	
		Fam	ily Income				
Less than \$10,000	776	992	215	274	561	717	
\$10,000-24,999	1,144	1,793	799	1,170	345	623	
\$25,000-49,999	1,767	2,993	2,646	4,357	(879)	(1,365)	
\$50,000-74,999	591	1,029	1,328	2,087	(737)	(1,058)	
\$75,000-99,999	152	270	1,327	2,542	(1,174)	(2,272)	
\$100,000-149,999	315	673	743	1,470	(428)	(797)	
\$150,000 & over	59	61	354	781	(295)	(720)	
Total	4,805	7,810	7,411	12,682	(2,607)	(4,872)	



## Figure B-9 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for Maryland in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits
Impact on Small Group (	Coverage	
Workers and dependents in insuring firms where ESI is discontinued	57,340	57,134
Workers and dependents in non-insuring firms who take-up ESI	30,731	31,040
Net change in employer coverage	(26,608)	(26,094)
Average premium per worker- currently \$7,227	\$6,877	\$6,879
Impact on Medica	id	
Increase in Medicaid enrollment for people losing ESI	655	630
Reduction in Medicaid enrollment for people gaining ESI	676	676
Net change in Medicaid enrollment	(21)	(46)
Change in Medicaid spending (millions)	\$0.9	\$0.8
Impact on Non-Group C	overage	
Increase in non-group coverage for people losing ESI	9,532	9,504
Reduction in non-group coverage for people gaining ESI	8,845	8,845
Reduction in non-group coverage due to premium increase <sup>a/</sup>		
Net change in non-group	687	659
Change in Uninsu	red	
People with ESI who become uninsured	47,153	47,001
People with Non-Group who become uninsured		
Uninsured people who take ESI	21,211	21,519
Net change in uninsured	25,942	25,482
Other Effects		-
Net change in uncompensated care (millions)	\$5.7	\$5.6

a/ Insurers are permitted to vary non-group premiums to reflect health status so there will be little change in premiums for those who now have coverage due to the migration of higher-cost people who lose ESI coverage to the non-group market.

Figure B-10 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill in Maryland

Change in Premium									
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change		
	Percenta	ge Change in F	Premiums unde	er Alternat	ive Rating Mod	dels			
-50% to -100%	0	0	0	0%	\$0.00	\$0.00	0%		
-25% to -49%	43,785	27,430	71,215	9%	\$7,137.47	\$5,070.38	-29%		
-10% to -24%	146,382	114,486	260,868	33%	\$7,143.32	\$5,862.38	-18%		
-10% to -1%	54,390	40,785	95,176	12%	\$7,377.03	\$6,962.00	-6%		
no chg +/- 1%	12,281	8,910	21,192	3%	\$6,873.60	\$6,887.02	0%		
+1% to +10%	47,844	37,872	85,716	11%	\$7,461.06	\$7,868.43	5%		
10% to 24%	68,510	61,899	130,409	17%	\$7,453.36	\$8,692.36	17%		
25% to 49%	42,641	35,138	77,780	10%	\$6,769.57	\$9,206.67	36%		
50% - 99%	19,678	19,254	38,931	5%	\$7,504.39	\$12,171.83	62%		
100% to 200%	54	0	54	0%	\$4,867.13	\$10,105.97	108%		
over 200%	0	0	0	0%	\$0.00	\$0.00	0%		
Total	435,565	345,774	781,339	100%	\$7,227.42	\$7,227.42	0%		
			Firm Size						
2-9	218,054	158,132	376,186	48%	\$7,389.42	\$7,332.58	-1%		
10-24	120,292	92,649	212,942	27%	\$6,734.18	\$6,580.46	-2%		
25-50	97,219	94,992	192,211	25%	\$7,474.38	\$7,792.06	4%		
Total	435,565	345,774	781,339	100%	\$7,227.42	\$7,227.42	0%		

## Figure B-11 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Maryland

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	4,211	12%	\$7,137.47	\$5,070.38	-29%
-10% to -24%	12,914	36%	\$7,143.32	\$5,862.38	-18%
-10% to -1%	4,622	13%	\$7,377.03	\$6,962.00	-6%
no chg +/- 1%	814	2%	\$6,873.60	\$6,887.02	0%
+1% to +10%	3,183	9%	\$7,461.06	\$7,868.43	5%
10% to 24%	4,686	13%	\$7,453.36	\$8,692.36	17%
25% to 49%	3,741	10%	\$6,769.57	\$9,206.67	36%
50% - 99%	1,525	4%	\$7,504.39	\$12,171.83	62%
100% to 200%	6	0%	\$4,867.13	\$10,105.97	108%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	35,701	100%	\$7,227.42	\$7,227.42	0%



## Figure B-12 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in Maryland

	Change in Number of People with Employer Coverage in Small Group Market						
	Number th Cove	nat Take Up erage	Number t Cove	hat Drop rage	Change in Employer Coverage		
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents	
	1	Fi	rm Size		1		
2-9 Workers	12,254	17,878	11,232	22,225	1,022	(4,347)	
10-24 Workers	6,872	10,294	5,761	11,093	1,112	(799)	
25-50 Workers	2,455	2,868	12,840	23,816	(10,385)	(20,948)	
		Mei	mber Age				
Age < 25	3,213	3,696	3,317	3,615	(104)	80	
Age 25-34	3,228	4,803	7,318	13,049	(4,090)	(8,246)	
Age 35-44	6,116	10,392	8,037	19,512	(1,920)	(9,120)	
Age 45-54	3,202	4,866	6,522	13,342	(3,320)	(8,476)	
Age 55-64	5,823	7,283	4,640	7,616	1,183	(333)	
		C	Gender				
Male	12,910	18,319	16,877	35,203	(3,967)	(16,884)	
Female	8,671	12,721	12,956	21,931	(4,284)	(9,210)	
		Self-report	ed Health Statu	ıs			
Excellent	16,165	22,692	22,705	45,869	(6,540)	(23,176)	
Good	3,994	6,394	6,381	10,074	(2,386)	(3,680)	
Fair	1,273	1,790	747	1,192	526	598	
Poor	148	163	0	0	148	163	
		Fam	ily Income				
Less than \$10,000	2,159	2,710	678	940	1,481	1,771	
\$10,000-24,999	5,440	7,584	2,867	3,946	2,573	3,638	
\$25,000-49,999	6,390	9,266	9,069	14,994	(2,679)	(5,728)	
\$50,000-74,999	2,533	3,458	5,633	9,798	(3,101)	(6,340)	
\$75,000-99,999	1,778	2,505	3,598	7,484	(1,820)	(4,979)	
\$100,000-149,999	1,845	3,521	3,512	8,733	(1,667)	(5,212)	
\$150,000 & over	1,437	1,995	4,476	11,239	(3,039)	(9,244)	
Total	21,581	31,040	29,833	57,134	(8,252)	(26,094)	

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).



## Figure B-13 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for Massachusetts in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits
Impact on Small Group Co	overage	
Workers and dependents in insuring firms where ESI is discontinued	64,138	62,965
Workers and dependents in non-insuring firms who take-up ESI	27,495	28,320
Net change in employer coverage	(36,643)	(34,645)
Average premium per worker- currently \$7,612	\$7,315	\$7,320
Impact on Medicai	d	
Increase in Medicaid enrollment for people losing ESI	3,196	3,194
Reduction in Medicaid enrollment for people gaining ESI	3,905	3,905
Net change in Medicaid enrollment	(709)	(712)
Change in Medicaid spending (millions)	\$3.7	\$3.7
Impact on Non-Group Co	verage	
Increase in non-group coverage for people losing ESI	10,068	9,870
Reduction in non-group coverage for people gaining ESI	4,829	5,009
Reduction in non-group coverage due to premium increase <sup>a/</sup>	1,126	1,126
Net change in non-group	4,113	3,735
Change in Uninsure	ed	
People with ESI who become uninsured	50,875	49,901
People with Non-Group who become uninsured	1,126	1,126
Uninsured people who take ESI	18,762	19,406
Net change in uninsured	33,239	31,622
Other Effects		
Net change in uncompensated care (millions)	\$7.2	\$6.9

a/ This proposal results in increased non-group enrollment for older people and reduced non-group enrollment of younger people resulting in an increase in non-group premiums averaging 1.5 percent.





## Figure B-15 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Massachusetts

Percent Change in Premium					
under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	8,509	16%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	14,716	28%	\$6,982.73	\$5,677.18	-19%
-10% to -1%	6,794	13%	\$7,526.01	\$7,157.38	-5%
no chg +/- 1%	1,497	3%	\$8,103.88	\$8,092.15	0%
+1% to +10%	6,965	13%	\$8,391.29	\$8,842.57	5%
10% to 24%	4,851	9%	\$7,353.27	\$8,577.20	17%
25% to 49%	6,166	12%	\$7,215.92	\$9,832.94	36%
50% - 99%	3,295	6%	\$7,064.60	\$11,352.28	61%
100% to 200%	394	1%	\$5,521.24	\$11,821.15	114%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	53,187	100%	\$7,611.72	\$7,611.72	0%



## Figure B-16 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in Massachusetts

	Change in Number of People with Employer Coverage in Small Group Market					
	Number th Cove	nat Take Up erage	Number t Cove	hat Drop rage	Change in Employer Coverage	
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents
		Fi	rm Size			
2-9 Workers	10,315	17,192	14,637	26,158	(4,321)	(8,966)
10-24 Workers	4,773	6,966	9,440	16,435	(4,667)	(9,469)
25-50 Workers	2,815	4,161	11,144	20,372	(8,330)	(16,211)
		Mei	mber Age			
Age < 25	4,008	4,659	3,277	3,501	731	1,157
Age 25-34	4,049	6,760	8,582	15,727	(4,533)	(8,967)
Age 35-44	5,259	9,543	6,712	15,764	(1,453)	(6,221)
Age 45-54	2,393	4,510	8,650	16,376	(6,258)	(11,866)
Age 55-64	2,193	2,849	8,000	11,596	(5,807)	(8,747)
		(	Gender			
Male	11,327	18,401	19,677	38,651	(8,350)	(20,250)
Female	6,575	9,919	15,544	24,314	(8,969)	(14,395)
		Self-report	ed Health Statu	ıs		
Excellent	14,085	22,504	26,888	49,671	(12,802)	(27,168)
Good	3,343	5,081	7,059	11,511	(3,716)	(6,430)
Fair	429	658	1,235	1,744	(807)	(1,086)
Poor	46	78	39	39	7	39
		Fam	ily Income			
Less than \$10,000	1,976	2,741	810	1,147	1,165	1,594
\$10,000-24,999	4,937	7,616	4,179	5,813	757	1,803
\$25,000-49,999	5,579	9,580	10,001	16,329	(4,422)	(6,749)
\$50,000-74,999	2,427	3,579	5,747	9,560	(3,320)	(5,981)
\$75,000-99,999	1,180	1,647	5,543	11,029	(4,363)	(9,382)
\$100,000-149,999	1,312	2,557	4,597	9,678	(3,285)	(7,121)
\$150,000 & over	492	600	4,344	9,409	(3,852)	(8,809)
Total	17,903	28,320	35,221	62,965	(17,319)	(34,645)

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).



## Figure B-17 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for New Hampshire in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits
Impact on Small Group C	overage	
Workers and dependents in insuring firms where ESI is discontinued	16,148	15,742
Workers and dependents in non-insuring firms who take-up ESI	5,522	5,523
Net change in employer coverage	(10,626)	(10,220)
Average premium per worker- currently \$8,436	\$8,094	\$8,094
Impact on Medicai	d	
Increase in Medicaid enrollment for people losing ESI	16	16
Reduction in Medicaid enrollment for people gaining ESI	241	241
Net change in Medicaid enrollment	(225)	(225)
Change in Medicaid spending (millions)	(\$0.5)	(\$0.5)
Impact on Non-Group Co	verage	
Increase in non-group coverage for people losing ESI	2,725	2,656
Reduction in non-group coverage for people gaining ESI	1,273	1,274
Reduction in non-group coverage due to premium increase <sup>a/</sup>		
Net change in non-group	1,452	1,383
Change in Uninsure	ed	
People with ESI who become uninsured	13,406	13,069
People with Non-Group who become uninsured		
Uninsured people who take ESI	4,008	4,008
Net change in uninsured	9,398	9,061
Other Effects		
Net change in uncompensated care (millions)	\$2.0	\$2.0

 a/ Insurers are permitted to vary non-group premiums by health status so there will be little change in premiums for those who now have coverage due to the migration of higher-cost people who lose ESI coverage to the non-group market.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

#### Figure B-18 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill in New Hampshire

Change in Premium							
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change
	Percenta	ge Change in F	Premiums unde	er Alternat	ive Rating Mod	dels	
-50% to -100%	0	0	0	0%	\$0.00	\$0.00	0%
-25% to -49%	6,305	7,628	13,933	6%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	46,260	30,548	76,809	35%	\$7,993.88	\$6,412.89	-20%
-10% to -1%	13,955	10,031	23,987	11%	\$8,199.65	\$7,740.54	-6%
no chg +/- 1%	4,229	3,330	7,559	3%	\$8,624.03	\$8,623.43	0%
+1% to +10%	16,344	15,339	31,683	15%	\$9,094.79	\$9,669.79	6%
10% to 24%	15,240	13,565	28,806	13%	\$8,705.09	\$10,065.40	16%
25% to 49%	11,778	9,020	20,799	10%	\$7,499.70	\$10,240.53	37%
50% - 99%	7,063	5,985	13,048	6%	\$8,355.25	\$13,379.96	60%
100% to 200%	48	51	99	0%	\$7,672.31	\$16,097.96	110%
over 200%	0	0	0	0%	\$0.00	\$0.00	0%
Total	121,224	95,499	216,722	100%	\$8,436.46	\$8,436.46	0%
			Firm Size				
2-9	58,827	41,378	100,205	46%	\$8,429.07	\$8,450.29	0%
10-24	34,366	26,526	60,892	28%	\$8,058.75	\$7,833.61	-3%
25-50	28,031	27,595	55,626	26%	\$8,915.04	\$9,146.53	3%
Total	121,224	95,499	216,722	100%	\$8,436.46	\$8,436.46	0%



## Figure B-19

## Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in New Hampshire

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	710	5%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	6,378	43%	\$7,993.88	\$6,412.89	-20%
-10% to -1%	1,696	11%	\$8,199.65	\$7,740.54	-6%
no chg +/- 1%	409	3%	\$8,624.03	\$8,623.43	0%
+1% to +10%	1,536	10%	\$9,094.79	\$9,669.79	6%
10% to 24%	1,600	11%	\$8,705.09	\$10,065.40	16%
25% to 49%	1,601	11%	\$7,499.70	\$10,240.53	37%
50% - 99%	965	6%	\$8,355.25	\$13,379.96	60%
100% to 200%	8	0%	\$7,672.31	\$16,097.96	110%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	14,903	100%	\$8,436.46	\$8,436.46	0%



## Figure B-20 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in New Hampshire

	Change in Number of People with Employer Coverage in Small Group Market						
	Number th Cove	at Take Up erage	Number t Cove	hat Drop rage	Change in Employer Coverage		
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents	
		Fi	rm Size				
2-9 Workers	1,984	3,084	3,277	6,108	(1,293)	(3,023)	
10-24 Workers	1,203	1,575	2,196	3,965	(993)	(2,390)	
25-50 Workers	507	863	3,064	5,670	(2,557)	(4,807)	
		Ме	nber Age				
Age < 25	671	771	746	790	(75)	(19)	
Age 25-34	594	1,081	1,985	3,974	(1,391)	(2,893)	
Age 35-44	1,026	1,673	1,580	3,955	(553)	(2,282)	
Age 45-54	552	916	2,268	4,176	(1,716)	(3,259)	
Age 55-64	850	1,082	1,958	2,848	(1,108)	(1,767)	
		C	Gender				
Male	2,141	3,363	4,644	9,274	(2,503)	(5,910)	
Female	1,552	2,159	3,893	6,469	(2,341)	(4,309)	
		Self-report	ed Health Statu	ıs			
Excellent	2,751	4,232	6,528	12,379	(3,777)	(8,147)	
Good	858	1,173	1,770	3,016	(912)	(1,843)	
Fair	60	91	240	347	(180)	(256)	
Poor	26	27	0	0	26	27	
Family Income							
Less than \$10,000	354	408	229	337	125	70	
\$10,000-24,999	1,331	1,730	994	1,364	337	366	
\$25,000-49,999	936	1,509	2,560	4,521	(1,625)	(3,012)	
\$50,000-74,999	434	768	1,608	2,742	(1,174)	(1,974)	
\$75,000-99,999	257	451	1,337	2,725	(1,080)	(2,275)	

## Figure B-21 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for New Jersey in 2006

	Impact of
Impact of Rating	Rating Laws
	and
	Elimination of
Laws Only	Mandatory



#### Figure B-22 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill in New Jersey

Change in Premium								
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change	
	Percenta	ge Change in F	Premiums unde	er Alternat	ive Rating Mod	dels		
-50% to -100%	0	0	0	0%	\$0.00	\$0.00	0%	
-25% to -49%	108,661	89,958	198,619	16%	\$7,116.22	\$5,265.99	-26%	
-10% to -24%	178,965	148,460	327,424	27%	\$8,084.77	\$6,632.25	-18%	
-10% to -1%	83,272	58,952	142,223	12%	\$8,062.91	\$7,601.38	-6%	
no chg +/- 1%	14,687	11,715	26,401	2%	\$8,127.74	\$8,127.22	0%	
+1% to +10%	78,925	69,271	148,196	12%	\$8,534.13	\$8,987.03	5%	
10% to 24%	106,722	98,164	204,886	17%	\$8,669.45	\$10,156.50	17%	
25% to 49%	79,805	62,150	141,954	11%	\$8,364.31	\$11,346.49	36%	
50% - 99%	23,221	20,438	43,659	4%	\$8,986.08	\$14,753.52	64%	
100% to 200%	860	964	1,824	0%	\$8,692.19	\$18,993.14	119%	
over 200%	0	0	0	0%	\$0.00	\$0.00	0%	
Total	675,116	560,072	1,235,188	100%	\$8,342.34	\$8,342.34	0%	
	Firm Size							
2-9	305,515	236,091	541,606	44%	\$8,423.42	\$8,471.52	1%	
10-24	227,837	181,440	409,276	33%	\$7,901.89	\$7,708.80	-2%	
25-50	141,764	142,541	284,305	23%	\$8,875.48	\$9,082.16	2%	
Total	675,116	560,072	1,235,188	100%	\$8,342.34	\$8,342.34	0%	



## Figure B-24 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in New Jersey

	Change in Number of People with Employer Coverage in Small Group Market					
	Number th Cove	nat Take Up erage	Number t Cove	hat Drop rage	Change in Employer Coverage	
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents
		Fi	rm Size			
2-9 Workers	19,554	31,358	20,598	36,896	(1,044)	(5,538)
10-24 Workers	11,382	16,594	12,670	22,601	(1,287)	(6,006)
25-50 Workers	4,379	5,531	15,622	30,613	(11,243)	(25,082)
		Mer	nber Age			
Age < 25	6,785	7,637	5,189	5,607	1,596	2,030
Age 25-34	6,231	9,830	10,412	19,632	(4,181)	(9,802)
Age 35-44	10,843	19,860	9,515	22,288	1,327	(2,428)
Age 45-54	6,652	11,068	11,893	23,519	(5,241)	(12,451)
Age 55-64	4,804	5,088	11,880	19,063	(7,076)	(13,975)
		C	Gender			
Male	22,495	34,787	28,219	56,902	(5,725)	(22,115)
Female	12,821	18,697	20,670	33,207	(7,849)	(14,510)
		Self-report	ed Health Statu	IS		
Excellent	26,892	40,987	37,302	71,890	(10,410)	(30,903)
Good	6,661	10,107	9,693	15,598	(3,032)	(5,491)
Fair	1,461	2,029	1,854	2,581	(392)	(552)
Poor	301	361	40	40	261	320
		Fam	ily Income			
Less than \$10,000	4,236	5,585	1,895	2,355	2,341	3,230
\$10,000-24,999	10,706	14,253	4,263	5,951	6,443	8,303
\$25,000-49,999	10,268	17,108	11,716	20,019	(1,448)	(2,910)
\$50,000-74,999	3,248	4,710	8,438	14,568	(5,190)	(9,859)
\$75,000-99,999	2,022	3,004	6,878	13,785	(4,856)	(10,781)
\$100,000-149,999	2,882	6,460	7,676	15,703	(4,794)	(9,244)
\$150,000 & over	1,953	2,364	8,024	17,729	(6,071)	(15,365)
Total	35,315	53,484	48,889	90,109	(13,574)	(36,625)

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).



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## Figure B-25 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for Oregon in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits				
Impact on Small Group	Coverage					
Workers and dependents in insuring firms where ESI is discontinued	41,241	40,967				
Workers and dependents in non-insuring firms who take-up ESI	29,122	29,243				
Net change in employer coverage	(12,118)	(11,725)				
Average premium per worker- currently \$6,726	\$6,352	\$6,353				
Impact on Medica	aid					
Increase in Medicaid enrollment for people losing ESI	1,138	1,138				
Reduction in Medicaid enrollment for people gaining ESI	1,528	1,528				
Net change in Medicaid enrollment	(390)	(390)				
Change in Medicaid spending (millions)	\$1.1	\$1.1				
Impact on Non-Group (	Coverage					
Increase in non-group coverage for people losing ESI	6,695	6,649				
Reduction in non-group coverage for people gaining ESI	4,112	4,112				
Reduction in non-group coverage due to premium increase <sup>a/</sup>	722	722				
Net change in non-group	1,861	1,815				
Change in Uninsured						
People with ESI who become uninsured	33,408	33,181				
People with Non-Group who become uninsured	722	722				
Uninsured people who take ESI	23,483	23,603				
Net change in uninsured	10,647	10,300				
Other Effects						
Net change in uncompensated care (millions)	\$2.3	\$2.2				

a/ This proposal results in increased non-group enrollment for older people and reduced non-group enrollment of younger people resulting in an increase in non-group premiums averaging 1.5 percent.

## Figure B-26 Distribution of Workers and Dependents in the Small Group Market by Change in Premium under the NAIC 1993/Enzi Bill in Oregon

Change in Premium							
	Workers	Dependents	Workers & Dependents	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change
	Percenta	ge Change in F	Premiums unde	er Alternat	ive Rating Mod	dels	
-50% to -100%	0	0	0	0%	\$0.00	\$0.00	0%
-25% to -49%	49,907	40,090	89,996	17%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	77,895	56,372	134,267	25%	\$6,467.70	\$5,294.72	-18%
-10% to -1%	40,658	31,685	72,343	13%	\$6,785.58	\$6,419.59	-5%
no chg +/- 1%	6,974	5,721	12,695	2%	\$7,005.95	\$7,007.29	0%
+1% to +10%	36,568	30,374	66,942	12%	\$6,946.01	\$7,312.46	5%
10% to 24%	40,614	32,993	73,607	14%	\$6,755.94	\$7,930.54	17%
25% to 49%	36,892	28,056	64,947	12%	\$6,549.26	\$8,896.27	36%
50% - 99%	13,384	10,733	24,116	4%	\$6,774.01	\$11,170.85	65%
100% to 200%	506	333	839	0%	\$7,142.76	\$15,401.58	116%
over 200%	0	0	0	0%	\$0.00	\$0.00	0%
Total	303,396	236,356	539,752	100%	\$6,726.35	\$6,726.35	0%
			Firm Size				
2-9	147,715	100,569	248,285	46%	\$6,667.97	\$6,781.31	2%
10-24	87,925	71,156	159,081	29%	\$6,351.01	\$6,221.84	-2%
25-50	67,756	64,631	132,387	25%	\$7,340.71	\$7,261.23	-1%
Total	303,396	236,356	539,752	100%	\$6,726.35	\$6,726.35	0%

## Figure B-27 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Oregon

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	5,870	19%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	7,827	26%	\$6,467.70	\$5,294.72	-18%
-10% to -1%	3,593	12%	\$6,785.58	\$6,419.59	-5%
no chg +/- 1%	537	2%	\$7,005.95	\$7,007.29	0%
+1% to +10%	3,233	11%	\$6,946.01	\$7,312.46	5%
10% to 24%	4,028	13%	\$6,755.94	\$7,930.54	17%
25% to 49%	4,020	13%	\$6,549.26	\$8,896.27	36%
50% - 99%	1,393	5%	\$6,774.01	\$11,170.85	65%
100% to 200%	89	0%	\$7,142.76	\$15,401.58	116%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	30,589	100%	\$6,726.35	\$6,726.35	0%

## Figure B-28 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in



## Figure B-29 Summary Impact of NAIC 1993 (Enzi) Small Group Rating for Vermont in 2006

	Impact of Rating Laws Only	Impact of Rating Laws and Elimination of Mandatory Benefits
Impact on Small Group Cover	age	
Workers and dependents in insuring firms where ESI is discontinued	7,733	7,538
Workers and dependents in non-insuring firms who take- up ESI	5,310	5,339
Net change in employer coverage	(2,423)	(2,199)
Average premium per worker- currently \$7,152	\$6,712	\$6,717
Impact on Medicaid		_
Increase in Medicaid enrollment for people losing ESI	624	622
Reduction in Medicaid enrollment for people gaining ESI	692	703
Net change in Medicaid enrollment	(68)	(81)
Change in Medicaid spending (millions)	\$0.9	\$0.9
Impact on Non-Group Covera	age	
Increase in non-group coverage for people losing ESI	1,156	1,124
Reduction in non-group coverage for people gaining ESI	988	995
Reduction in non-group coverage due to premium increase <sup>a/</sup>	361	361
Net change in non-group	(193)	(232)
Change in Uninsured		_
People with ESI who become uninsured	5,953	5,792
People with Non-Group who become uninsured	361	361
Uninsured people who take ESI	3,630	3,641
Net change in uninsured	2,684	2,512
Other Effects		
Net change in uncompensated care (millions)	\$0.6	\$0.5

a/ This proposal results in increased non-group enrollment for older people and reduced non-group enrollment of younger people resulting in an increase in non-group premiums averaging 4.5 percent.



## Figure B-31 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Vermont

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	1,337	21%	\$7,116.22	\$5,265.99	-26%
-10% to -24%	1,453	23%	\$7,071.73	\$5,808.75	-18%
-10% to -1%	721	12%	\$7,005.46	\$6,593.55	-6%
no chg +/- 1%	122	2%	\$7,423.72	\$7,407.13	0%
+1% to +10%	527	8%	\$7,160.44	\$7,524.99	5%
10% to 24%	849	14%	\$7,376.35	\$8,611.26	17%
25% to 49%	781	13%	\$7,252.63	\$9,784.01	35%
50% - 99%	393	6%	\$6,794.47	\$11,329.13	67%
100% to 200%	51	1%	\$5,597.57	\$12,640.84	126%
over 200%	0	0%	\$0.00	\$0.00	0%
Total	6,233	100%	\$7,152.31	\$7,152.31	0%

#### Figure B-32 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in Vermont

	Change in Number of People with Employer Coverage in Small Group Market							
	Number that Take Up Coverage		Number t Cove	hat Drop rage	Change in Employer Coverage			
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents		
Firm Size								
2-9 Workers	1,718	2,795	2,220	3,579	(502)	(784)		
10-24 Workers	1,450	1,929	1,081	1,845	368	84		
25-50 Workers	440	615	1,228	2,114	(788)	(1,499)		
		Ме	nber Age					
Age < 25	891	1,002	279	306	611	696		
Age 25-34	1,137	1,728	717	1,321	420	407		
Age 35-44	910	1,563	592	1,286	319	277		
Age 45-54	427	754	1,242	2,156	(815)	(1,403)		
Age 55-64	243	293	1,700	2,470	(1,457)	(2,177)		
		C	Gender					
Male	2,405	3,572	2,438	4,529	(34)	(957)		
Female	1,203	1,767	2,091	3,009	(888)	(1,243)		
		Self-report	ed Health Statu	us				
Excellent	2,885	4,371	3,057	5,248	(173)	(877)		
Good	640	851	1,262	2,003	(622)	(1,152)		
Fair	83	116	207	284	(124)	(168)		
Poor	0	1	4	4	(3)	(3)		
Family Income								
Less than \$10,000	480	604	174	223	305	381		
\$10,000-24,999	1,074	1,418	442	629	632	789		
\$25,000-49,999	1,261	1,910	1,596	2,497	(335)	(587)		
\$50,000-74,999	386	642	804	1,324	(419)	(682)		
\$75,000-99,999	136	195	739	1,366	(603)	(1,170)		
\$100,000-149,999	230	527	469	828	(239)	(302)		
\$150,000 & over	42	43	306	672	(264)	(629)		
Total	3,607	5,339	4,530	7,538	(922)	(2,199)		



## Figure B-35 Distribution of Groups in the Small Group Market by Firm Size and Change in Premium under the NAIC 1993/Enzi Bill in Washington

Percent Change in Premium under Alternative Rating Models	Number of Groups	Percent of Total	Current Law Cost per Worker	Policy Cost per Worker	Average Change in Premium
-50% to -100%	0	0%	\$0.00	\$0.00	0%
-25% to -49%	3,857	9%	\$8,146.73	\$5,896.50	-28%
-10% to -24%	17,480	40%	\$7,400.79	\$5,988.77	-19%
-10% to -1%	4,011	9%	\$7,022.04	\$6,646.75	-5%
no chg +/- 1%	1,294	3%	\$6,818.58	\$6,814.77	0%
+1% to +10%	4,389	10%	\$7,558.07	\$7,945.39	5%



## Figure B-36 Change in Number of People with ESI in the Small Group Market under the Enzi Bill in Washington

	Change in Number of People with Employer Coverage in Small Group Market							
	Number that Take Up Coverage		Number that Drop Coverage		Change in Employer Coverage			
	Workers	Workers and Dependents	Workers	Workers and Dependents	Workers	Workers and Dependents		
Firm Size								
2-9 Workers	15,790	24,788	14,668	29,050	1,123	(4,261)		
10-24 Workers	9,119	12,965	8,785	16,301	333	(3,336)		
25-50 Workers	2,609	4,396	13,826	26,833	(11,217)	(22,437)		
		Ме	nber Age					
Age < 25	4,064	4,842	3,379	4,065	685	777		
Age 25-34	3,726	6,855	8,790	16,954	(5,064)	(10,100)		
Age 35-44	6,738	12,102	8,347	22,556	(1,609)	(10,455)		
Age 45-54	4,389	6,918	9,260	17,894	(4,871)	(10,976)		
Age 55-64	8,601	11,433	7,503	10,714	1,097	719		
		(	Gender					
Male	15,641	24,515	19,369	41,018	(3,728)	(16,503)		
Female	11,877	17,634	17,910	31,166	(6,034)	(13,531)		
		Self-report	ed Health Statu	us				
Excellent	20,799	32,363	29,202	57,511	(8,402)	(25,148)		
Good	5,513	7,919	7,021	12,886	(1,508)	(4,967)		
Fair	971	1,605	1,056	1,785	(85)	(180)		
Poor	234	262	0	0	234	262		
Family Income								
Less than \$10,000	3,126	4,417	822	1,158	2,303	3,259		
\$10,000-24,999	7,994	11,616	4,339	7,466	3,655	4,150		
\$25,000-49,999	7,708	12,494	11,380	19,668	(3,672)	(7,174)		
\$50,000-74,999	3,826	5,873	7,945	15,605	(4,119)	(9,732)		
\$75,000-99,999	2,091	3,055	5,321	11,552	(3,230)	(8,497)		
\$100,000-149,999	2,209	4,039	3,969	8,611	(1,761)	(4,572)		
\$150,000 & over	564	654	3,502	8,123	(2,939)	(7,470)		
Total	27,518	42,149	37,279	72,183	(9,762)	(30,034)		

## Attachment C Summary Description of the Health Benefit Simulation Model (HBSM)

## SUMMARY DESCRIPTION OF THE HEALTH BENEFIT SIMULATION MODEL (HBSM)

The purpose of this document is to provide a summary of the data and methods used in the Lewin Group Health Benefits Simulation Model (HBSM). We begin by summarizing the overall modeling approach used to simulate the cost and coverage impacts of programs to expand insurance coverage. We also provide a discussion of key components of the model that are most relevant to some of the policy proposals that have emerged in recent years. A more detailed documentation of the full model is available upon request.

We present our summary of HBSM in the following sections:


Figure C-1 Flow Diagram of the Health Benefits Simulation Model (HBSM)



HBSM is designed to facilitate comparisons of alternative health reform initiatives using uniform data and assumptions. For example, take-up rates for Medicaid and various tax credit/premium voucher proposals are simulated using uniform take-up equations and modules. Uniform methods are also used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. The model uses a series of uniform table shells for reporting the impacts of these policies on households, employers and governments. This uniform approach assures that we can develop estimates of program impacts for very different policies using consistent assumptions and reporting formats. The use of uniform processes also enables us to simulate the impact of substantially different policy options in a short period of time.

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual, given the covered services and cost-sharing provisions of the health plan provided under the proposal. This includes simulating the increase in utilization among newly insured people and changes in utilization resulting from the cost sharing provisions of the plan. In general, we assume that utilization among newly insured people will increase to the level reported by insured people with similar characteristics. We also simulate the impact of changes in cost sharing provisions (i.e., co-payments, deductibles, etc.) on utilization.

HBSM is based upon a representative sample of households in the U.S., which includes information on the economic and demographic characteristics of these individuals as well as their utilization and expenditures for health care. The HBSM household data are based upon the 1999 through 2001 Medical Expenditures Panel Survey (MEPS) that we use together with the March 2005 Current Population Survey (CPS). We also used the Kaiser/HRET survey of employers for policy scenarios involving employer level decisions. We adjusted these data to show the amount of health spending by type of service and source of payment as estimated by the office of the Actuary of the Centers for Medicare and Medicaid Services (CMS) and various agencies. The methods used to develop these baseline data are discussed below.

Changes in employer costs are assumed to be passed-on to workers in the form of changes in wage growth over time. For example, policies that increase employer costs would result in a corresponding reduction in wages for affected workers, with a corresponding reduction in income and payroll tax revenues. Similarly, reductions in employer costs are assumed to be passed on to workers as wage increases. HBSM includes a tax module that simulates tax effects due to these changes in wages as well. The model will simulate wage pass-through under varying assumptions on how long it would take for the labor markets to adjust.

The model includes a simulation of health insurance premiums in the private small group and individual markets using the range of rating practices permitted in each state. This permits us to simulate the impact of options for implementing rate compressions proposals. It is also designed to simulate "adverse selection" that may result under policies that give employers and/or individuals a choice of alternative insurance pools with their own unique rating practices.

For example, some of the proposals analyzed in this study would give employers the option of enrolling in a public insurance pool at a community-rated premium. This would tend to attract employers and individuals with high health care costs who find that the community-rated

premium is less than the cost of an experience-rated plan for that group in the private market. The HBSM insurance market simulation is based upon a "synthetic firm" methodology, which we present below.

#### B. Baseline Database

The key to simulating changes in the health care system is to develop a baseline database that depicts the U.S. health care system in detail. Our HBSM baseline data is based upon the 1999 through 2001 Medical Expenditures Panel Survey (MEPS) data, which provide information on sources of coverage and health expenditures for a representative sample of the population. These data are adjusted to reflect the population and coverage levels reported in the 2005 Current Population Survey (CPS) data (with adjustments for under-reporting discussed below). We also statistically match workers in these data to the Kaiser/HRET survey of employers which provides additional detail on coverage provided through work.

The creation of the baseline data for the model is presented in the following sections:

- Household data;
- Employer data; and
- Benchmarking data.

# 1. Household Database

The HBSM baseline data is derived from a sample of households that is representative of the economic, demographic and health sector characteristics of the population. HBSM uses the 1999 through 2001 MEPS data to provide the underlying distribution of health care utilization and expenditures across individuals by age, sex, income, source of coverage and employment status. The use of data for three years substantially increases sample size, thus permitting us to develop more stable estimates of narrowly defined policy options.

We re-weighted the MEPS household data to reflect population control totals reported in the 2005 March CPS data. These weight adjustments were performed with an iterative proportional-fitting model, which adjusts the data to match approximately 250 separate classifications of individuals by socioeconomic status, sources of coverage and job characteristics in the CPS.<sup>8</sup> Iterative proportional fitting is a process where the sample weights for each individual in the sample are repeatedly adjusted in a stepwise fashion until the database simultaneously replicates the distribution of people across each of these variables in the state.<sup>9</sup>

This approach permits us to simultaneously replicate the distribution of people across a large number of variables while preserving the underlying distribution of people by level of healthcare utilization and expenditures as reported in MEPS. These data can be further "tuned" in the re-weighting process to reflect changes in health service utilization levels (e.g.,

<sup>&</sup>lt;sup>8</sup> To bolster sample size for state level analyses, we have pooled the CPS data for 1998 through 2001. This is important when using the model to develop state-level analyses.

<sup>&</sup>lt;sup>9</sup> The process used is similar to that used by the Bureau of the Census to establish final family weights in the March CPS.

hospitalizations).<sup>10</sup> This approach implicitly assumes that the distribution of utilization and expenditures within each of the population groups controlled for in this re-weighting process are the same as reported in the MEPS data.

We also "aged" the health expenditure data reported in the MEPS database to reflect changes in the characteristics of the population through 2006. These data are adjusted to reflect projections of the health spending by type of service and source of payment in the base year (i.e., 2006). These spending estimates are based upon health spending data provided by CMS and detailed projections of expenditures for people in Medicare and Medicaid spending across various eligibility groups. The result is a database that is representative of the base year population by economic and demographic group, which also provides extensive information on the joint distribution of health expenditures and utilization across population groups.

#### 2. Employer Database

We re-weighted the MEPS household data to reflect population control totals reported in the 2005 March CPS data. The model includes a database of employers for use in simulating policies that affect employer decisions to offer health insurance. We used the survey of employers conducted by the Kaiser Family Foundation and the Health Research and Educational Trust (HRET). These data include about 2,000 randomly selected public and private employers with 3 or more workers, which provide information on whether they sponsor coverage and the premiums and coverage characteristics of the plans that insuring employers offer.

We statistically match each MEPS worker with one of the firms in the Kaiser/HRET data. Experience has shown that it is important that the individuals assigned to each firm be consistent with the employer's workforce characteristics. The Kaiser/HRET data provide information on the distribution of workers by wage level. However, additional information such as age of worker and family/single status for insured people are not included in the database. To use these data in our analysis, we statistically matched the Kaiser/HRET data with employers surveyed in the 1991 Health Insurance Association of America (HIAA) employer survey data, which provides detailed information on the characteristics of each employer's workforce including number of workers by: <sup>11</sup>

Full-time/part-time status;

- Age;
- Gender;
- Coverage status (eligible enrolled, eligible not enrolled and ineligible);
- Policy type for covered people (i.e., single/family); and
- Wage level;

The employer health plan eligibility data in the database is important to simulations of policies affecting employers. One important consideration is that many of those who do not have employer coverage work for a firm that offers coverage to at least some of their workers. About 81.5 percent of all workers are employed by a firm that covers at least some of their workers

<sup>&</sup>lt;sup>10</sup> Feature not used for RWJF study.

<sup>&</sup>lt;sup>11</sup> We controlled for worker wage levels, industry, firm size and other characteristics when matching these firms.

(*Figure C-2*). However, only about 75 percent of these people are eligible and enrolled. About 10.2 percent are ineligible and about 14.3 percent are eligible but have declined coverage.<sup>12</sup>



Figure C-2<sup>13</sup> Workers by Employer Insurance Status (in millions)

Source: Lewin Group analyses of the Medical Expenditures Panel Survey (MEPS) data.

The model controls for the workforce characteristics for each firm in matching individuals to firms. While the firm data provide information on the number of people in the firm with these characteristics, they do not provide the "joint distribution" across these groups (e.g., by age, sex, income etc.). We estimate the joint distribution for each firm using a process called "iterative proportional fitting." In this approach, we begin with the joint distribution of workers across these variables as reported nationally in the CPS, and scale them in an iterative process so that in the aggregate they replicate the aggregate number of workers in the firm for each worker characteristic. Each non-zero cell of the joint distribution matrix for each firm is treated as an individual worker, who is matched to MEPS individuals based upon these individual characteristics.

Thus, if a firm reports that it employs mostly low-wage female workers, the firm tended to be matched to low-wage female workers in the MEPS data. This approach helps assure that Kaiser/HRET firms are matched to workers with health expenditure patterns that are generally consistent with the premiums reported by the firm. This feature is crucial to simulating the effects of employer coverage decisions that impact the health spending profiles of workers going into various insurance pools. Controlling for the joint distribution of workers within firms

<sup>&</sup>lt;sup>12</sup> HBSM baseline data based upon Lewin Group Analysis of the February and March CPS data for 1997.

<sup>&</sup>lt;sup>13</sup> For example, it tells us how many workers there are in each of four age groups and the number of workers who are male and female, but it does not tell us how many of the people in each age group are males and how many are females.



provision, including exemption for people changing jobs. This approach provides an impact of potential crowd-out with and without the waiting period requirement.

Finally, we estimate an increase in enrollment among the currently eligible but not enrolled population resulting from expansions in eligibility for Medicaid and SCHIP, which has been called the "spill-over." This estimate is based upon evaluations of programs that expand coverage for children to higher income groups. One study of a coverage expansion for children in California indicated that for each newly eligible child enrolled, up 0.86 currently eligible but not enrolled children also enrolled. Similar results have been reported for SCHIP outreach programs around the country. These results are used as a basis for modeling the spill-over effect associated with Medicaid eligibility expansions.<sup>14</sup>





- a/ Based upon percentage of people eligible to participate in Medicaid who enroll.
- Probabilities of enrollment initially based upon the percentage of people without insurance who purchased non-group coverage by family income as a percentage of income.

Source: Lewin Group Estimates.

#### D. Employer and Employee Take-up Simulations

HBSM models the effects of proposals designed to expand coverage by changing the cost of insurance to the employer and the employee. These include employer tax credits, premium subsidies and other programs that subsidize and/or reduce the cost of insurance to the employer. We assume that premium subsidies will be viewed by employers and employees as a

<sup>&</sup>lt;sup>14</sup> Christopher Trenholm and Sean Orzol, "The Impact of the Children's Health Initiative (CHI) of Santa Clara County on Medi-Cal and Healthy Families Enrollment," (report to the Davil and Lucile Packard Foundation), Mathematica Policy Research, inc., September 2004.

reduction in the cost of insurance, resulting in a price response by both employers and workers. We estimate these price responses using Lewin Group multivariate analyses that measure how the likelihood of offering and taking coverage carries with the price of coverage.

In this section, we explain how we simulate employer and employee take-up in proposals that provide premium subsidies, and present some illustrative results.

# 1. Employer Decisions to Provide Coverage

We developed a multivariate model of the employer decision to offer coverage which reflects the impact of price on the employer's purchase decision. We used the 1997 RWJF Survey of Employers which provides data on a representative sample of establishments. These data include information on the size of the firm, industry and workforce characteristics of establishments. Data include both firms that offer insurance and those that do not. It also provides information on the characteristics of the health plans offered by each employer including premium costs and the share of the premium paid by the employer. These data were used to estimate a multivariate model that shows how the likelihood that a firm will offer coverage varies with wage level, workforce composition, firm size, industry, other firm characteristics and the price of health insurance.<sup>15</sup>

The effect of price on the purchase of a good or service is typically summarized by what economists call "price elasticity." For example, the implicit price elasticity for firms with under ten employees is -.87. This means that for each 1.0 percent reduction in price, there is an increase of 0.87 percent in the number of firms offering insurance. The implicit price elasticity declines as firm size increases to -0.41 for firms with 10 to 20 workers, and -0.22 for firms with 1,000 or more workers (*Figure C-4*).

<sup>&</sup>lt;sup>15</sup> While the RWJF data includes premium information for employers that offer coverage, no data is provided on the premiums faced by firms that do not offer coverage. To model the price effect we imputed premiums to non-insuring firms with a multivariate model of how premium levels vary with the workforce and firm characteristics that we estimated from the RWJF data on insuring establishments.

Figure C-4 Employer Health Insurance Price Elasticity Estimates by Firm Size <sup>a/</sup>



 a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The model simulates the effect of employer premium subsidies using this multivariate model of the employer decision to offer coverage. For each non-insuring employer in the data, we estimate the change in the price of insurance resulting from the premium subsidies. The model then simulates the decisions to offer coverage based upon the predicted price elasticity for the employer.

The model reflects variations in firm price elasticity depending upon the characteristics of the firm. For example, the model shows that the firm price elasticity tends to decline as age and income rise, as shown in *Figures C-5* and C-*6*. This results in a lower estimated price elasticity among currently insuring firms -- averaging about -0.56 for firms with 10 or fewer workers -- because the employers that offer coverage tend to have older and more highly compensated workers.

In addition, we estimated multivariate models predicting the percentage of the premium paid by the worker using the RWJF employer data. These equations measure how premium shares vary with the characteristics of the firm, their workforce and the amount of the total premium. These amounts are used to estimate the cost of insurance for workers in each firm selected to offer coverage in response to the program.

Once firms are selected to offer coverage, we simulate enrollment among workers assigned to these plans. The enrollment decision is simulated with a multivariate model of the likelihood that eligible workers will take the coverage offered to them based upon data reported in the 1996 MEPS data for people offered coverage through an employer. The model measures how take-up varies with the characteristics of the individual as well as the employee premium contribution required by the employer.

Figure C-5 Employer Health Insurance Price Elasticity Estimates for Firms with Under 10 Workers by Average Wages and Salaries per Worker <sup>a/</sup>



Average Wages and Salaries Per Worker

 a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure C-6 Employer Health Insurance Price Elasticity Estimates for Firms with Under 10 Workers by Age of Workers <sup>a/</sup>



Average Age of Worker

a/ Based upon multivariate analysis of the 1997 Robert Wood Johnson Foundation (RWJF) Survey of Employer Characteristics. "Health Benefits Simulation Model (HBSM)," The Lewin Group, August 2003.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

#### 2. Individual Take-up of Health Insurance

Also, some proposals provide tax credits to individuals for the purchase of private coverage, which can include employee contributions for ESI and premium payments for non-group coverage. We simulate the impact of these proposals based upon a multivariate analysis of how the likelihood that an individual will take coverage varies with the amount of the premium. This estimate is based upon a pooled time-series cross-section analysis of private employer coverage reported in the Current Population Survey for the 1987 through 1997 period.<sup>16</sup> These analyses indicate a price elasticity of -0.34 percent, which means that on average, a one percent real reduction (i.e., inflation adjusted) in private employer premiums, corresponds to an increase in the percentage of people with insurance of 0.34 percent.<sup>17</sup>

Our price elasticity estimates vary by age, income and other demographic characteristics. For example, the percentage increase in coverage resulting from a one percent reduction in premiums ranges from a high of 0.55 percent among people with incomes of \$10,000 to 0.09 percent among people with incomes of \$100,000 *(Figure C-7)* (i.e. a price elasticity of -0.55 to -0.09). Similarly, the percentage increase in coverage resulting from a one percent reduction in premiums ranges from 0.46 percent for people age 20 to 0.30 percent among people age 60 *(Figure C-8)* (i.e. a price elasticity of -0.46 to -0.30). Thus, the model shows that older people and people in higher income groups are less sensitive to changes in price than other population groups.





\$0 \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000 \$70,000 \$80,00**\$**90,000 \$100,000 Income

a/ Indicates a price elasticity ranging between –0.55 to -0.09 by income. Source: Lewin Group estimates.

<sup>&</sup>lt;sup>16</sup> This required imputing premiums based upon employer survey data developed by the Kaiser Family Foundation (KFF) and the Health Research and Education Trust.

<sup>&</sup>lt;sup>17</sup> See Sheils, J., Haught, R., "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy", (report to The National Coalition on Health Care), The Lewin Group, October 18, 1999.

Figure C-8 Percentage Change in Coverage Resulting from a One-PePercentage179.954 45ultin6.99.954 45ult0ion



# Figure C-9 Estimated Cost of Selected Health Benefits Plans <sup>a/</sup>



in premiums (25 percent)]. This is then applied to the number of people in the affected group who now have coverage (about 19.2 million workers) to estimate the change in coverage, which we estimate to be about 3.0 million workers (i.e., 15.5 percent increase over 19.2 million covered workers).

# E. Insurance Market Simulation Model

A number of proposals have emerged in recent years that would offer people a community rated alternative to private coverage, resulting in shifts in coverage and possibly adverse selection. Other proposals would alter the way in which insurance is regulated that would have differential impacts by age of policy-holder and other health risk groups. Examples of these policies include proposals to permit small employers to purchase coverage through the Federal Employees Health Benefits Program and creation of "association health plans (AHPs)" that are exempt from state insurance rating regulations.

We developed HBSM into a model of insurance markets. We did this by creating an employer database that holds information on both firm characteristics and the demographic and health spending information for each individual in those firms. Because no such database now exists, we matched firms in the KFF/HET data to individuals in the HBSM MEPS household data such that for each firm, there is one MEPS worker for each of the workers that each firm reported they employed. This type of database is typically referred to as a "Synthetic Firm" database.

Using these data, we can simulate the premiums each firm would be charged in their market based upon the rating practices and state regulations that apply in each state. The health expenditure data in the database permits us to simulate experience rating and medically underwritten premiums. These data provide a basis for estimating how employer premiums would be affected by changes in regulation of premiums. It also permits simulation of the potential for adverse selection under proposals creating government sponsored insurance pools.

In this section, we describe the creation of the synthetic firm data and the methods used to simulate the effect of proposed health reforms. Our discussion is presented in the following sections:

- Creating Synthetic Firm Database;
- Rating methods for insurance pools;
- Take-up for non-insuring firms;
- Employer shift to less comprehensive coverage;
- Worker take-up; and
- Example policy simulation.

#### 1. Synthetic Firms

To be able to simulate employer decisions under alternative health reform plans, it is necessary to develop a database of "synthetic firms" that include both detailed information on employer health plans and the health service use of each worker and dependent in each firm. We create one synthetic firm for each worker in the MEPS data. Once the worker is assigned to one of the KFF/HRET employers, we populate the firm by statistically matching each firm to a sample of

workers randomly drawn from the MEPS data for 1999 through 2001, who match the workforce profiles estimated for each firm in the database.<sup>23</sup>

The model simulates health insurance premiums for each synthetic firm based upon the rating rules used in each state and reported health expenditures for workers and dependents assigned to each firm. Premiums are estimated for each firm based upon the rating rules that apply in the firm's state of residence. This includes the use of age rating and rating bands in the small group market where applicable, experience rating for larger firms and costs for self-funded plans. This simulation of the premiums employers face in the marketplace is crucial to analyses of proposals that would modify rating practices, or offer coverage alternatives such as small employer pools using their own rating methods.

*Figure C-11* presents the distribution of employers in the Lewin model by average benefits costs per-member-per-month (PMPM) under a standard benefits package. We estimate average premiums of about \$283 PMPM in 2006, which includes benefits and administrative costs for employer health plans over the number of covered workers and dependents. There is wide variability in health plan costs due to differences in administrative costs, claims experience, health status rating and variations in rating practices across states.



Figure C-11 All Insuring Employers by Premium Cost PMPM in 2006: Includes Benefits and Administration <sup>a/</sup>

a/ Estimates for a standard benefits package. Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

<sup>&</sup>lt;sup>23</sup> For example, an insuring firm with five low-wage females who work part-time would be matched to five low-wage females in MEPS who are working part-time and have employer coverage.

*Figure C-12* illustrates that the variability in PMPM premium costs varies widely across employers by size of group. For example, among firms with fewer than 10 workers, PMPM premiums range from about \$460 for firms in the 10 percent most costly firms compared with average costs of \$157 for firms in the 10 percent least costly firms. By comparison, PMPM premiums in firms with 1,000 or more workers vary from \$372 for the 10 percent most costly groups to \$215 for the least costly 10 percent of firms.

#### Figure C-12 Estimated Average Health Insurance Costs (PMPM) for Most Costly and Least Costly 10 Percent of Employer Groups in 2006: Includes Benefits and Administration <sup>a/</sup>



a/ Estimates for a standard benefits package. Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

#### 2. Modeling the Effect of Insurance Pools

One of the most crucial elements of insurance pooling models is the manner in which pool premiums are determined. As discussed above, group premiums in today's market typically vary with the age of the worker, health status and experience (i.e., claims history). Many proposals would use mechanisms for determining premiums in the pool that differ from those used in the insurance markets. This can have a dramatic effect on coverage and premiums in both the pool and the traditional insurance market. There are three ways in which premiums are set under most small group proposals. They include:

• **Uniform Pool Premium:** In this model, premiums in the pool are set at a single amount per enrollee regardless of age and risk factors. Some of those proposals that would extend FEHBP to small groups would permit plans to charge only a single uniform premium that varies only with family status (i.e., single vs. family etc.). This approach would tend to attract higher-cost groups that find the premium in the pool to be less than what they are paying in the traditional insurance market.

- **Risk factor rating of pool premiums:** In this model, plans in the pool are free to set premiums according to any risk factors they choose. This means that pools can fully adjust for health status and age even in states that limit the use of health status and age ratings in the traditional market. Under this model, groups with younger and healthier members would tend to enroll in the pool because they can offer these groups lower premiums than can be charged in the traditional market. Premiums in the traditional market typically increase due to the migration of lower-cost people to the pool.
- State rating laws apply in pool: Under this approach, plans selling coverage in the pool must follow the same rating rules that apply to coverage sold in the traditional market, including limit on age and health status rating. Under this model, premiums in the pool are expected to be the same and in the insurance markets, except to the extent that the pool can achieve savings in administration and/or benefits costs.

Thus, if the pool is less able to vary premiums with risk factors than the insurers in the traditional market, the pool will tend to acquire a disproportionate share of high-cost groups, with lower-cost people remaining in the traditional market. Conversely, if rating variation in the pool is permitted to be greater than is required in the traditional insurance market, the pool will acquire lower-cost people that left the higher-cost population in the traditional insurance market. This phenomenon - known as "adverse selection" - can have significant implications for the distribution of groups across the pool and traditional insurance markets. This, in turn, will result in premium adjustments in the pool and the traditional insurance market, which will result in further shifts in coverage.

*Figure C-13* illustrates how the model would simulate a pool that is required to set its premiums based upon the average cost of people enrolled in the pool, regardless of risk characteristic. The figure shows the distribution of insuring firms based on the premiums the firms would pay permember per-month (PMPM) under current insurer rating practices. If the pool were established with a uniform premium of \$283 – which is our estimate of the average premium in the small group market in 2006 – firms with premiums in excess of that amount would enroll in the pool with the rest remaining in the traditional market. Under this example, the premium in the pool would need to be increased to \$356 PMPM to collect premiums sufficient to meet pool costs.

The model simulates these effects on the equilibrium price of insurance in an iterative process. For example, in this example the small pool premium is reset at \$356 PMPM while the premium for those who remain in the traditional insurance market is adjusted to reflect the migration of more costly groups to the pool. Similarly, premiums in the traditional market are adjusted to reflect the accumulation of lower-cost people in the pool. Enrollment in the pool and the private market is then re-simulated at these premium levels. This process is repeated multiple times to arrive at an equilibrium pool enrollment and premium estimate (equilibrium is defined to be the point where total costs are roughly equal to the cost of benefits and administration for the pool).

The model can also simulate the effect of permitting greater variation in premiums by risk factors than is permitted in the traditional market. Under this model, the pool would tend to accumulate lower-cost groups with higher-cost groups remaining in the traditional market. We simulate the resulting changes in premiums in the pool and the insurance markets using the

iterative process described above; the pool and the insurance market are in equilibrium (i.e., premiums equal costs).





Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Pool premiums are affected by other factors as well. For example, some non-insuring employers are expected to enroll as coverage at a lower premium is made available to them. Also, some small group pool proposals permit the sale of coverage that is exempt from state regulations of insurance such as mandatory benefits and solvency standards. This would tend to attract lowercost groups that are more willing to accept the reduction in benefits in exchange for the lower premium. Our approach to modeling these effects is summarized below.

#### Employer Decision to Shift to Lower-cost Plans 3.

The impact of insurance pools on firms that already offer coverage is more complex in cases where benefits under the pool differ from those now offered by the employer. For example, the President has proposed the creation of small group insurance pools - called "Association Health Plans (AHPs)" - that would be exempt from state minimum benefits requirements. While the exemption from mandated benefits reduces the cost of insurance (estimated to be 5.0 percent to 7.5 percent), many employers will prefer to continue with their existing benefits.

a/ Estimates for a standard benefits package.

# 5. Individual Market Simulations

We model the effects of changes affecting non-

mandatory benefits add between 5.4 percent and 22.0 percent to the price of insurance.<sup>25</sup> However, this is believed to overstate the cost impacts on coverage because most consumers would want to retain many of these benefits. The Congressional Budget Office (CBO) has assumed in its analyses of Association Health Plan proposals that preempting mandatory benefits would reduce premiums by 5.0 percent.<sup>26</sup> However, none of these studies valued mandatory benefits costs at the state level.

In this analysis, we assumed that mandatory benefits in New York increase premiums by about 10.0 percent. This assumption is based upon discussions with New York actuaries in earlier studies, and our own analysis of the cost of some of the major mandatory benefits in the state including mental health, substance abuse and maternity care. A summary of mandatory benefits in New York is attached.

We estimated the impact of the mandatory benefits exemption in other states based upon a similar analysis of the cost of key mandatory benefits in each state. These estimates were all adjusted to be in proportion to our assumption of 10.0 savings for New York. *Figure C-15* presents our estimates of the cost of mandatory benefits as a percentage of premiums for each of the states with community rating.

#### 2. Learning from the Health New York (HNY) Program

New York is unique in that it already offers a benefits package that is exempt from minimum benefits to firms that do not now offer insurance. The HNY program permits carriers to offer a benefits package that is exempt from minimum benefits to small firms employing lower-wage workers that have not offered coverage in the past 12 months. To qualify, an employer must meet the following requirements:

- Thirty percent of workers must have annual earning of less than \$32,000;
- The firm must have 2 to 50 workers;
- The employer must pay at least half of the premium;
- At least half of workers must enroll; and
- The firm must not have offered coverage in the past 12 months.

The cost of the benefits package is also subsidized through a state funded re-insurance program which pays 90 percent of benefits costs between \$7,500 and \$75,000 for individual enrollees (costs in excess of \$75,000 are the responsibility of the carrier). Low-income individuals and sole proprietors are also eligible for the program.

<sup>&</sup>lt;sup>25</sup> General Accounting Office (GAO). (1999, August). "Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance" (GAO/HEHS-96-161). Washington, DC

<sup>&</sup>lt;sup>26</sup> Baumgardner, J., et al. (2000, January), "increasing Small-Firm Health Insurance Coverage through Association Health Plans and Health Marts. Washington DC: Congressional Budget Office (CBO).

The combined effect of the subsidy and the exemption from mandatory benefits is estimated to be 28 percent, with the exemption from mandatory benefits accounting for 10 percent and the subsidy accounting for the remainder.<sup>27</sup>

#### Figure C-15 Estimated Percentage of Premiums Attributable to Minimum Benefits Provisions in States using Community Rating

		Major Mandatory Benefits			
States with Community or Modified Community Rating	Mandatory Benefits as a Percent of Premiums	Maternity Care	Mental Health	Substance Abuse- Alcohol	Substance Abuse – Alcohol and Drugf

to elimination of certain benefits affect the likelihood of offering coverage. However, we can assume that the price response associated with a shift to fewer benefits will be less than the response to a change in premiums for a given benefits package.

Instead, we estimated the impact of the exemption from mandatory benefits based upon the experience of the Health New York (HNY) program, which allows carriers to sell a benefits package that is free of mandatory benefits. This program is available only to small employers of lower-wage workers who have not offered insurance for at least 12 months.

Because a benefits package free of mandatory benefits is already available in New York for lower-wage small groups, the mandatory benefits exclusion would have no impact the lowwage groups in New York. Based upon the figures presented in *Figure C-16*, about 68 percent of workers and dependents in small non-insuring firms are in the low-wage firms that already have access to such a package. Thus, the mandatory benefits exemption under the Enzi Bill could potentially affect only 32 percent of workers and dependents in New York's non-insuring firms in addition to insuring firms in the small group market.

We estimated the impact of the exemption from mandatory benefits based upon the percentage of eligible people in small firms who enrolled in the HNY. There will be an estimated 30,000 people in small firms who will be enrolled in HNY in 2006. This is equal to about 2.9 percent of all people in non-insuring firms that meet the earnings eligibility rules of the program.

The next step was to adjust the estimated take-up rate for eligible small firms (i.e., 2.9 percent) to reflect that much of the reduction in premiums in HNY is attributed to the reinsurance subsidy. Data from the 2005 evaluation of HNY indicated that reinsurance premium subsidies have reduced premiums for small firms by about 19 percent.<sup>28</sup> We estimate an additional 10 percent reduction in premiums for HNY due to the mandatory benefits exclusion. We then prorated enrollment across these two sources of savings in proportion to the amount of the premium reduction. This resulted in a take-up rate of 1 percent attributed to the mandatory benefits exemption.

We incorporated this into our estimated price response by adjusting the implicit price elasticity for each firm so that it is in proportion to the adjusted enrollment rate for firms that are eligible for HNY (i.e., 1.0 percent). This was estimated based upon the ratio of the adjusted Health New York take-up rate (1.0 percent) to the percentage increase in enrollment for that group that would have been predicted with the price elasticity models alone.<sup>29</sup>

<sup>&</sup>lt;sup>28</sup> "Report on the Healthy New York Program 2005," (report to the State of New York Insurance Deaprtment), EP&P Sonsulting Inc., December 31, 2005.

<sup>&</sup>lt;sup>29</sup> This is computed by taking the ratio of the HNY enrollment rate (1.0 percent) among eligible firms to the percentage of HNY eligible firms that would have been estimated to enroll based upon the price elasticity estimates alone.

# Table C-16Estimated Percentage of People in Small Group Market Enrolled in the<br/>Healthy New York Program.

	Workers and Dependents in Non-Insuring Firms					
	Eligible for Healthy New York Program	Not Eligible for Healthy New York Program				
Workers and Dependents in Non-insuring Firms with 2 to 50 Workers <sup>a/</sup>						
Workers	662,530	315,670				
Dependents	348,637	122,910				
Total in Non-insuring Firms	1,011,167	438,580				
Small Firms Enrolling in Healthy New York <sup>b/</sup>						
Number Enrolled In Healthy New York	30,648	NA				
Percent Enrolling	2.9%	NA				
Percent Enrolled Adjusted for to Subsidy Effect	1.0%	NA				

a/ Includes workers and dependents in firms with 2 to 50 workers. Estimates exclude those who are covered under a spouse's health plan as a dependent.

b/ HNY data for participating carriers indicate that reinsurance subsidies reduced premiums by 19 percent in addition to the 10 percent reduction due to the mandatory benefits exclusion.

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).