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March 7, 2006

Mr. Todd McCracken
President
National Small Business Association
1156 15th Street, NW
Suite 1100
Washington, D.C.

Subject:
Health Insurance Marketplace Modernization and Affordability Act of 2006

Dear Todd:

In 2003 the National Small Business Association (NSBA) engaged Mercer Oliver Wyman Actuarial Consulting, Inc. (Mercer) to analyze the "Small Business Health Fairness Act of 2003" (H.R. 660 and S. 545). This legislation would have encouraged the formation of federally certified Association Health Plans (AHPs) by exempting these plans from various state laws that govern health insurance sold to small employers today. In that analysis, we identified several components that would, in our opinion, result in segmentation and destabilization of the small group market that would drive average premiums higher and cause fewer employers to be insured. A copy of this original report can be found at the following website: www.nsbaadvocate.com/docs/mercer_ahp_report.pdf.

A new bill, "Health Insurance Marketplace Modernization and Affordability Act of 2006," (HIMMAA) sponsored by Senators Enzi and Nelson is being offered. Its goal is to eliminate or neutralize those factors in the original bill that would cause the adverse results in our modeling, while improving the small group market. In lieu of AHPs, the HIMMAA enables the formulation of Small Business Health Plans (SBHPs). The NSBA has engaged Mercer to model the key elements of the HIMMAA to determine if the corrective actions included in the bill will have the intended results, according to our model.

Executive Summary

Mercer used an actuarial model it had developed for its 2003 analysis to assess how the HIMMAA proposed legislation would affect small firms' premiums and the number of uninsured in this market compared to the results in our original study.

This new analysis shows that federal SBHP legislation will alleviate some of the health insurance cost pressures faced by small employers. Many of the components of the previously proposed AHP legislation that caused an increase in the number of uninsured have been removed or modified. According to our modeling, the proposed SBHP legislation will result in a decrease of approximately 900,000 members in the number of uninsured. This represents an 8% decrease in the uninsured in the small employer market.

In brief, we found that once federal SBHP legislation is fully implemented:

- In aggregate, small employers will experience modest decreases in their health insurance premium costs. Health insurance premiums would decrease by 12% in aggregate for all small employers. The magnitude of decreases will vary significantly by state. The premium decreases will be modest in states that already have adopted rating regulations equal to or broader than those contained in the proposed legislation. The aggregate premium decreases will be greater in states that currently have very restricted rating rules.

- SBHPs would increase the number of insureds as a result of NAIC-based rating rules, low cost options and administrative efficiencies. The number of insureds in the small group market increases by approximately 900,000. This increase would result from attracting better risks into the rating pool through the introduction of NAIC rating rules in many states, the availability of low cost plans, and administrative efficiencies associated with streamlining of filings and other administrative processes among the states.

- The proposed legislation eliminates the rating advantage federal AHPs would have had under previously proposed legislation. Because AHPs were not subject to state regulations including rating rules, they would have been able to generate lower premiums through a combination of expanded rating bands and risk selection processes, including re-underwriting at time of renewals, that state-regulated insuring entities were either precluded from using or whose use was limited. The proposed SBHP legislation has eliminated this unfair playing field by including rules to prevent these problematic practices and requiring all insuring entities to abide by the same regulations.

- Our modeling of SBHP legislation results in a net increase of almost 2 million insured members when compared to our modeling of proposed AHP legislation. AHPs generated "savings" by enjoying a preferred playing field when compared to the insuring entities operating in the state-regulated markets. While this competitive advantage may benefit some employers in the short run, it results in segmentation of the market in the long run. The result was higher aggregate costs and more uninsureds for the market as a

whole after four years. SBHP legislation has eliminated the unfair playing field and introduced reforms affecting the entire market. This results in lower costs and fewer uninsureds for the market as a whole.

These results indicate that SBHP legislation may be part of a multi-faceted solution to rising health care premiums for small employers. It is not the sole solution since this legislation does not address the underlying cause of high premiums, such as the high cost of health care in general, advanced technologies, or the demands of an aging society.

Critical Assumptions Regarding the Interpretation of the Bill

The results presented in this letter are based upon interpretations we have made regarding provisions in the bill. If these interpretations are not consistent with the language contained in the final bill, then our results may not accurately reflect the impact the legislation may have on the market.

Scope of Analysis: The scope of our analysis is limited to small groups as defined by HIPAA, employer groups consisting of two to fifty employees. We have not considered the impact of extending this definition to include groups of size one or groups larger than fifty employees.

Fully Insured SBHPs: SBHPs must be fully insured and marketed by state licensed insurance companies and or HMOs (collectively referenced as insuring entities throughout the rest of the letter). These insuring entities must meet the capital and solvency requirements within each state that they operate; comply with the consumer protection laws in each state; pay the applicable premium taxes; and be part of any assessments associated with high risk pools and/or guarantee funds.

Level Playing Field: Insuring entities would be allowed to create SBHPs directly and/or adopt SBHP rules for their non-SBHP business. This creates an even playing field. We are also assuming that insuring entities that have been operating in individual states with more restrictive rating rules will be able to operate in these states under the same rules as new entrants.

Federal Rating Rules: The SBHP federal rating rules are those contained in the Model Small Employer Health Insurance Availability Model Act of 1993 adopted by the National Association of Insurance Commissioners (NAIC). We will reference this as the NAIC Model Bill. The NAIC Model Bill allowed for unlimited use of the following case characteristics: age, gender, geographic area, family composition, group size, and participation in wellness programs. Industry can also be used as a case characteristic but the highest factor cannot be more than 15% greater than the lowest factor. We will reference these case characteristics as rating factors.

Within a class of business, rates for groups with identical case characteristics can vary ±25% from the index rate for morbidity. An index rate in one class cannot exceed an index rate in another class by more than 20%. The maximum rate increase any employer group can receive during any twelve month period is the change in case characteristics plus medical trend plus 15% for morbidity.

Mandated Benefits: SBHPs would be allowed to market plans that will not be subject to all state benefit mandates. We will refer to these as "low cost plans." The version of the bill that we analyzed required SBHPs to offer only those mandates that have been adopted by forty-five or more states. It has come to our attention that other forms of low cost plans are being considered. Our assumption regarding savings from mandated benefits will be applicable as long as these other forms result in benefits that are not richer than the benefits resulting from the forty-five state rule.

Assumptions

The following section describes the differences in the key assumptions between the current analysis and the previous study. If an assumption is not cited, then it is identical to that employed in the original analysis.

Savings from Mandated Benefits: Our original analysis provided for a cost savings of 5% from mandated benefits and 2.5% savings from avoidance of other state-regulated costs such as premium taxes, assessments for state high-risk pools, participation in state guarantee funds and solvency requirements. Since SBHPs must be fully insured, these licensed insuring entities will be subject to the premium taxes, assessments and solvency requirements in place in each state. Thus, the savings from mandated benefits will be reduced from 7.5% to 5.0%.

Administrative Savings: In our original analysis, we did not assume any savings associated with administrative costs. There are provisions within HIMMAA that provide for "harmonization" of certain consumer protections and regulatory reporting processes that currently vary significantly by state. If these are fully realized, we believe that insuring entities operating in multiple states should be able to realize some administrative savings. Since not all insuring entities operate in multiple states, the savings associated with harmonization will vary by company. We believe a conservative estimate is a savings of 2.5% from harmonization of state regulation.

Price Responsiveness: Unlike our original model which simulated movements between the regulated market, the AHP market and the uninsured market, this analysis focuses on the movements between the insured market and the uninsured market. The reason for this difference

is our assumption that SBHPs will not have any rating advantage resulting from an unlevel playing field over the insuring entities operating in each of the states. This eliminates the need to simulate how groups will move between two insured markets operating under different rating rules as was the situation with AHP proposed legislation. The SBHP model is designed to explain how small employers will migrate between the being insured and uninsured over time under different starting rating rules.

In order to determine the migration between the insured and uninsured market, we need to make assumptions regarding the price responsiveness for different types of firms (typically referred to in the economic literature as "elasticity of demand"). Elasticity determines the number of groups that will add or drop insurance due to changes in premiums.

In our original AHP modeling, we needed to consider cross elasticity, or the price responsiveness of groups willing to retain insurance, but move between two differently regulated markets. Since SBHP proposed legislation creates an equal playing field from a rate regulation perspective, we do not need to consider cross elasticity.

We have retained all the other elasticity assumptions contained in the original report.

Premium Variation: There is a significant variation among regulations adopted by individual states. Some states require pure community rating (where age/gender, morbidity and other case characteristics are not allowed); some require community rating by class (where case characteristics may be used, but rates cannot vary by health status or experience); and some have adopted the NAIC Model Law or similar rating structures; some states have adopted rating rules that are more liberal than the NAIC Model Law. A few states have not adopted any rating restrictions in the small group market. Many states have "customized" the NAIC Model Law to restrict certain rating factors; reduce the variation associated with morbidity; reduce the maximum annual increase associated with changes in morbidity.

We have reviewed the rating regulations in the various states using multiple sources and have grouped the states into three broad classifications based upon the existing rating laws which we shall reference as Class:

- Class 1: Pure Community Rating
- Class 2: Community Rating by Class through NAIC Model Law with rating bands less than ±25%
- Class 3: NAIC Model Law with rating bands equal to or greater than ±25%. This includes states with no rating rules as well.

Our model assumes that SBHPs would be able to charge premiums consistent with the NAIC Model Law or the state-specific rating regulations if those state-specific regulations are more liberal than the NAIC Model Law. Insuring entities operating in states with rating laws that are more restrictive than the NAIC Model Law could also select under which rating rules they wish to operate. We are assuming that all insuring entities will choose the more liberal NAIC Model Law rating rules in these states.

Health Care Cost Inflation: As in the original study, this analysis does not consider health inflation. This is such an important factor that we are including it here, even though it has not changed. The premiums are frozen at 2000 levels. This will enable the reader to directly compare the results of this analysis with the results or our original AHP modeling. The changes in premiums predicted by both models will be in addition to underlying health cost inflation.

We believe these assumptions are reasonable based on our review of existing literature as documented in the original paper and our knowledge of the health care marketplace and actuarial principles. As with any model, however, the results are sensitive to the assumptions used. Analyses using different assumptions will generate different results.

Methodology

Establishment of Baseline Population: As in the original AHP study, we created a baseline population to simulate the characteristics of the current small employer health insurance market. Data from the Employee Benefit Research Institute (EBRI) was used to estimate the number of members in the small group market within each state.[1] The corresponding premium for small groups for each state was estimated from the 2000 Medical Expenditure Panel Survey (MEPS).[2] Unlike the original study, we needed to develop a baseline for each rating Class. We then aggregated the baselines from the three Classes. *The aggregate baseline has not changed from our original study.*

The "baseline" market represents the actual market as of 2000 and includes both insured and uninsured. We estimate that there were about 24.8 million members (workers and dependents) insured in the small group market, representing $51.7 billion in premium in 2000. The average premium per worker for these groups was about $4,000 in 2000 (Table 1).

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1 Employee Benefit Research Institute tabulations of data from the March 2001 Current Population Survey

2 Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2000 Medical Expenditure Panel Survey - Insurance Component.

Table 1: Baseline Insured Small Group Population	
Premium	$ 51,702,891,556
# Groups	1,843,749
# Employees	12,906,244
# members	24,779,988
Premium Per Employee	$ 4,006.04

We estimate that there are another 11.7 million people in families headed by someone who works for a small employer who are uninsured in the baseline market.

Simulation of Market Changes: We used the same small group data that we employed in our original study. These data were from insurers operating in the small employer market in states that had not adopted any limitations in rates or had adopted the initial NAIC model or a variation of that model which provided for a wider range of rating flexibility. This sample data represented about one million members. The information included an average age/gender factor, a morbidity factor, premiums and claims for an entire year. The morbidity factors for each state were indexed so they all represented a percentage of an index rate (midpoint rate).

Some of the data received was from states with some type of rating restrictions, albeit, more liberal rating restrictions. Even liberal rating restrictions have an impact on the decision of some employers to purchase insurance or become uninsured. As such, modifications were made to the data received to account for the impact of the rating restrictions. Distributions from states without rating restrictions were used to perform the modifications.

The next step was to develop SBHP premium (which includes the assumed aggregate 7.5% savings SBHPs will enjoy: 5% from relief of mandated benefits and 2.5% from harmonization of functions across state lines) for each Class.

The model simulates the movement of groups entering the market and leaving the market. The movement in and out of the insurance market is determined by the elasticities previously described in this report. Our results reflect the market after HIMMAA is fully implemented and the transition period is fully completed, which we will reference as the “ultimate market.”

For each Class, estimates are made regarding the overall change in the premiums for the insured market at the end of each year. Changes in the premiums are determined by comparing the change in morbidity and age/gender. Premiums in each market are adjusted accordingly.

As in the original model, a random variable representing material changes in morbidity is applied to the entire population to simulate significant changes occurring at the group level. This also simulates changes in morbidity that may result in a rate change in the aggregate. The rate increase due to change in morbidity at the specific group level is limited to 15% per year in the NAIC Model Bill.

As in our original model, uninsured groups cannot become insured in subsequent years unless there is a premium that is less than the premium that this group would have paid (if they had been insured) during the baseline.

This process is replicated through four renewal periods for each class.

Normalization: The results for each year are then normalized to the population within that Class. The results of all Classes are then added to generate aggregate nationwide results

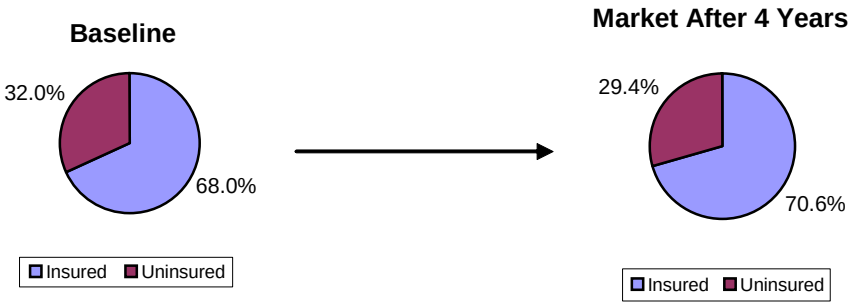
Results

Overall Findings

SBHP legislation will expand insurance coverage versus a reduction in coverage if proposed AHP legislation was enacted. Our analysis concludes that the proposed SBHP legislation will have a positive impact on the number of uninsured in the small employer market and could be part of a multi-faceted approach to resolving the high cost of medical insurance premiums.

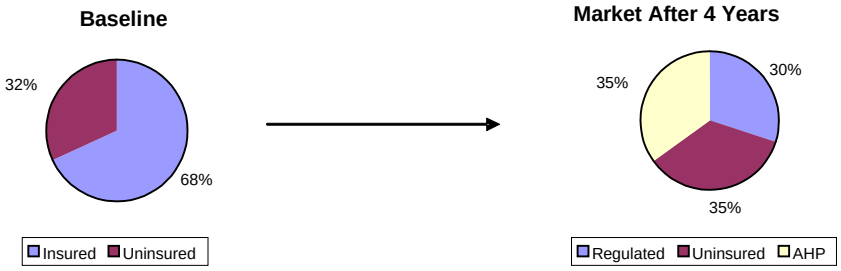
Enrollment in small employer insured plans would increase from 24.8 million members in the baseline to 25.7 million after 4 years. The percentage of the entire small employer group market that is uninsured would drop from 32% in the base year to 29% after 4 years.

Figure 1: Summary Impact of SBHP Legislation on Enrollment in the Small Employer Marketplace



This compares to the results of our analysis of proposed AHP legislation which resulted in a decreased enrollment in the insured market as shown in the following chart.

Figure 2: Summary Impact of AHP Legislation on Enrollment in the Small Employer Marketplace



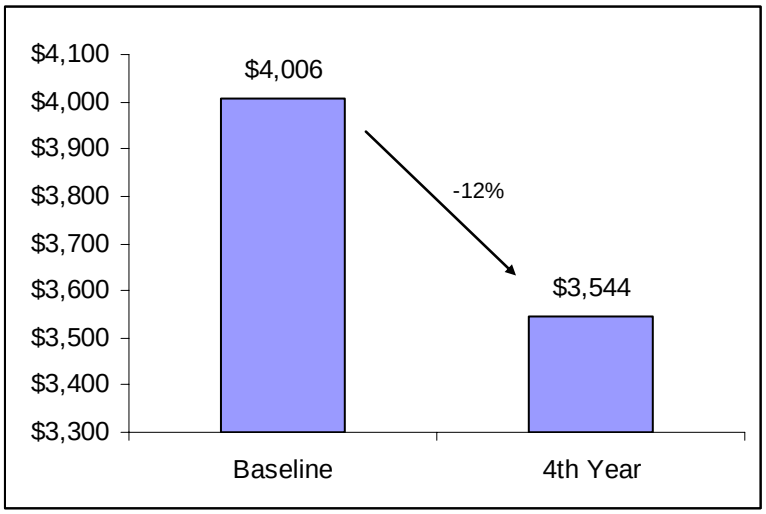
Our model of previously proposed AHP legislation showed that the total number of insured in the small employer market would decline from 24.8 million members in the baseline to 23.8 million after 4 years as a result of firms dropping coverage in response to the introduction of AHPs. The proposed SBHP legislation would result in an increase in the number of insured of almost one million members, or a net gain of almost 2 million members between the two bills.

Specific Results

Impact on the Cost of Health Insurance for Small Employers

Small employers would enjoy modest decreases in health insurance costs compared to a 6% net increase generated by proposed AHP legislation. The proposed SBHP legislation would result in aggregate health insurance premiums decreasing by 12 % for small employers nationwide.

Figure 3: Aggregate Change in Health Insurance Premiums SBHP Legislation



The following chart shows the details of the average change in premiums.

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

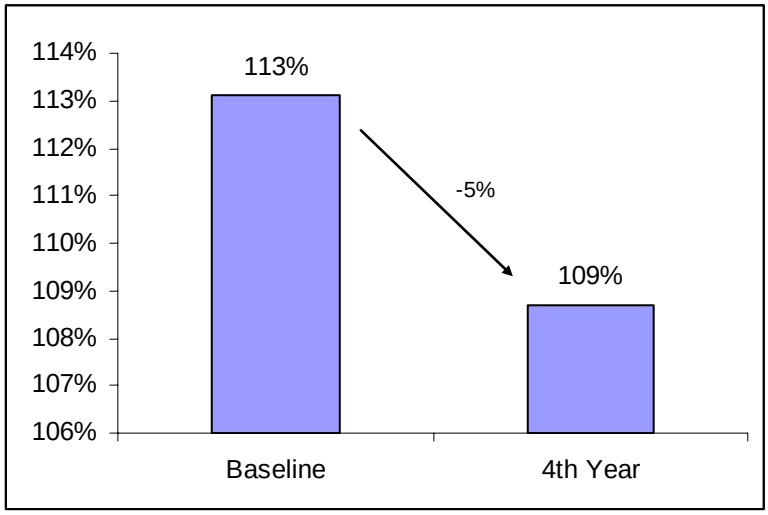
Lower premiums result in an increase in the number of insureds.

This decrease in premium compares to a net premium *increase* of 6% generated when we modeled proposed AHP legislation.

The decrease in premium for SBHPs is attributable to the expansion of rating bands and rating factors in some states, introduction of low cost plans and savings resulting from standardization of some administrative processes among the states.

As shown in Figure 4, the aggregate morbidity of the insured market improves by 5%. This is a result of attracting the healthier, previously uninsured risks into the pool.

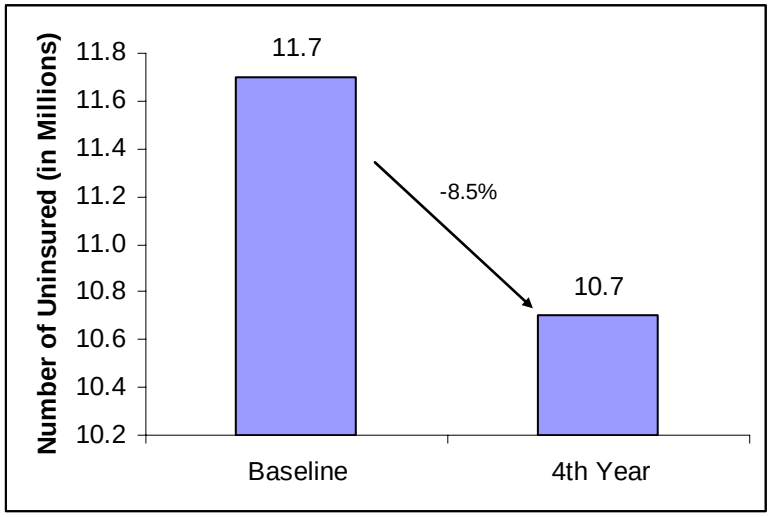
Figure 4: Changes in Aggregate Morbidity for SBHPs



Impact on the Uninsured

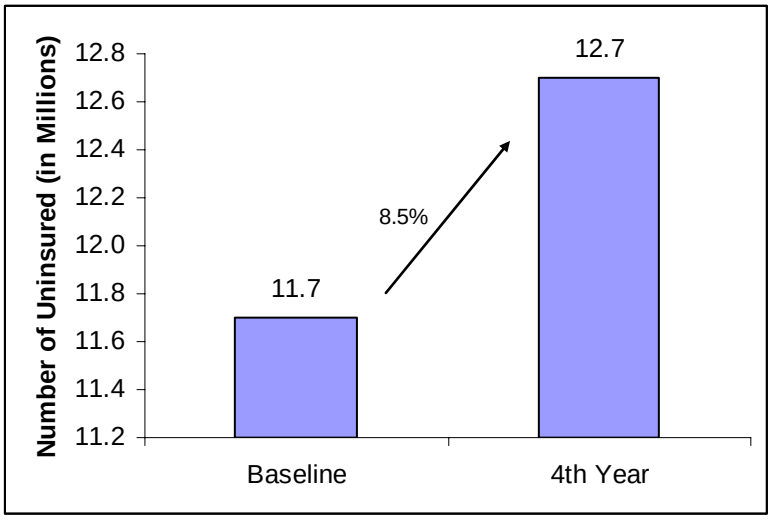
SBHP legislation would decrease the number of uninsured by 900,000 compared to a net increase in the number of uninsured under AHP legislation. The modeling estimates a 900,000 decrease in the number of uninsured in the small group market if SBHP legislation is enacted.

Figure 5: Changes in the Number of Uninsured under Proposed SBHP Legislation



This compares to the results of our modeling of AHP legislation.

Figure 6: Number of Uninsured in Small Group Market Increase by Almost 1 Million under AHP Legislation



These results indicate that the HIMMAA legislation includes significant improvements over the previously proposed AHP legislation. Our model shows that if the legislation as we have described in this letter is enacted, the aggregate small group premium per employee will decrease by about 12%, the number of people with insurance in the small group market will increase by slightly under one million members and the number of uninsured will decrease by the same amount. This compares to a net increase in premium of 6% and net increase in the number of uninsured of almost 1 million under proposed AHP legislation.

While the SBHP legislation has potential to reduce the number of uninsured, it is not going to address the underlying causes of high health insurance premiums, which are high health care costs. However, it can be part of an integrated approach to make health insurance more accessible to a significant number of employers in the small employer market.

We cannot emphasize enough how dependent our results are on the assumptions we have stated in this letter. We have modeled the ultimate market, after all states are through the transition period. Material changes to the legislation, such as a reduction in the deviations allowed for variation from the index rate from ±25% to ±10%, transition rules that fail to create an even playing field, failure to standardize certain administrative functions such as filings, market conduct audits, financial reviews, and consumer protections, will significantly impact our modeling results.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Karen Bender

Beth R. Fritchen

Karen Bender, FCA, ASA, MAAA

Beth Fritchen, FSA, MAAA