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Report to the Ranking Minority Member, Committee on Small Business and Entrepreneurship, U. S. Senate

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PRIVATE HEALTH INSURANCE

Small Employers Continue to Face Challenges in Providing Coverage

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Abbreviations

AHRQ	Agency for Healthcare Research and Quality
COSE	Council of Smaller Enterprises
EBRI	Employee Benefit Research Institute
EPO	exclusive provider organization
ERISA	Employee Retirement Income Security Act
GPCI	Geographic Practice Cost Index
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
HRET	Health Research and Educational Trust
MEPS	Medical Expenditure Panel Survey
NAHU	National Association of Health Underwriters
POS	point of service
PPO	preferred provider organization

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United States General Accounting Office
Washington, DC 20548

October 31, 2001

The Honorable Christopher "Kit" Bond
Ranking Minority Member
Committee on Small Business
and Entrepreneurship
United States Senate

Dear Senator Bond:

Many small employers—generally defined as those with 50 or fewer employees—do not offer health benefits to their workers. This is particularly true for the smallest employers—those with fewer than 10 employees. Partly as a result, workers employed by small employers, and these workers' families, are about twice as likely to be uninsured as individuals in households with a worker at a large employer. The Congress and states have enacted laws and continue to consider proposals intended to assist small employers in purchasing coverage, but many small employers continue to cite cost as a major obstacle to providing coverage. Concerned about the affordability of health insurance for small employers, you asked that we review the challenges small employers face in providing health insurance for their employees. Specifically, we examined

- small and large employers' health insurance premiums and benefit plans,
- insurers' costs to provide health insurance to small and large employers,
- the effect of state efforts to restrict the premiums that insurers charge small employers, and
- other state efforts to help make coverage more affordable for small employers.

To compare premiums for coverage offered by small and large employers and the health characteristics of individuals insured through small and large employers, we analyzed data available from the Agency for Healthcare Research and Quality's (AHRQ) Medical Expenditure Panel Survey (MEPS)—both its survey of employers' health plan premiums (insurance component) for 1996 and 1998 and its survey of individuals' demographics, employment, health characteristics, and medical spending

and utilization (household component) for 1996.[1] We obtained unpublished data from the Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) *Employer Health Benefits 2000 Annual Survey* to compare aspects of health plans provided by small and large employers. Unless otherwise noted, the MEPS and Kaiser/HRET data include health plans that are fully insured—that is, the employer purchases the plan from a third-party insurer—and those that are self funded—that is, the employer assumes some or all of the financial risk associated with providing coverage. To analyze the effects of state premium restrictions, we obtained premium quotes through insurance agents affiliated with the National Association of Health Underwriters (NAHU) for three hypothetical small employers in a selected city in each of five states (California, Florida, Maryland, New York, and Texas) with varying approaches to regulating insurance premiums for the small group market. To obtain state-specific information on the small group market, we interviewed state insurance regulators in these states. We also interviewed health policy experts, insurers,[2] actuaries, and associations representing these groups; reviewed relevant literature on the small group health insurance market; and drew on our earlier work.[3]

Appendix I provides more detailed information on our methodology. We performed our work from April 2000 through October 2001 in accordance with generally accepted government auditing standards.

Results in Brief

Small and large employers purchasing health insurance had, on average, comparable premiums in 1998, but this comparison does not fully capture the challenges facing small employers in providing health insurance for their employees. Although the premiums were similar, the health plans offered by small employers were slightly less generous on average—they had slightly higher average cost-sharing requirements for their employees and were somewhat less likely to offer some benefits, excluding, for

[1]The 1996 version of the MEPS household component was the most recently available at the time of our analysis that had complete information allowing us to link individuals' characteristics, including health status, and their insurance status, including the size of the employer offering their coverage. We were able to use the most recently available MEPS insurance component (1998) to compare premiums among small and large employers.

[2]For the purposes of this report, the term "insurers" is used to include managed care organizations and insurance carriers that provide fee-for-service health insurance coverage.

[3]A list of related GAO products is included at the end of this report.

example, mental health services and chiropractic care. Furthermore, many small employers would likely have had to pay higher-than-average premiums if they provided coverage to their uninsured workers and dependents, including those who were offered coverage but declined and those who were not offered coverage. Based on self-reported health characteristics, uninsured workers and their families at small employers were less healthy than those who were insured by comparably sized employers; and in most states, insurers could charge more to groups with less healthy individuals.

Insurers' costs to administer employer-based health insurance and protect against potentially large health care costs result in a larger share of small employers' premium dollars being spent on these nonbenefit expenses than large employers'. From 20 percent to 25 percent of small employers' premiums typically go toward expenses other than benefits, compared with about 10 percent for large employers. These administrative expenses include insurers' marketing and billing, which increase the per-person cost of insurance more for smaller groups than for larger ones because there are fewer people to share the cost. In addition, insurers bear other expenses that are unique to or higher for small employers, including expenses incurred to protect themselves from potentially large health care costs. For example, because they cannot predict the health status and the accompanying costs of small groups as well as they can for large groups, insurers in many states are allowed to review the medical history of each individual in the group and charge higher premiums for groups with individuals in poor health, a practice known as medical underwriting. Insurers are most likely to medically underwrite very small groups for which there is the greatest concern that the employers are purchasing coverage only because they anticipate a need for it. Insurers may also add a surcharge to a small employer's premium to lessen the impact of potentially large health care costs.

Nearly all states have enacted laws that limit the extent to which insurers can vary premiums charged to small employers on the basis of the health and other risk factors of the group. State laws that more tightly restrict variation in premiums can make coverage more affordable for small employers with high-risk employees but may also increase the cost of insurance for healthier groups. For example, in New York, a state with tight restrictions, a small employer with older workers, including some in poor health, would pay the same premium as an employer of the same size and geographic location with younger, healthier workers. In contrast, a small employer in Texas with older and less healthy workers could pay two and a half to nearly four times as much as an employer of the same

size and geographic location with younger, healthier employees. Twelve states did not allow insurers to adjust premiums for the health characteristics of enrollees in 1996. Small employers in these states had average premiums about 6 percent higher, compared with the other states, when adjusted for geographic differences in cost of physician services.

Besides premium restrictions, other state efforts to make insurance more affordable for small employers have had limited results. Few small employers appear interested in lower-cost benefit packages that require significantly higher cost sharing by individuals or that scale back the benefits that are covered. Pooling small employers into purchasing cooperatives makes it easier for employees to access a broader selection of plan options, but it has not resulted in reduced premiums when compared to similar plans available outside of the cooperatives. A few states have recently established programs that provide temporary tax incentives or subsidies to encourage small employers to offer coverage to their employees. However, previous studies of the effects of tax incentives on individual and small employer behavior suggest that the incentives need to represent a significant portion—half or more—of the premium and to be in place permanently to result in any significant number of newly covered individuals.

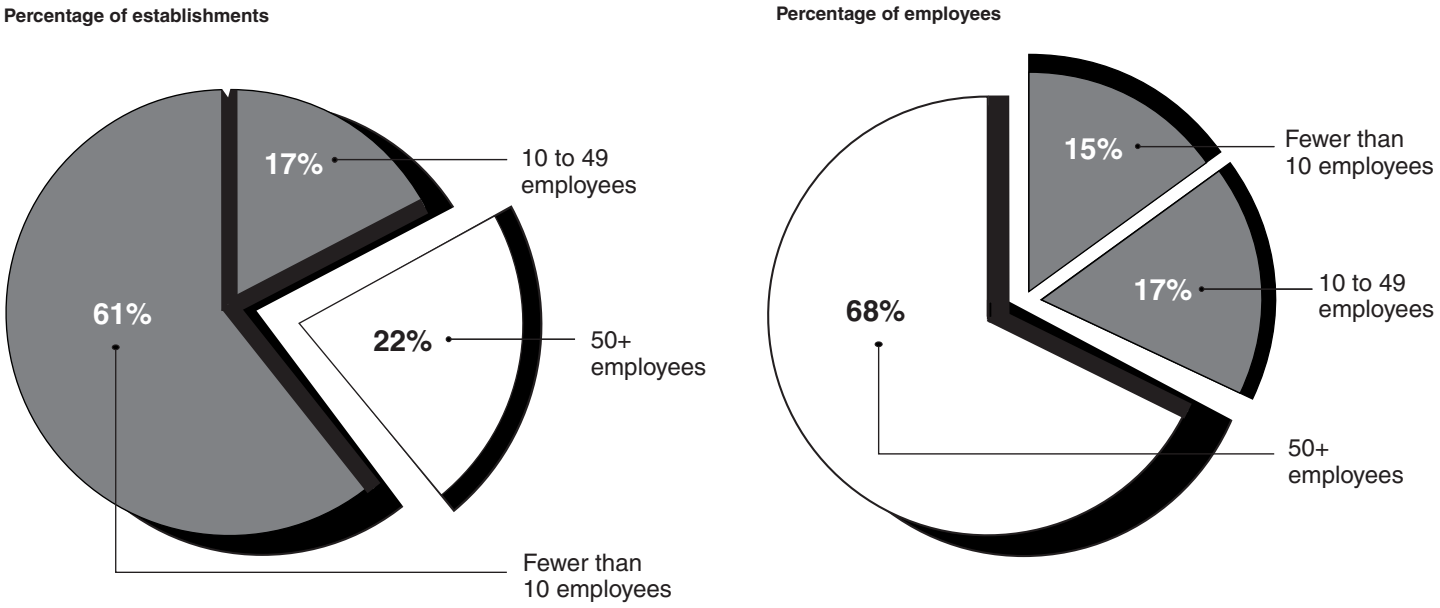
Background

Small employers with fewer than 50 employees represent more than three-fourths of all U.S. private establishments and employ nearly one-third of the private sector workforce. (See fig. 1.) However, small employers are less likely than large employers to offer health insurance to their employees. In 1998, whereas 96 percent of employers with 50 or more employees offered health insurance, 71 percent of employers with 10 to 49 employees provided coverage and only about 36 percent of employers with fewer than 10 workers offered health benefits to their employees.[4] The primary reason small employers cited for not offering coverage was cost.[5]

[4]Data are from AHRQ's MEPS Insurance Component, 1998, and GAO analysis.

[5]See Paul Fronstin and Ruth Helman, "Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey," *EBRI Issue Brief No. 226 and Special Report SR 35*, Employee Benefit Research Institute (Oct. 2000), p.15.

Figure 1: Small Employers Make Up the Majority of U.S. Private Establishments, But Employ a Smaller Share of Private Sector Employees, 1998



Source: AHRQ's MEPS Insurance Component, 1998.

During the early 1990s, concern about small employers' access to health insurance and the affordability of providing coverage to their employees led most states to adopt small group insurance market reforms. While the extent and scope of reforms varied across states, most states included

- reforms guaranteeing that small employers seeking coverage would be accepted for at least certain plans offered by insurers (known as guaranteed issue);
- guarantees that small employers could renew health insurance even if they had high claims except under certain circumstances, such as the failure to pay premiums (guaranteed renewal);
- limits on how long insurers could deny coverage for medical conditions individuals had at the time they obtained coverage (limits on preexisting condition exclusions); and
- limits on the variation allowed in premiums.

States regulate insurance products sold within their borders, but their laws do not affect all employers. The Employee Retirement Income Security Act of 1974 (ERISA) generally preempts states from directly regulating employer-sponsored health plans. Thus, employers that assume the risk for, or "self-fund," their employees' health benefits are largely exempt from state regulation, including premium taxes and mandated benefits.[6] The MEPS data from 1998 show that approximately 52 percent of large employers self-funded at least one health plan, compared with 11 percent of small employers.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established minimum federal standards that further enhanced state efforts to ensure access to health insurance for small employers. While many of the state reforms already met or exceeded the HIPAA minimums, HIPAA ensured consistency in the definition of small employers (those with 2 to 50 employees) and established minimum standards regarding guaranteed issue, guaranteed renewal, and limits on preexisting conditions applying to both insured and self-funded health plans. States could exceed these minimum standards in their own statutes and regulations. While HIPAA helped ensure that small employers would have access to insurance, it did not impose any restrictions on premiums or otherwise address the affordability of insurance for small employers.

[6]All states have enacted laws that require insurers to provide certain health care benefits. Every insurance plan to which the mandates apply must provide certain specified coverage. In addition, some mandates require that insurers make certain benefits available. While specific mandated benefits vary considerably by state, they commonly include treatment for alcoholism, coverage for mammograms, and coverage for a variety of health care services including those from chiropractors and podiatrists.

Similar Premiums for Small And Large Employers May Mask Coverage Differences And Potentially Higher Costs to Small Employers for Those Not Insured

Average annual health insurance premiums—the total amount paid by both employers and employees—were nearly the same for small and large employers in 1998. Small employers' premiums were slightly higher than large employers' for single coverage and slightly lower for family coverage. However, while small and large employers paid similar premiums, small employers' coverage was generally less generous—their plans covered slightly fewer benefits and required those insured to pay higher out-of-pocket costs. Furthermore, many small employers would likely have had to pay higher than average premiums if they had provided coverage to their uninsured workers and their dependents, including those who were offered coverage but declined and those who were not offered coverage. This is because more of these uninsured individuals reported not being in excellent health than did those with insurance and most states allow insurers to charge small employers higher premiums to cover individuals in poorer health.

Small Employers Pay About the Same as Large Employers But Get Less Value

Overall, average health insurance premiums for small and large employers varied only slightly. The total amount paid by the employer and employees for single coverage was on average slightly higher for small employers than for larger ones in 1998. Specifically, the average annual single premium was 4 percent higher ($83 more) for all small employers and 8 percent higher ($182 more) for the smallest of these—those with fewer than 10 employees. Average annual family premiums, however, were lower for small employers compared to large employers—about 3 percent lower for all small employers ($180 less) and 7 percent lower for the smallest of these ($357 less).[7] (See table 1.) Within these average premiums, however, employers may find a considerable range of available premiums. For example, analysis of 1996 MEPS data indicates that annual single premiums at the smallest employers ranged from $995 to $4,540 per employee—about 456 percent—in 1996. In comparison, single premiums at

[7]Workers covered through small employers more often purchase single rather than family coverage, perhaps in part because small employers typically pay a slightly higher share of single premiums and a slightly smaller share of family premiums than large employers. Specifically, according to 1998 MEPS data, 59 percent of workers covered through small employers had single coverage compared to 45 percent through large employers, with the remainder having family coverage. Small employers paid an average of 86 percent of single premiums and 72 percent of family premiums; large employers paid an average of 81 percent for single coverage and 76 percent for family coverage.

small and large employers varied by about 369 percent and about 306 percent, respectively.[8]

Table 1: Average Annual Single and Family Premiums by Size of Employer, 1998

	Average annual premiums[a]		
Type of coverage	Smallest employers (fewer than 10 employees)[b]	Small employers (fewer than 50 employees)	Large employers (50 or more employees)
Single	$2,334	$2,235	$2,152
Family	$5,265	$5,442	$5,622

[a]Premiums represent both employee and employer shares.

[b]These employers are also included in calculating the premiums for small employers.

Source: AHRQ's MEPS Insurance Component, 1998.

While small and large employers generally paid, on average, about the same amount for health insurance coverage, small employers received less value for their premium dollars for several reasons. Small employers generally purchased coverage with higher cost-sharing requirements for their employees compared to larger employers. Also, small employers tended to receive slightly fewer covered benefits for the same premiums paid by large employers.

To make coverage more affordable, small employers tend to purchase plans that require higher deductibles and higher maximum annual out-of-pocket costs for their employees. Average annual deductibles in preferred provider organizations—the plan type most often purchased by workers covered by small employers[9]—are more than $100 higher for employers

[8]These ranges represent the 5th to the 95th percentiles. Average annual family premiums varied by 371 percent at the smallest employers while they varied 322 percent at small employers and 332 percent at large employers. The variation in premiums may result from several factors, including differences in benefits purchased and the risk characteristics of groups purchasing coverage.

[9]A preferred provider organization is a type of managed care plan that offers a choice of health care providers but offers financial incentives to use preferred health care providers. In 2000, 40 percent of workers covered by small employers purchased preferred provider organization plans compared to 25 percent purchasing point-of-service plans, 23 percent purchasing health maintenance organization plans, and 12 percent purchasing indemnity plans.

with 3 to 50 employees than for larger employers.[10] A higher deductible typically translates into a lower premium. For example, actuarial experts estimate that a plan with an annual $200 deductible would reduce claims costs by about $65 per year compared to the same plan with a $100 deductible.[11] Further, workers covered through small employers typically are potentially liable for higher out-of-pocket costs than those employed by larger employers. Specifically, about 35 percent of workers covered through small employers have maximum annual out-of-pocket limits that are $2,500 or more, compared to about 20 percent of workers covered through large employers.[12]

In addition, workers covered through small employers are less likely to receive certain benefits. As shown in figure 2, while workers covered through small employers were nearly as likely as those covered through large employers to have coverage for prescription drugs and adult physicals, they were slightly less likely to have coverage for other services such as prenatal care and mental health.[13] The largest differentials between small and large employers—as much as 15 percentage points—were for benefits less likely to be covered by employers of any size, such as chiropractic care, oral contraceptives, and acupuncture.

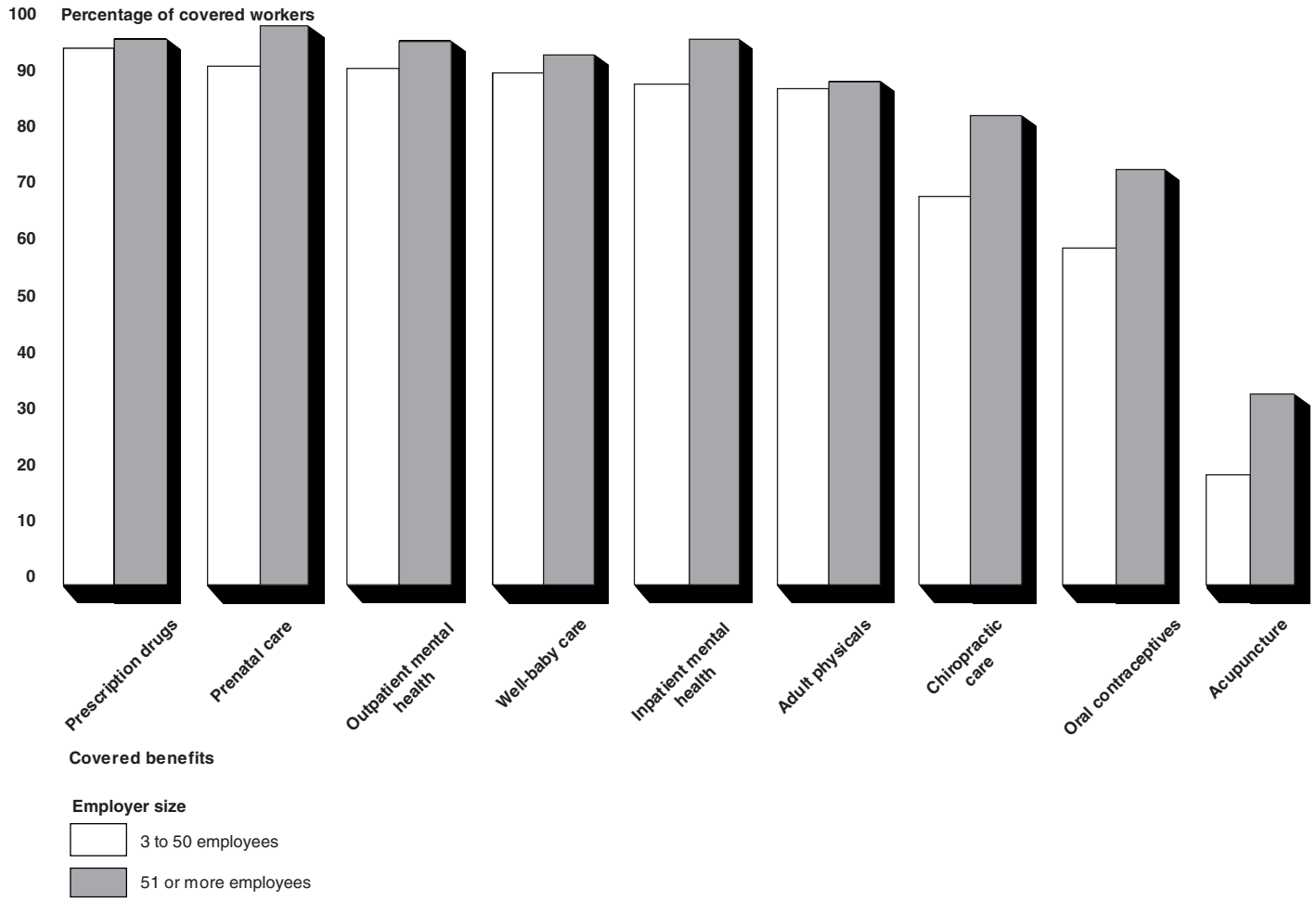
[10]These are unpublished data from Kaiser/HRET *Employer Health Benefits 2000 Annual Survey*. For preferred provider organizations, the average annual deductible for preferred providers is $281 for employers with 3 to 50 workers compared to $174 for larger employers; for nonpreferred providers the average annual deductible is $489 for small employers compared to $344 for large employers. The differentials in deductibles are considerably less among fee-for-service and point-of-service plans.

[11]William F. Bluhm, Principal Editor, *Group Insurance* (Winsted, Conn.: ACTEX Publications, Inc., 2000), p.438.

[12]These are unpublished data from Kaiser/HRET *Employer Health Benefits 2000 Annual Survey*. Small employers' workers enrolled in preferred provider organizations also had less generous lifetime maximum benefits—10 percent had lifetime maximums of less than $1 million compared with 3 percent of those in large employer plans.

[13]Under the Pregnancy Discrimination Act of 1978 health insurance sponsored by employers with 15 or more workers must cover expenses for pregnancy-related conditions on the same basis as it does for other medical conditions. Firms not offering prenatal care benefits are primarily those with fewer than 15 employees. Unpublished data from the Kaiser/HRET *Employer Health Benefits 2000 Annual Survey* indicate that 85 percent of workers insured through the smallest employers—employers with 3 to 9 workers—had coverage for prenatal care whereas 97 percent of workers covered by employers with 25 to 50 employees were in plans containing prenatal care benefits.

Figure 2: Comparison of Selected Benefits Offered, by Employer Size, 2000



Source: GAO analysis of unpublished data from Kaiser/HRET *Employer Health Benefits 2000 Annual Survey*.

Insured at Small and Large Employers Reported Similar Health Characteristics

Individuals covered by small employers' health care plans had, on average, health characteristics that were similar to those insured through large employers. Table 2 shows that selected demographic and self-reported health characteristics of individuals insured through small and large employers did not vary significantly. Specifically, whether they were insured through small or large employers, about the same percentages of individuals reported excellent physical and mental health. Moreover, nearly the same percentage of those insured through the smallest

employers—those with fewer than 10 employees—reported being in excellent health (39.5 percent).

Table 2: Selected Demographics and Self-Reported Health Characteristics for Individuals Insured Through Small and Large Employers, 1996

	Individuals insured through employers[a]	
Selected demographics and self-reported health characteristics	**Small employers (2 to 50 employees)**	**Large employers (51 or more employees)**
Demographics		
Average age in years	29.8	29.7
Percentage less than 40 years old	67.0%	67.3%
Percentage with self-reported health characteristics		
Select medical conditions[b]	26.1%	27.0%
Excellent physical health	43.0%	40.2%
Excellent mental health	51.8%	50.6%

[a]Individuals insured through employers include workers and their covered dependents.

[b]Select medical conditions include those that AHRQ identified as prevalent, expensive, or relevant to policy. These include conditions that are (1) long-term and life-threatening—such as cancer, (2) chronic and manageable—such as arthritis, and (3) of policy interest—such as Alzheimer's disease.

Source: GAO analysis of AHRQ's MEPS Household Component, 1996.

Uninsured at Small Employers May Be Greater Health Risks and Could Prompt Higher Premiums

Compared to individuals insured through small employers, uninsured workers at these employers and their dependents appear to be less healthy.[14] Therefore, they could represent greater risks to insurers if small employers provided coverage to the uninsured. As shown in table 2, individuals insured through small employers had similar self-reported health characteristics when compared to those insured through large employers. However, our analysis of 1996 MEPS data shows that uninsured workers and their dependents at small employers considered themselves to be less healthy than their insured counterparts.[15] This difference was particularly evident for workers from age 30 to 64 years

[14]Uninsured workers include those who are not offered health insurance coverage and those who are offered coverage but decline it.

[15]Overall, the self-reported health status of individuals in households in which one adult works for a small employer was similar to those in households in which an adult works for a large employer. We do not report the self-reported health status of individuals in the small employer households who may be insured through public programs or other sources.

and their dependents.[16] The MEPS data showed that a smaller share of uninsured individuals in this age group reported being in excellent physical health—about 27 percent—compared to about 36 percent for insured people of similar ages. In addition, a smaller percentage of uninsured individuals reported having excellent mental health. (See table 3.)

Table 3: Self-Reported Health Characteristics for Workers of All Ages and Workers 30 to 64 Years Old, Including Their Dependents, by Insurance Status at Small Employers, 1996

	At least one individual in household works for small employer (2 to 50 employees)			
	Workers of all ages and dependents		Workers 30 to 64 years old and dependents	
Self-reported health characteristics	Insured	Uninsured	Insured	Uninsured
Excellent physical health (percent)	43.0	34.7	36.4	27.1
Excellent mental health (percent)	52.0	44.6	47.0	37.0

Source: GAO analysis of AHRQ's MEPS Household Component, 1996.

Unless prevented from doing so by state law, insurers often screen small employers for health and other risk factors associated with their workers when setting health insurance premiums and charge more for higher-risk groups. For example, we obtained premium quotes for hypothetical small employers in a selected city in each of four large states. Table 4 shows that in Austin, Texas the relatively high-risk small employer group would pay anywhere from 82 percent to 290 percent more than a relatively low-risk group. In the other three locations, premium quotes were 29 percent to 132 percent higher for the relatively high-risk small employer group.[17] Small

[16]We focused on the self-reported health characteristics of individuals from 30 to 64 years of age because a high proportion of younger individuals is uninsured regardless of the size of their employers.

[17]HIPAA's nondiscrimination provisions prohibit insurers or employers from excluding, providing less coverage to, or charging higher premiums to any individual in a group due to his or her health status, but the entire group could be charged a higher premium (or have benefit exclusions). Also, HIPAA requires insurers to offer insurance to any small employer, but does not restrict the premium charged. Some state laws may provide further restrictions on underwriting or premiums, as discussed in the following sections.

employers that had workers considered to be higher risk typically would have had to pay more for health insurance than healthier groups for the same coverage.

Table 4: Percentage Difference in Monthly Premiums for Low- and High-Risk Hypothetical Small Employer Groups in Selected Localities

	Percentage difference in premium quotes obtained from different insurers for low- and high-risk small employer groups	
Locality	**Lowest difference**	**Highest difference**
Austin, Texas	82	290
Baltimore, Maryland	29	132
Orlando, Florida	65	94
Sacramento, California	36	82

Notes: Ranges represent differences in premium quotes obtained from multiple insurers in selected states. For example, for Baltimore, Maryland, five insurers provided 10 premium quotes for the low-risk hypothetical small employer group and 10 quotes for the high-risk group. The lowest of the 10 differences between the quotes for the low- and high-risk groups was 29 percent and the highest was 132 percent.

We also collected premium quotes for a fifth location—Albany, New York—but premiums did not vary in Albany because state law allows premiums to vary only by geographic location, number of employees and dependents covered, and type of coverage purchased.

The lowest risk group consists predominantly of individuals in their 20s. The highest risk group consists of women of childbearing age, men in their 50s, several smokers, and one individual with juvenile-onset diabetes. See appendix II for a detailed description of the hypothetical small employer groups.

Source: Premium quotes obtained from agents in collaboration with NAHU.

Insurers' Costs to Provide Coverage Are Higher for Small Employers

Insurers' administrative costs and expenses (other than benefits) are higher for small employers than for large employers. As a result, insurers spend a smaller share of small employers' premium dollars on benefits and more on administrative and other expenses than they do for large employers'.[18] For smaller employers, administrative costs such as marketing and billing are spread over fewer people. Furthermore, because large employers typically assume the risk for their employee health

[18]Health insurance premiums are typically composed of two elements—the expected medical claims associated with the benefits covered and the insurers' costs for the administrative activities required to provide coverage. Insurers typically set premiums by applying a "loading factor"—that is, an additional charge—to the expected medical claims of the group. This loading covers the insurers' administrative expenses, such as billing, enrollment, claims payment, taxes, risk charges, underwriting, broker commissions, overhead, and profit, and varies by type of plan and the size of the group being insured.

benefits by self-funding rather than purchasing insurance, other expenses, such as premium taxes, can be avoided. Insurers also report the potential for adverse risk selection—or purchasing of insurance by those with relatively high health care needs—is greater with the smallest groups, and to remain financially viable, insurers generally take steps to avoid covering a disproportionate share of these costly groups. Therefore, insurers may attempt to mitigate the difficulty of predicting the risk of a small group compared to a large group by reviewing the medical history of individuals in the group—called medical underwriting—or adding a premium surcharge to better ensure that they can cover costs resulting from unexpectedly large health care costs.

Administrative Costs Account for More of Small Employers' Premiums

Our analysis of existing data indicates that, overall, insurers' administration costs and expenses, other than benefits, typically account for about 20 percent to 25 percent of small employers' premiums compared to about 10 percent of large employers' premiums.[19] These expenses can range from around 5 percent to 30 percent of the premium dollar, depending on the size of the employer, type of plan, and insurer.[20] The smaller the size of the group the larger the share of the premium that goes towards paying for expenses other than benefits. This is due in part to the fact that small employers have fewer individuals over which to spread expenses and certain costs are lower or can be avoided by large employers. Insurers' administrative activities, such as marketing and billing, increase small employers' premiums more because, with fewer people to share the costs, they cannot obtain the financial savings afforded to larger groups. For example, if it costs an insurer $5 a month to generate a bill for each employer, this cost spread over a group of five people would increase each person's monthly premium by $1. In contrast, for a group with 100 people this same activity would increase the monthly premium for each person by only 5 cents.

In addition, some expenses associated with insurance for most small employers may be avoided or reduced for large employers who assume the

[19]This estimate is based on our analysis of information from health insurance experts, published studies, and health insurers.

[20]Data from the late 1980s indicate a larger differential in administrative costs, with small employers' administrative costs as high as 40 percent of premiums compared to costs as low as 5 percent for large employers. However, some of these differences may have narrowed due to the growth in managed care and improvements in information technology.

financial risk for their employees' health coverage or perform some administrative functions internally. By self-funding, large employers avoid expenses such as state premium taxes assessed on insurance sold in the state that typically represent about 1 percent to 3 percent of health insurance premiums.[21] In addition, large employers may perform some administrative activities, such as employee enrollment and education, which insurers or agents perform for, and therefore charge, small employers. Large employers typically purchase insurance with the assistance of benefits consultants, whom they pay a fixed hourly or lump sum fee. A recent survey by Kaiser/HRET estimated that the average administrative cost borne internally by large employers—those with 200 or more employees—for providing health benefits is approximately $250 per covered worker.[22] This would increase the cost per covered employee by approximately 6 percent. Small employers, on the other hand, typically purchase insurance through agents whose fees can account for as much as 8 percent to 10 percent of the insurance premium.

Insurers May Screen Small Employers More Closely for Potential Risks

Where permitted by state law, insurers may also incur additional expenses assessing small employers' risks and protecting themselves against the greater uncertainty in risk associated with these groups. Insurers are more concerned about increased financial risk to cover people through small employers for three reasons. First, insurers are unable to predict risk as accurately for small employers as they are for large employers. Estimates of a group's future expenses that are based on prior health care use tend to be more accurate the larger the group is.[23] Actuaries indicate that until a group approaches about 500 people its prior health care use and costs are not reliable enough to be the only data used in setting premiums. Second, insurers report that small employers, especially those with two or three employees, may be costly because they are more likely to seek coverage only when their employees anticipate needing it, a phenomenon known as adverse selection. Third, since smaller groups generate smaller amounts of

[21]ERISA preempts all state law as it pertains to an employee benefit plan, except such laws regulating state insurance and premium taxes. States, however, maintain the ability to regulate and impose taxes on insurance sold in their state. Self-funded health plans are generally not deemed to be insurance and are not subject to state insurance regulations or taxes.

[22]Comparable data are not available regarding the costs borne internally by employers with fewer than 200 employees.

[23]The concept that events cannot be predicted for a few individuals but can be forecast relatively accurately for a large group of individuals is known as the law of large numbers.

premium revenue, insurers may be less willing to assume the potential risk of one individual incurring a catastrophic accident or illness that could elevate costs significantly and generate expenses exceeding premium revenues contributed by the group as a whole.

To protect against these risks, insurers may review the medical history for each individual in the small group and set the group's premiums accordingly—a practice known as medical underwriting. The degree to which medical underwriting is done depends on the size of the group. Very small groups are often screened most extensively, with each person required to provide a detailed medical history. As the group size increases, approaching 20 individuals or more, fewer questions may be asked. Such individual level assessments are not typically done for large employers so this cost accrues only for insurers when selling coverage to small employers.

Furthermore, some insurers may add a surcharge of 1 percent to 5 percent of small employers' premiums to increase their financial reserves—a pool of money they invest to help ensure that there will be sufficient funds should an unanticipated large expense occur. This surcharge tends to be higher when the insurer is less certain of the risk of the group and may be imposed in lieu of or in addition to medical underwriting. However, not all states permit these activities and not all insurers underwrite small groups or add a risk surcharge.

State Reforms to Restrict Small Employers' Premiums Have Varying Impact

Most states have enacted laws—generally referred to as state rating reforms—that restrict how much small employers' health insurance premiums can vary. How these restrictions affect premiums depends on the latitude each state allows insurers when setting these premiums. Nearly all states have restricted insurers' ability to vary small employers' premiums to some degree. Tight restrictions allow no or little variation in premiums, while looser restrictions allow premiums to vary widely according to the health risk and demographic characteristics presented by each small employer. In states that do not allow insurers to set premiums based on health status, small employers with employees who have health conditions pay the same premiums as those with employees who do not have any health conditions, all other characteristics being the same. In states allowing insurers to adjust premiums for health and other characteristics, premiums for small employers with high-risk employees can be several times higher than those for employers with low-risk employees. Overall, average premiums, adjusted for geographic differences in the cost of physician services, were about 6 percent higher in states that did not allow rates to vary for employees' health status than

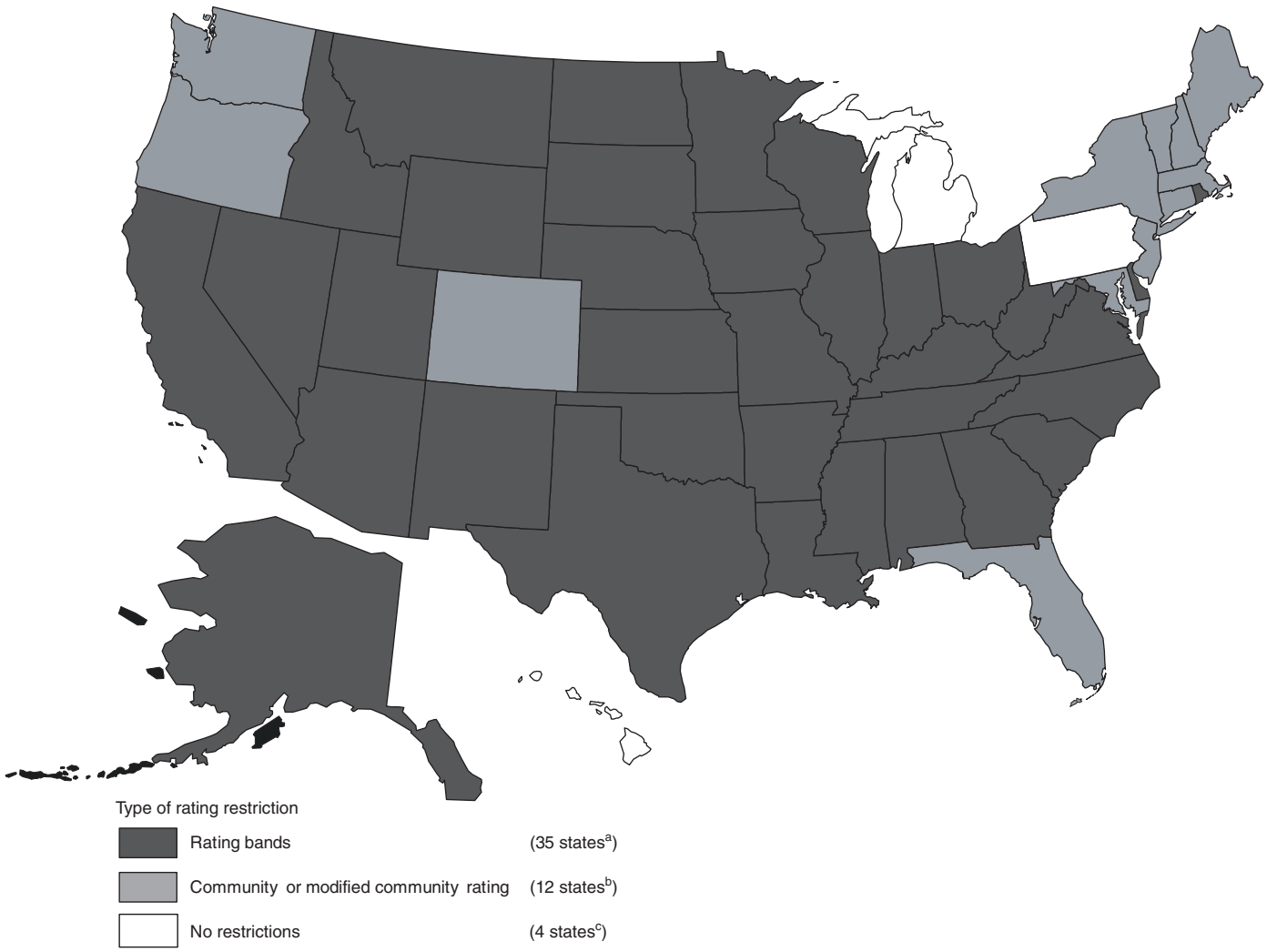
in those that did. However, our analysis found that states prohibiting insurers from setting premiums based on health status did not have a higher proportion of high-risk individuals insured through small employers than states with more flexible restrictions.

State Premium Restrictions and Their Effects on Small Employers Vary Widely

To differing degrees, state laws restrict the variation allowed in small employers' health insurance premiums. Two states—New York and Vermont—have adopted a premium restriction practice called community rating that essentially requires insurers to charge all small employers of the same size a common rate regardless of their employees' and their dependents' ages, health, or other demographic characteristics. In these states, premiums are allowed to vary only for geographic location of the group, plan or benefit design, and family size. As of June 2000, 10 other states had adopted modified community rating laws that also prohibit variation in premiums based on the health status of employees, but may allow some variation for other factors. For example, Maryland allows premiums for small employers to vary only by limited amounts for age, geographic location, and family size.

Most other states allow premiums to vary based on health as well as other factors, but restrict the degree to which variation is allowed; these restriction categories are called rating bands. In these states, insurers can charge higher premiums for small employers insuring employees with certain characteristics—such as older individuals, women of childbearing age, smokers, individuals in poor health, and employees in certain industries—that are considered high risk or costly. However, the amount of variation is limited. For example, California allows insurers to consider age, family size, geographic area, and health factors when setting premiums, but limits the amount of variation for health factors to plus or minus 10 percent. Other states with rating bands allow much wider variation for health and other factors. For example, Texas allows factors such as age, sex, geography, group size, industry, and health to be considered in setting premiums, but limits the amount premiums can be adjusted for health to plus or minus 25 percent. As of June 2000, 35 states used rating bands when setting premiums. (See fig. 3.)

Figure 3: States' Small-Employer Premium Restrictions, June 2000



[a]While Arizona and New Mexico are classified as rating band states, modified community rating applies to specific insurers. Restrictions in Arkansas, Louisiana, Missouri, North Dakota, and Tennessee apply to a subset of the small group market, and Virginia's restrictions only apply to certain types of plans.

[b]Restrictions in Oregon apply to a subset of the small group market.

[c]The District of Columbia, Hawaii, Michigan, and Pennsylvania had no market-wide rating restrictions. However, in Hawaii certain insurers use community rating; and in Michigan and Pennsylvania one insurer in each state uses community rating.

Source: Data from Georgetown University, Institute for Health Care Research and Policy, Washington, D.C.

The differences in state restrictions can greatly affect the premiums paid by small employers, particularly for those considered to be high risk. To illustrate these differences, we obtained premium quotes from several insurers in a selected city in each of five states representing different approaches to restricting premiums for the following three hypothetical small employers:

- Group 1: Low-risk group of 10 individuals, predominantly in their 20s, with few smokers, and none with any identified existing health conditions.
- Group 2: The same as group 1, but one of the workers has juvenile-onset diabetes.
- Group 3: A relatively high-risk group of 10, with several members in their 50s, several smokers, several women of childbearing age, and one member with juvenile-onset diabetes.

The extent to which the second and third groups paid higher premiums than the first group depended on the state's premium restrictions. (App. II provides a description of the hypothetical groups and the premium quotes we obtained within these localities.) For example, see the following.

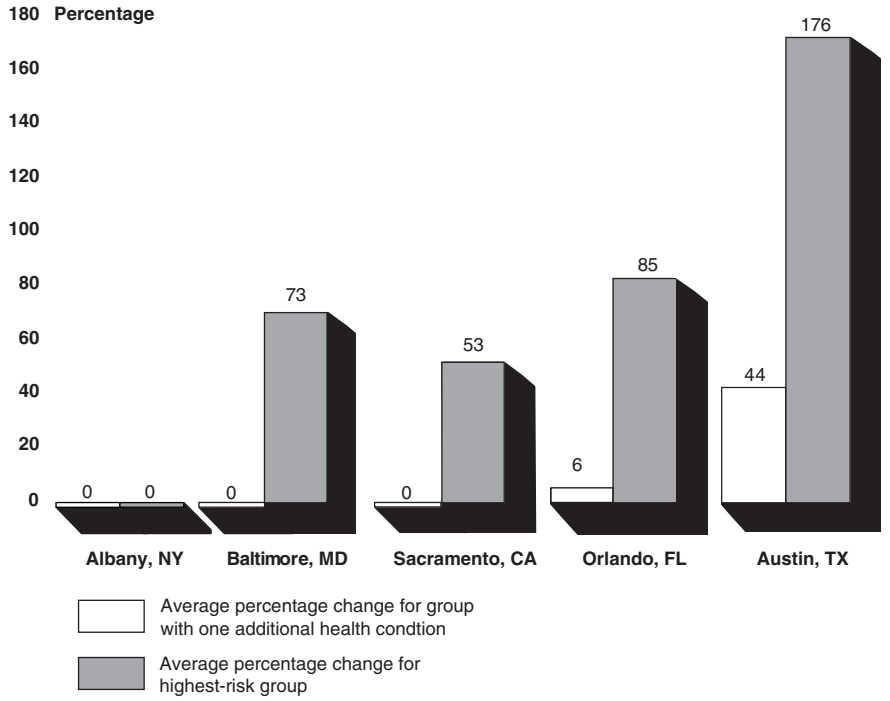
- In New York (which has community rating and does not allow rates to vary for health or other factors), each of the groups paid the same premium.
- In Maryland (which does not allow premiums to vary for health but does allow limited variation for other factors), group 2 with one employee with juvenile-onset diabetes paid the same as group 1, and premiums were on average 73 percent higher for group 3 (with older workers, women of childbearing age, and more smokers).
- In California (which allows up to a 10-percent variation for health) and Florida (which allows up to a 15-percent variation for health[24]), premiums were on average the same or slightly higher for group 2, and 53 percent to 85 percent higher for group 3 than for group 1.

[24]Florida changed its law to allow this variation for health characteristics in July 2000; previously, Florida had not allowed variation in premiums for health characteristics.

- In Texas (which allows up to a 25-percent variation for health), where premiums can vary for multiple factors, the differences were most pronounced. On average, the insurers would charge the second group 44 percent more than the low-risk group, while they would charge the highest-risk group 176 percent more. Several insurers would have charged the high-risk group premiums two and a half to nearly four times as much as the low-risk employer.

As shown in figure 4, for each location we compared the average percentage change in premiums for the group with one health condition (group 2) and the high-risk group (group 3) to the low risk group (group 1).

Figure 4: Average Percentage Change in Premiums Quoted for Three Hypothetical Small Employers With Increasing Risk Characteristics in Selected Localities, 2000



Notes: New York and Maryland do not permit variation in premiums for health conditions, but Maryland allows limited variation for other factors such as age. California, Florida, and Texas permit variation to different degrees for health conditions, and also allow variation for other factors.

The first bar above each locality represents the average percentage change from group 1 to group 2 (as defined above) of all the premium quotes received from insurers. The second bar above each locality represents the average percentage change from group 1 to group 3 (as defined above) of all the premium quotes received from insurers.

See appendix II for a list of premium quotes we received, the percentage change between groups, and the average of these percentage changes for all responding insurers within each locality.

Source: Premium quotes obtained from agents in collaboration with NAHU.

Average Premiums Were Slightly Higher in States That Do Not Allow Adjustments for Health

By making the cost of coverage similar for low- and high-risk groups, states with tighter restrictions might be expected to attract a larger share of high-risk small employers, and thereby have higher average premiums, than states without tight restrictions. Based on 1996 MEPS data—adjusted for geographic cost differences[25]—average annual single premiums for fully insured small employer plans[26] were about 6 percent higher in states that prohibited premium adjustments for health characteristics ($2,150) than in other states and the District of Columbia that either had rating bands allowing limited variation for health characteristics or had no restrictions ($2,034). Average annual family premiums were about 7 percent higher in states that prohibited premium adjustments for health characteristics ($5,189) than in the other states and the District of Columbia ($4,855).[27]

While average premiums were slightly higher in states prohibiting the use of health characteristics to set premiums, these states do not appear to have a higher proportion of high-risk groups insured in the small group market based on certain characteristics associated with risk. Using the 1996 MEPS, we compared average medical expenditures and use, demographic characteristics, and self-reported health characteristics for individuals insured through a small employer in states that (1) prohibited

[25]To help mitigate potential distortions due to underlying cost differences in the states, we adjusted the premiums based on the 1997 Geographic Practice Cost Index (GPCI) developed by the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services. The GPCI attempts to measure the relative cost differences involved with operating a private medical practice in different areas compared to the national average. The GPCI is used to vary Medicare payments among fee schedule areas according to the extent that relative costs vary. Also, factors that we did not account for, such as differences among states in plan benefit levels, industry mix, and plan type, could explain some of the difference in premiums.

[26]Excludes self-funded health plans. ERISA generally preempts states from regulating these employer-sponsored health plans.

[27]As of 1996, 12 states had implemented community or modified community rating and 34 states had rating bands in place. Four states and the District of Columbia had not implemented any type of rating reform. MEPS data show that without adjusting for geographic differences, average annual single and family premiums were 12 percent and 13 percent higher, respectively, in the 12 states that prohibited premium adjustments based on health—those with community or modified community rating—compared to the remaining states and the District of Columbia.

premiums from varying for health characteristics and (2) allowed at least some variation for health or had no restrictions. We found individuals in both groups of states to have generally similar expenditures, use, demographic characteristics, and health characteristics.

Other State Efforts Have Had A Limited Effect on Affordability

States have undertaken other efforts to help small employers purchase health insurance, but have had limited success in addressing affordability issues. Attempts to reduce premiums by allowing insurers to offer less generous, scaled-back benefit packages have not been widely embraced by small employers. State and private efforts to pool small employers into purchasing cooperatives have made it easier for small employers to offer a broader choice of plans to their employees, but most efforts have not resulted in expected premium reductions when compared to similar plans available outside of the cooperatives. A few states have recently begun to provide tax incentives or subsidies to small employers offering insurance. While these initiatives are too new for their effect to be fully evaluated, previous studies suggest that tax incentives need to represent a significant portion—half or more—of the premium to significantly increase coverage.

Scaled-Back Benefit Packages May Make Insurance More Affordable, But Have Limited Appeal

Scaled-back benefit plans that cover fewer services or have higher out-of-pocket requirements can reduce premiums, but they have not been widely purchased when offered.[28] For example, see the following.

- Illinois officials reported that 25 people were enrolled in plans with scaled-back benefits when they were offered in the 1990s. The Illinois Department of Insurance stopped approving the sale of these plans in 1997.
- Florida allows insurers to offer a basic low-cost plan that contains most of the state's mandated benefits but has high deductible and coinsurance requirements. Few of these plans were sold, accounting for less than 1 percent of premiums collected in Florida's small group market.

[28]Scaled-back benefit packages (also known as "bare bones" policies) can provide less expensive coverage by being exempted from certain state-mandated benefits or by restricting other major benefits, such as providing less than 30 days of inpatient hospital care or maximum annual benefits of $50,000 or less instead of the more comprehensive coverage typically offered through most benefit plans. These plans also may have high deductibles ($1,000 or more), no out-of-pocket cap on coinsurance of 20 percent on all services, or high annual maximum out-of-pocket costs (up to $5,000).

- Texas allows insurers to offer basic and catastrophic benefit plans. Both plans cover many common benefits, such as maternity, outpatient services, and hospital charges, and the catastrophic plan has deductibles as high as $5,000 and maximum out-of-pocket expenses up to $10,000. Data provided by the Texas Department of Insurance indicate that, at peak enrollment in 1997, only 53 basic and catastrophic plans were sold.
- In 1999, a major national health insurer introduced a set of scaled-back benefit plans designed for small employers. The plan reimburses a maximum of $50 of the cost of a doctor's visit and pays as little as $100 toward the cost of inpatient hospitalization after the 10th day. A year after introducing the program, which is available in about 30 states, the company acknowledged that the experiment failed to generate much interest from small employers.

Experts attribute the poor sales of scaled-back policies to a desire among small employers to offer benefits comparable to those offered by large employers. Also, experts have reported that employees tend to be averse to high deductibles, for example, those of $1,000 or more. Furthermore, some small employers may not even be aware of the availability of these scaled-back benefit plans because agents, whose commissions tend to be lower for these plans, may not market them aggressively.

Purchasing Cooperatives Generally Have Not Made Insurance More Affordable

Private and public efforts to allow small employers to join together and purchase health insurance have not, in most cases, lowered the cost of coverage. In general, small-employer purchasing cooperatives try to function like large employers to obtain lower premiums, offer more plan options, and achieve administrative economies of scale. In 2000, 20 states had laws allowing small employers to pool together into cooperatives for the purpose of purchasing health insurance, and several recent congressional proposals would further encourage the development of similar purchasing arrangements.[29] However, most cooperatives account for a small share of each state's small group market (typically, less than 5 percent of small employers), and several cooperatives recently have failed. We reported in 2000 on the experience of five relatively large, geographically dispersed cooperatives, most of which offered a wide range of benefit options and administrative services to participating small employers. For similar plans, premiums inside the cooperatives were

[29]See H.R. 2990, Quality Care for the Uninsured Act of 1999 (Oct. 1999) and H.R. 1774, Small Business Health Fairness Act of 2001 (May 2001).

about the same as those available outside.[30] Specifically, we reported that individuals in a group made up of 20- to 30-year-olds in the cooperatives in California, Connecticut, and Florida paid average monthly premiums ranging from $108 to $187 in 1999. The premiums for individuals in a comparable group outside the cooperatives in these states ranged from $101 to $169. A 1997 national survey found similar average monthly single premiums for small employers participating in any pooled purchasing group—$180, compared with $172 for nonparticipants.[31]

Tax Incentives and Subsidies May Not Be Sufficient to Substantially Increase Coverage

Several states have recently offered tax incentives or other subsidies to small employers that offer insurance to their employees.[32] These actions have the potential to make premiums less expensive and encourage more small employers to offer coverage and more individuals to purchase it. Two recently implemented efforts to lower premiums for small employers provide assistance for up to about 18 percent of the average premium. For example, starting in 2000, Kansas allowed employers to receive a refundable tax credit for the first 5 years they provide health insurance to their employees.[33] The credit is worth up to $420 per employee per year for the first 2 years and then decreases to no more than $315 for the remaining

[30]See *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices* (GAO/HEHS-00-49, Mar. 31, 2000). This report reviewed the experience of small employer purchasing cooperatives in California, Connecticut, Florida, North Carolina, and Texas. Several other recent studies have also concluded that small employer purchasing cooperatives have not generally offered premiums lower than are available outside the cooperatives. See, for example, Elliot K. Wicks et al, "Barriers to Small-Group Purchasing Cooperatives, Purchasing Health Coverage for Small Employers," Economic and Social Research Institute, March 2000, and Elliot K. Wicks and Mark A. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," *The Milbank Quarterly* (Vol. 78, No. 4, 2000). Wicks notes that the Council of Smaller Enterprises (COSE) in Ohio, which dominates the small group market in Cleveland, appears to offer lower premiums than are typically available to small employers outside the cooperative. However, whereas the other cooperatives we reviewed had 3 to 18 participating insurers, COSE has 2 participating insurers and nearly all of its enrollment is with a single insurer.

[31]See Long and Marquis, "Pooled Purchasing: Who Are The Players?" *Health Affairs* (July/Aug.1999). This survey looked at small employers participating in a variety of pooled purchasing arrangements.

[32]In addition, some recent congressional proposals would provide tax incentives to low-income workers or small employers to encourage their employees to purchase health insurance.

[33]Employers cannot have contributed to a health insurance premium on behalf of an employee in the last 2 years prior to receiving the credit. The 2-year period runs backward from the date of application to the Kansas Insurance Department.

3 years. Massachusetts makes payments to qualified small employers providing health benefits to eligible low-income employees of up to $400 per employee per year for single coverage and $1,000 for family policies. Assistance is also available in Massachusetts to eligible employees for their portion of the premium.

As part of its Healthy New York Program, the state has recently initiated a unique subsidy intended to assist certain small employers and working uninsured individuals in obtaining coverage. The state is providing financial reimbursement to health maintenance organizations (HMO), with other insurers able to participate on a voluntary basis, to cover high-cost claims—a type of reinsurance known as "stop-loss" coverage. This could help address concerns about the potential for some HMOs and insurers receiving a disproportionate share of high-cost enrollees and the greater uncertainty in the risk for insurers providing coverage to small employers. Specifically, the New York program covers 90 percent of each enrolled individual's claims between $30,000 and $100,000.[34] Also, the stop-loss coverage—along with a standardized, scaled-back benefits package that HMOs must offer—is intended to make health insurance more affordable and accessible. New York estimates that the program will cost the state about $300 to $500 for each enrolled individual. However, because the program just started at the beginning of 2001, it is too early to assess its effectiveness.

These tax incentives and subsidies reduce the net cost to small employers of providing health insurance, but it is uncertain whether they will be sufficient to encourage many new small employers to begin offering coverage. At small employers, even large premium subsidies may not persuade a significant number of workers—particularly low-income workers—to purchase health insurance when it is offered. A 1997 study estimated that, for workers eligible to participate in employer-sponsored coverage, subsidies as high as 75 percent would only increase participation rates from 89 percent to 93 percent.[35] In addition, some

[34]New York has allocated $219 million for a 2½-year period starting January 1, 2001. Of this amount, $163 million (about 75 percent) is targeted to cover eligible small employers and $56 million (about 25 percent) is to cover eligible low-income working individuals whose employers do not provide health benefits.

[35]See Michael Chernew, Kevin Frick, and Catherine G. McLaughlin, "The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?" *Health Services Research*, Vol. 32, No. 4 (1997), p.453. This study also identifies other studies that concluded that reducing premiums by as much as 50 percent would not greatly increase the provision of insurance at small employers.

studies have indicated that tax incentives to individuals need to represent a significant portion of the premium—perhaps half or more—to result in many individuals newly purchasing health insurance.[36] However, the Kansas and Massachusetts subsidies would represent less than 20 percent of a small employer's typical single coverage premium. Furthermore, the temporary nature of some state programs—such as the Kansas subsidy that lasts for 5 years—may limit their effectiveness. Experts report that small employers may be hesitant to begin offering coverage even with subsidies if they are uncertain that the subsidy will be available for the long term because employers do not want to drop coverage once they begin offering it.

Concluding Observations

While federal and state reforms over the last decade have generally made health insurance more accessible for small employers, many small employers and their employees continue to face challenges in affording health insurance. Recognizing the difficulties and costs that many small employers face in offering their employees health insurance, the Congress has considered several proposals to assist small employers in sponsoring health insurance, such as proposed tax incentives and new purchasing arrangements. These efforts are directed toward helping to make health insurance more affordable for small employers by subsidizing costs for the employers or their employees or by helping small employers gain some of the advantages large employers have in purchasing health insurance. The complexity and diversity of the small-group health insurance market as well as the experience of the states in regulating premiums and trying other approaches to expand coverage are important considerations in crafting effective reforms.

Small employers often get less value for their premium dollar than large employers and, in states that do not tightly restrict premium variation, small employers with high-risk employees may pay substantially higher premiums than those with lower-risk employees. As a result, many small employers with uninsured workers and dependents in such states may face higher premiums if they provide coverage because fewer of these uninsured individuals report being in excellent health and they therefore may represent a higher risk to insurers.

[36]For example, see Congressional Budget Office, *Options to Expand Federal Health, Retirement, and Education Activities* (Washington, D.C.: June 2000).

States' experiences indicate that efforts to increase affordability and access can have some benefits—such as increasing the availability of a wider array of plan options for small employers or helping to ensure that small employers with high-risk employees pay lower premiums. However, they generally have not made coverage more affordable overall or been sufficient to encourage many new small employers to begin providing coverage. Other efforts, such as purchasing cooperatives and scaled-back benefit offerings, have not attracted a large share of the small group market to date. Further, recently enacted temporary state subsidies and incentives may not be sufficient to encourage many small employers to offer coverage.

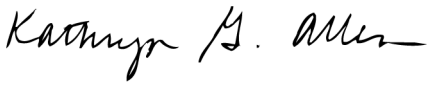
Comments From External Reviewers

Several private insurance experts, an expert on the MEPS database, and a health insurance industry representative provided comments on a draft of this report. In general, these reviewers concurred with our findings. Two reviewers noted that while health insurance premiums were higher in states that implemented tighter rating restrictions compared to the remaining states, other factors in local health care markets, such as the types of plans available or mix of industries, might also explain these differences. We revised the report to reflect that these other factors may also account for some premium differences across groups of states. Another reviewer further emphasized that while federal and state small-group reforms have made health insurance more accessible, affordability still remains a major obstacle to more small employers offering coverage to their workers. The reviewers also made technical comments that we incorporated where appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its date. At that time, we will send copies to other interested congressional committees and other parties. We will also make copies available to others on request.

Please call me at (202) 512-7118 or John Dicken, Assistant Director, at (202) 512-7043 if you have any questions. Major contributors to this report include N. Rotimi Adebonojo, JoAnne Bailey, and Joseph Petko.

Sincerely yours,



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Methodology

To review the affordability of health insurance in the small group market we:

- reviewed literature on the small group market;
- analyzed three Medical Expenditure Panel Survey (MEPS) data files—the 1996 Household Component[1] and the 1996 and 1998 Insurance Components;
- analyzed the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) *Employer Health Benefits 2000 Annual Survey*;
- obtained health insurance premium quotes for three hypothetical small employer groups in California, Florida, Maryland, New York, and Texas;
- interviewed insurance regulators in California, Florida, Maryland, New York, and Texas; and
- interviewed health insurance experts, actuaries, and insurers' representatives.

Our analyses of the MEPS and Kaiser/HRET benefit data are further discussed below, and appendix II includes additional information regarding the premium quotes we obtained in the five states.

Medical Expenditure Panel Survey

MEPS, conducted by the Agency for Healthcare Research and Quality (AHRQ), consists of four surveys and is designed to provide nationally representative data on health care use and expenditures for U.S. civilian noninstitutionalized individuals. For our analysis, we used two of the four surveys: the Household Component and the Insurance Component. The Household Component is a survey of individuals regarding their demographic characteristics, health insurance coverage, and health care use and expenditures. The Insurance Component's list sample is a survey of employers regarding the health insurance they offer and their premiums.[2] We consulted with AHRQ staff regarding MEPS, and in some

[1]The 1996 version of the MEPS Household Component was the most recently available at the time of our analysis that had complete information allowing us to link individuals' characteristics, including health status, and their insurance status, including the size of the employer offering their coverage.

[2]The Insurance Component consists of two subcomponents—a household sample and a list sample. We used the list sample subcomponent, a survey conducted independently from the Household Component. The list sample surveys business establishments and governments throughout the United States and is designed to provide national and state-level estimates of the amount, types, and costs of health insurance available to Americans through their workplaces.

cases AHRQ or the Bureau of the Census had programmers perform analyses at our request in order to provide us with additional data or to ensure that the confidentiality of the data was not compromised.

The 1996 Household Component

We used the 1996 MEPS Household Component to compare nonelderly individuals with health insurance through small and large private employers according to select demographic and health characteristics.[3] To compare insured individuals, we identified the size of the employers through which the coverage was obtained using variables created with the assistance of AHRQ. We classified insured individuals by employer size according to the responses provided by the policyholders, who were either self-employed individuals or wage earners (employees). Our analysis also included dependents that had coverage through the policyholder. We classified the following as insured through a small employer: (1) self-employed individuals who reported 50 or fewer employees at their firms and (2) wage earners at single location establishments with 50 or fewer employees.[4] We excluded from our analysis wage earners at establishments with 50 or fewer employees whose employers had more than one establishment—approximately 21 percent of the private, employer-sponsored population—because we could not determine with certainty whether the employers would have 50 or fewer employees or more than 50 employees for all locations combined.[5] We classified self-employed and wage earners reporting more than 50 employees, regardless of the number of establishments, as insured through large employers.

When an individual had multiple sources of coverage from two different sized employers—for example, if he or she was a policyholder on one plan and a dependent on a spouse's plan—we assigned the individual to the employer size of the plan for which he or she was a policyholder. Less than 1 percent of persons were dependents on more than one private employer-sponsored plan, and we randomly assigned each of these individuals to either the small or large employer through which he or she

[3]Nonelderly individuals—those under 65 years old—are most likely to be covered by employer-sponsored health insurance.

[4]A firm may consist of a single or multiple establishments. In the case of a single establishment firm, the firm and the establishment are identical.

[5]These individuals had demographic characteristics and self-reported health status similar to those with coverage through small and large employers.

had insurance. Table 5 shows the unweighted and weighted sample sizes on which our analyses are based.

Table 5: MEPS Sample and Estimated Population Sizes, December 1996

	Nonelderly (individuals under 65 years old) insured through a small private employer[a]	Nonelderly (individuals under 65 years old) insured through a large private employer[b]
Sample size (unweighted)	1,397	4,646
Estimated population size (weighted)	19.4 million	61.8 million

[a]Includes only those nonelderly individuals insured through a current, private employer with 2 to 50 employees.

[b]Includes only those nonelderly individuals insured through a current, private employer with 51 or more employees.

Source: GAO analysis of AHRQ's MEPS Household Component, 1996.

We also compared characteristics of insured and uninsured individuals from households with at least one individual working for a small employer. For these analyses we included uninsured nonelderly individuals living in households for which we could determine that at least one adult was employed by a small private employer. Furthermore, only those persons eligible to obtain health insurance from within the household were included.[6] Our analysis of the uninsured is based on a sample size of 1,462, representing a population of 16.1 million uninsured individuals in households with at least one worker at a small employer.

In addition, we compared the risk characteristics of individuals insured through small employers in states that prohibited adjustment of premiums based on the health or claims experience of a group with those insured in states that allowed premiums to vary for these health characteristics. (See table 6 for the two state groupings.) To determine which states prohibited the use of health characteristics in setting premiums in 1996, we used

[6]AHRQ provided us with a file that identified persons believed to be able to obtain health insurance from one another. For example, a nondisabled, nonstudent, adult child residing with his or her parents would not be considered eligible to obtain coverage from a parent. This adult child would be included in our analysis only if he or she worked for a small or large employer. In this case, the adult child would be considered separately from his or her parents.

information from the Institute for Health Policy Solutions, the Blue Cross and Blue Shield Association's Survey of Plans, and the Health Policy Tracking Service of the National Conference of State Legislatures. We supplemented this information with telephone calls to insurance regulators in eight states to clarify any inconsistencies.

Table 6: Groupings Based on Whether States Allow the Use of Health Characteristics in Setting Premiums, 1996

States in which premiums could not be adjusted to reflect health characteristics of the group	States in which premiums could be adjusted to reflect health characteristics of the group
Connecticut	Alabama[a]
Florida	Alaska
Kentucky	Arizona
Maine	Arkansas
Maryland	California
Massachusetts	Colorado
New Hampshire	District of Columbia[a]
New Jersey	Delaware
New York	Georgia
Oregon	Hawaii[a]
Vermont	Idaho
Washington	Illinois
	Indiana
	Iowa
	Kansas
	Louisiana
	Michigan[a]
	Minnesota
	Mississippi
	Missouri
	Montana
	Nebraska
	Nevada
	New Mexico
	North Carolina
	North Dakota
	Ohio
	Oklahoma
	Pennsylvania[a]
	Rhode Island
	South Carolina
	South Dakota
	Tennessee

States in which premiums could not be adjusted to reflect health characteristics of the group	States in which premiums could be adjusted to reflect health characteristics of the group
	Texas
	Utah
	Virginia
	West Virginia
	Wisconsin
	Wyoming

[a]Alabama, the District of Columbia, Michigan, and Pennsylvania had no market-wide rating restrictions in 1996. However, in Pennsylvania and Michigan, the Blue Cross plans, which had a significant share of the small group market, offer small employers a community rate. Also, in Hawaii, the Blue Cross plans, which had a significant share of the small group market, applied limited community rating in the small group market.

Sources: GAO review of information from the Institute for Health Policy Solutions, the Blue Cross and Blue Shield Association's Survey of Plans, the Health Policy Tracking Service of the National Conference of State Legislatures, and selected state insurance regulators.

1996 and 1998 MEPS Insurance Component

To compare the premiums for health insurance provided through small and large firms, we obtained premium data from the 1998 MEPS Insurance Component's list sample. The premium data we present include national estimates for insurance provided by small employers (those with fewer than 50 employees) as well as large employers (those with 50 or more employees).

To assess the effect of rating reforms that prohibit the use of health characteristics in setting premiums in the small group market, the Bureau of the Census and AHRQ staff conducted data analyses of the 1996 MEPS Insurance Component at our request. We also requested that AHRQ weight premiums to reflect plan enrollment. The premium data we present include the average premiums for insurance at small employers (those with 50 or fewer employees) in our two state groupings—those that prohibit varying of premiums according to the health characteristics of the group and those that permit premiums to be adjusted for these characteristics. In addition, we also present a national range of premiums for employers, representing from the 5th to the 95th percentile in premium costs.

Comparison of Health Benefits

To compare benefits generally purchased by small and large firms, we used data from the Kaiser/HRET *Employer Health Benefits 2000 Annual Survey*. Kaiser/HRET surveyed randomly selected public and private employers that had from 3 to more than 300,000 employees. The survey's overall response rate was 45 percent. Kaiser/HRET provided us with

unpublished data to reflect the employer size categories (3 to 50 employees and 51 or more employees) we requested. We weighted the results by plan type (including indemnity plans, health maintenance organizations, preferred provider organizations, and point-of-service plans) to reflect enrollment patterns among small and large employers.

Appendix II: Health Insurance Premium Quotes

In collaboration with the National Association of Health Underwriters (NAHU), an association that represents professional health insurance agents and brokers, we obtained health insurance quotes for three hypothetical small employer groups in a selected city in each of five states. We selected states based on size and geography. In addition, we considered the type of rating reforms they implemented. We selected two states where premiums cannot vary by health status: (1) New York, which requires community rating that allows premiums to vary for benefit design, family size, and geographic location, and (2) Maryland, which requires modified community rating that allows variation for age, family size, and geography. We also selected three states where premiums can vary to different degrees by health, along with other factors. Florida amended its rating system in July 2000 to permit limited variation in premiums for health status. California and Texas have rating bands that allow premiums to vary for health and other factors. Within each state, we obtained quotes for a selected city—specifically, (1) Albany, New York, (2) Baltimore, Maryland, (3) Sacramento, California, (4) Orlando, Florida, and (5) Austin, Texas. We asked that agents associated with NAHU solicit quotes from the three to five major insurers active in each locality's small group market. Specifically, based on their expertise, agents solicited quotes for the most popular and actively marketed benefit packages from these insurers.[1] The agents did not disclose the purpose of the survey to the insurers from whom they received premium quotes. In addition, some premium quotes from the insurers were preliminary and could have been subjected to further underwriting. The survey instrument was pretested in Atlanta, Georgia.

Each of the three hypothetical employer groups for which coverage was sought had 10 workers, 3 of whom were part-time and ineligible for health insurance. The group applying for coverage consisted of a total of 10 individuals—the 7 eligible workers and 3 dependents. The employer was to pay for all of the cost of coverage for the employees and nothing toward the cost of coverage for the dependents. The employees in the first group were relatively healthy, ranging in age from 25 to 34 years old. The employees in the second group were similar to the first except one person reported a serious medical condition—juvenile-onset diabetes. The employees in the third group were given characteristics that were higher

[1]All benefits packages included maternity benefits and, for benefits that were not included in the most popular plan but were offered by most other insurers, the agents requested that optional coverage for these benefits be included to make the plans as comparable as possible.

risk than the other two groups. In addition to the serious medical condition, these workers in the third group were older, had a higher proportion of smokers and women of childbearing age, and were employed by a restaurant—an industry considered to be higher risk by some insurers.

We received 147 premium quotes from 18 different insurers in the five states. Some insurers reported premiums for different plan types (including health maintenance organizations, (HMO), preferred provider organizations (PPO), point-of-service (POS) plans, and an exclusive provider organization (EPO)[2]) as well as different options within these plan types. Table 7 shows the health insurance premium quotes we received for each of the three small employer groups.

Table 7: Monthly Premium Quotes for Three Hypothetical Small Employer Groups With Increasing Risk Characteristics in Selected Localities, 2000

City/state/insurer	Plan type/ deductible/ copayment[a]	Group 1[b]	Group 2[c]	Percentage change from group 1 to group 2	Group 3[d]	Percentage change from group 1 to group 3
Albany, New York						
Insurer 1	HMO/NA/$10	$1,976	$1,976	0	$1,976	0
	PPO/$500/$10	2,150	2,150	0	2,150	0
Insurer 2	HMO/NA/$15	2,020	2,020	0	2,020	0
Insurer 3	PPO/$1,250/$12	3,712	3,712	0	3,712	0
Average percentage change				0		0
Baltimore, Maryland						
Insurer 1	HMO/NA/$10	1,614	1,614	0	2,340	45
	POS/$200/$10	1,939	1,939	0	2,864	48
Insurer 2	HMO/NA/$10	2,414	2,414	0	3,118	29
	POS/$200/$10	2,091	2,091	0	3,953	89
	PPO/$250/$20	2,018	2,018	0	3,816	89
Insurer 3	PPO/$250/$20	1,675	1,675	0	3,886	132
Insurer 4	HMO/NA/$5	1,746	1,746	0	2,863	64
	POS/$200/$5	1,976	1,976	0	3,241	64
Insurer 5	HMO/NA/$10	1,667	1,667	0	3,063	84
	PPO/$750/$10	1,761	1,761	0	3,314	88
Average percentage change				0		73

[2]An EPO is a managed care plan that requires its members to remain within the network to receive benefits. Out-of-network services are not covered except for a medical emergency.

City/state/insurer	Plan type/ deductible/ copayment[a]	Group 1[b]	Group 2[c]	Percentage change from group 1 to group 2	Group 3[d]	Percentage change from group 1 to group 3
Sacramento, California						
Insurer 1	HMO/NA/$5	$1,312	$1,312	0	$1,989	52
	HMO/NA/$10	1,177	1,177	0	1,753	49
	HMO/NA/$15	1,101	1,101	0	1,638	49
	HMO/NA/$20	1,033	1,033	0	1,564	51
	HMO/NA/$10	1,101	1,101	0	1,753	59
	POS/$0/$15	1,623	1,623	0	2,570	58
Insurer 2	HMO/NA/$5	1,406	1,406	0	2,005	43
	HMO/NA/$10	1,356	1,356	0	1,970	45
	HMO/NA/$15	1,300	1,300	0	1,855	43
	HMO/NA/$20	1,185	1,185	0	1,690	43
	HMO/NA/$25	1,154	1,154	0	1,646	43
Insurer 3	EPO	557	557	0	1,014	82
	HMO/NA/$10	1,289	1,289	0	1,748	36
	HMO/NA/$10	1,615	1,615	0	2,200	36
	PPO/[e]/$25	359	359	0	565	57
	PPO/$5,000/$20	724	724	0	1,135	57
	PPO/[f]/$10	1,829	1,829	0	2,827	55
Insurer 4	HMO/NA/$15	1,731	1,731	0	2,520	46
	HMO/NA/$10	1,820	1,820	0	3,100	70
	POS/$300/$10	2,094	2,094	0	3,012	44
	PPO/$500/$35	1,447	1,447	0	2,496	72
	PPO/$250/$15	1,838	1,838	0	3,127	70
Average percentage change				0		53
Orlando, Florida[g]						
Insurer 1	PPO/$500/$10	1,644	1,807	10	3,184	94
	PPO/$500/$15	1,610	1,769	10	3,117	94
	PPO/$500/$15	1,539	1,691	10	2,980	94
	PPO/$500/$15	1,487	1,634	10	2,879	94
Insurer 2	HMO/NA/$10	1,587	1,587	0	2,839	79
Insurer 3	PPO/$500/$15	2,018	2,055	2	3,521	74
	HMO/NA/$15	1,441	1,459	1	2,371	65
Average percentage change				6		85
Austin, Texas						
Insurer 1	PPO/[h]/$10	1,623	2,469	52	4,185	158
Insurer 2	PPO/$250/$15	1,603	2,985	86	5,195	224
Insurer 3	PPO/$250/$10	1,674	1,713	2	3,053	82
Insurer 4	PPO/$300/$10	1,508	2,445	62	5,876	290
Insurer 5	PPO/$250/$10	1,541	1,527	-1	3,134	103
Insurer 6	PPO/$250/$15	1,796	2,865	59	5,393	200
Average percentage change				44		176

[a]This column shows an individual's out-of-network deductibles and in-network office visit copayments. No out-of-network deductibles are shown for HMOs as they usually only pay for in-network-services. Therefore, we indicated these deductibles as not applicable (NA) for HMOs. POS plans typically allow patients to go out of the network.

[b]Group 1 included 10 enrollees, primarily young with no health conditions and few high-risk characteristics. Specifically, group 1 included five employees purchasing single coverage, (four 25- to 28-year-old males, one a smoker; one 26-year-old, nonsmoking female) and two employees purchasing family coverage (one 29-year-old married, nonsmoking female with a 25-year-old spouse and one 34-year-old married, nonsmoking male with a 34-year-old spouse and a 7-year-old female child).

[c]Group 2 included 10 enrollees similar to group 1 but with one of the adults reporting a serious health condition. Specifically, group 2 included five employees purchasing single coverage (four 24- to 27-year-old males, one a smoker; one 25-year-old, nonsmoking female with juvenile-onset diabetes) and two employees purchasing family coverage (one 28-year-old married, nonsmoking female with a 25-year-old spouse and one 33-year-old married, nonsmoking male with a 34-year-old spouse and a 7-year-old female child).

[d]Group 3 included 10 enrollees, primarily older individuals with one reporting a health condition and others with increased risk characteristics, including sex, smoking status, and a higher-risk industry. Specifically, group 3 included five employees purchasing single coverage (four 25- to 48-year-old females, one a smoker and one with juvenile-onset diabetes; one 55-year-old male, who is a smoker) and two employees purchasing family coverage (one 51-year-old married, nonsmoking male with a 46-year-old spouse and one 58-year-old married male, who is a smoker, with a 48-year-old spouse and a 12-year-old male child).

[e]No deductible was provided.

[f]No deductible was provided.

[g]Florida began to allow insurers to use a health factor for setting premiums as of July 1, 2000. Therefore, some insurers may not have been using the health factor when these quotes were obtained.

[h]Out-of-network deductible was not available.

Source: Premium quotes obtained in collaboration with NAHU.

Related GAO Products

Health Insurance: Proposals for Expanding Private and Public Coverage (GAO-01-481T, Mar. 15, 2001).

Health Insurance: Characteristics and Trends in the Uninsured Population (GAO-01-507T, Mar. 13, 2001).

Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices (GAO/HEHS-00-49, Mar. 31, 2000).

Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards (GAO/HEHS-99-100, May 12, 1999).

Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998).

Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance (GAO/HEHS-96-161, Aug. 19, 1996).

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