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An Examination of State Non-Group and Small-Group Health Insurance Regulations

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Health Insurance Regulations

By

Anthony T. Lo Sasso¹

Abstract

The present upswing in state-level efforts to “do something about health care,” combined with presidential campaign-related rhetoric, suggests that health care is back with a vengeance on the public consciousness. Many states are proposing what appear to be new strategies to cover the uninsured when in reality the “new” strategies rely on old approaches that have not proven highly effective in the past, notably community rating and guaranteed issue regulations. Using data culled from a popular health insurance distributor and the published literature provides a compelling portrait of the predictable distortions that can result from regulations aimed at improving perceived deficiencies in the non-group and small group health insurance markets.

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1. Introduction

Periodically state politicians decide to take it upon themselves to “do something about health care.” At present there is a clear upswing in state initiatives designed to improve access to affordable health care. Massachusetts, for example, has already implemented a program intended to eliminate uninsurance in the state through a combination of policies including an employer “pay or play” mandate, Medicaid expansions, and, controversially, an individual mandate to purchase coverage. California is wrestling with a similar proposal introduced by Governor Schwarzenegger in early 2007. Pennsylvania, Illinois, and a number of other states are considering programs of their own. It remains unclear how these initiatives will play out (see Sack 2007). A far bigger question is what effect any of these initiatives will have on the health status of the newly insured or the population in general. While beyond the scope of this monograph, it seems to be largely forgotten in health policy circles and the general consciousness that insurance (of all kinds) is fundamentally about protection from *financial* disaster and that the causal link between health insurance and health is tenuous at best (see Levy and Meltzer 2004 for an excellent critical review of the literature).²

The early- to mid-1990s was another such period in which health care issues rose to the top of federal and state agendas. While few have forgotten the Task Force on National Health Care Reform under the Clinton Administration, more easily forgotten are the concurrent efforts by states to provide universal health insurance coverage. While it is popular to think that the states picked up where the Clinton initiative left off, it can be credibly argued that the debate originated in the states. Indeed, it is not so much that the debate reverted to the states after the failure of the Clinton initiative, but that the states led and the Clinton administration tried to

² One does not buy automobile insurance to become a better driver; indeed, it could be more likely that the opposite would occur.

follow. Massachusetts, Washington, Kentucky, Oregon, Florida, Colorado, and California are but a few of the states that entertained ambitious plans in the early 1990s to increase insurance coverage. In general these efforts collectively led nowhere, though certain portions of state proposals were nonetheless enacted and in some cases later retracted³—chiefly from the standpoint of this monograph rating regulations and guaranteed issues requirements in non-group and small group health insurance markets. Some of these same states have re-emerged in the current era with new proposals. In some cases these new proposals repeat the same mistakes of the old proposals. California’s initiative, for example, includes strong premium rating regulations in the non-group market.

Insofar as a number of states are presently considering health insurance coverage expansions that rely at least in part on further regulation of the individual (also known as non-group) and small group health insurance markets to arrive at coverage goals, this monograph provides a considered review of the major policy issues facing such regulation. The study discusses the existing health policy literature regarding guaranteed issue requirements and health insurance rating restrictions. It provides some empirical observations using data from multiple sources including the Survey of Income and Program Participation (SIPP) collected by the Census Bureau to explore the effects of such underwriting and rating restrictions on levels of non-group health insurance coverage. Using data culled from a popular health insurance distributor and the published literature, this study examines the experience under different combinations of such insurance rules and regulations in the health care markets in several different states.

³ Kentucky and Washington eliminated earlier community rating and guaranteed issue requirements in their non-group markets.

2. A Brief Examination of Insurance Theory

Noted economist Mark Pauly in 1970 demonstrated quite convincingly from a theoretical perspective that community rating is an inefficient strategy to either match appropriate health insurance policies to individuals or to increase coverage (Pauly 1970). The opposite of community rating is individual experience rating, in which the individual is charged a premium equal to his or her expected (or average) health care utilization. Essentially, community rating represents an effort to subsidize the premiums of the sick by taxing the premiums of the healthy. Ignoring for a moment the predictable changes in enrollment (lower enrollment among the healthy due to higher premiums and higher enrollment among the unhealthy due to lower premiums), strictly speaking, such a tax/subsidy mechanism would cause the healthy to buy less insurance coverage than they otherwise would prefer in the absence of the tax and the unhealthy to buy more insurance coverage than they otherwise would prefer in the absence of the subsidy. Put differently, because of the price distortions the insurance purchased does not provide the ideal, most desired coverage for either the sick or the healthy. Moreover, Pauly also observes that community rating represents a redistribution of income from the healthy to the sick. While all redistributions involve value judgments, it is clearly not the case that all healthy are high income and all unhealthy are low income, according to Pauly. Hence redistributive aims could certainly be accomplished in a more efficient manner than through community rating.

Beyond the fact that community rating will induce individuals to buy the “wrong” policy given their preferences, it will also induce some individuals, specifically healthier individuals, not to buy health insurance at all—or more formally opt to self-insure with out-of-pocket expenditures plus perhaps some discounted or free health care from safety net providers (Lo Sasso and Meyer 2006). Others with a working spouse may opt for group insurance coverage. It

is also likely that the unhealthy will find a community-rated non-group policy more appealing given the subsidy; combining a guaranteed issue requirement may make hitherto unavailable coverage possible. Hence the demand response will call for an even larger tax/subsidy transfer than if this dynamic response was ignored. While it is plausible that healthier individuals are more price elastic with respect to insurance premiums than sicker individuals, insurers are essentially forced to guess about the demand response when deriving the community-rated premiums. In addition, in some settings insurers might be constrained by state price controls. If the higher community-rated premium is too high, the insurer will be left with only the sickest individuals most desperate for coverage; if the community-rated premium is too low, the insurer may not be able to cover health care claims with premium revenues, which could lead to another round of premium increases. This second round of premium increases will cause the remaining relatively healthy to drop coverage and the pool of remaining covered individuals shrinking to include a still sicker pool of enrollees. Under assumptions about insurers repeatedly unable to predict enrollment of sicker enrollees, the process would continue until only the sickest of sick remain in the market paying very high de facto experience rated premiums.

The process described above was explicated far more systematically by Rothschild and Stiglitz (1976) in their path-breaking work on insurance markets. Nonetheless, far from an academic fancy, such “adverse selection death spirals” have been documented in health insurance markets (see for example Cutler and Reber, 1998). In practice, spirals would be unlikely to occur indefinitely as employers or insurance companies would eliminate plans that are obviously experiencing significant adverse selection, which was the case in the example explored by Cutler and Reber (1998). Moreover, adverse selection spirals are most likely to be caused by or at least aggravated by regulation. An individual mandate could in principle

alleviate the selection issue, though the effect of a health insurance mandate is questionable particularly given the limited success of other insurance mandates.⁴

It might be worthwhile at this point to comment on the aforementioned practice of experience rating in health insurance. Some may find it objectionable, *prima facie*, to charge sick individuals more for health insurance. Again it is important here to go back to first principles of insurance. Insurance *only* works for indemnification against risks that have yet to reveal themselves—risks that are known only probabilistically. Just as one cannot buy homeowner’s insurance after one’s house has burned down and expect to be financially indemnified, expecting an insurer to pay for claims for adverse health outcomes that have already revealed themselves is similar folly. Forcing an insurer to sell an insurance product at a premium that is below the expected health care expenditures is analogous to selling a ten-dollar bill for five dollars: it is a great deal for the purchaser, but not a sustainable business practice for the seller. For the practice to be sustainable the seller must necessarily offset those money-losing sales with an equal number of sales of five-dollar bills for ten dollars. Thus as long as people keep buying the over-priced five-dollar bills the system can work. But herein poses the difficulty with community rating: the people buying the over-priced five-dollar bills might get wise to the fact that it is not a good deal, and, presuming there is nothing to prevent them from no longer making, the purchase they will drop out of the market.

However, advocates of community rating are not necessarily concerned with inefficiencies in matching individuals to their optimal experience-rated policy. As Len Nichols has observed: “[T]hose who prefer economic efficiency as an organizing principle for private

⁴ The efficacy of individual mandates to purchase health insurance is certainly subject to debate. Virtually all states have implemented compulsory automotive insurance, yet data suggests that the mandates have mixed success: roughly 15% of motorists are uninsured, which bears a striking, if ironic, similarity to the percentage lacking health insurance (Insurance Research Council 2006). This point regarding the questionable enforceability of an individual health insurance mandate has been made elsewhere (see Tanner 2006).

health insurance markets are willing to trade coverage for the absence of coercion, and those who prefer social solidarity are willing to trade inefficiency and coercion for universal coverage” (Nichols 2000, p. 179). Hence the critical issue in deciding the fate of policy initiatives aimed at using insurance market regulation and employer and/or individual mandates to affect coverage remains (as always) in the political realm. Nonetheless, the political nature of the decision regarding insurance market regulations does not obviate the need for a solid and reasoned consideration of their effectiveness as means to improve health insurance coverage.

3. The What, When, and Why of the State Regulatory Initiatives

Beginning in the early-1990s states became active with regulatory efforts aimed at improving the perceived inequities and inefficiencies in the small group and non-group health insurance markets. While small group regulatory efforts were more common—indeed by now every state in the union has implemented some type of rating restriction in the small group market—in many cases the small group regulations were done in tandem with similar regulations implemented in the non-group health insurance market. Excluding guaranteed renewability of policies, which was mandated as part of the federal Health Insurance Portability and Accountability Act (HIPAA) passed in 1996, thirty-three states implemented some type of regulation affecting the non-group health insurance market during the 1990s (Blue Cross and Blue Shield Association 2000). The regulations included guaranteed issue requirements, limits on exclusions for pre-existing conditions, reinsurance requirements, minimum loss ratio requirements, and premium rate restrictions. It is clear that each of these regulations is likely to have a distinct effect on the market for non-group health insurance. For example, limiting an insurer’s ability to exclude coverage for certain pre-existing conditions is likely to marginally

increase premiums for all non-group policies (Marsteller, et al. 1998). The Council for Affordable Health Insurance (CAHI) used an actuarial model in 2006 to estimate the costs associated with 61 mandated state benefits. The state mandates range from required mammography coverage in all 50 states (adds less than 1% to the cost of a typical policy) to coverage of Wilms' tumor, a rare kidney disease affecting children, in one state (adds less than 1% to the cost of a typical policy) to mental health parity in 42 states (adds between 5-10% to the cost of a typical policy) (CAHI 2006).

There are a number of websites that summarize state health policies in the non-group and small group markets. One comprehensive website is www.statehealthfacts.org sponsored by the Kaiser Family Foundation and collected and maintained by researchers at the Georgetown Health Policy Institute. Currently seven states have community rating in the non-group health insurance market (Maine, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington). In these states insurers are not allowed to charge differential premiums based on the health of applicants. Community rating regulations are subdivided between so-called pure community rating requiring insurance carriers to charge the same premiums for all plan participants regardless of age, gender, health status, or other factors, and adjusted or modified community rating which allows for some premium differentials typically by age or gender. Of the states mentioned here only New Jersey, New York⁵, and Vermont are pure community-rated states. The other four states, however, implemented adjusted community rating regulations, which still allow limited premium variation by specified amounts.

In all but one of the above cases community rating was combined with a strong guaranteed issue requirement; that is, insurance carriers were required to offer all health

⁵ Strictly speaking New York is an adjusted community rating state because geographic variation in premiums within the state is allowed.

insurance policies to any interested party. If the guaranteed issue requirement is not combined with community rating, the effect of the policy in isolation is unclear because carriers could simply offer policies with very high experience-rated premiums. Likewise, community rating without guaranteed issue is also unlikely to have a broad impact as carriers could simply not offer a policy to potentially risky individuals. Oregon, which implemented its adjusted community rating regulation in 1996, did not combine the rating restrictions with a guaranteed issue requirement. Because insurers in Oregon were able to choose not to offer a policy to individuals, one would expect that the state's non-group market is better functioning relative to more heavily regulated states. I will investigate this later.

In addition to the seven currently community rated states, New Hampshire and Kentucky previously implemented community rating along with guaranteed issue, but later eliminated both requirements. Both Kentucky and New Hampshire maintain restrictions on rating, but allow premium variation for health status and other characteristics. An additional nine states also have limits on premium rating by health status and other characteristics in the form of rating bands, but do not have a guaranteed issue requirement.

More interesting than summarizing the current status of state health policy is documenting the reasoning behind the enactment (or removal) of aggressive state-level health insurance regulations. In 1993 New York implemented pure community rating, only allowing rating differentials for geographical region (Hall 2000a). A common theme behind the implementation of community rating and guaranteed issue regulations appears to have been a most likely misguided attempt to protect Blue Cross/Blue Shield plans that were still operating under community rating in the face of the relatively new (at the time) competitive threat posed

by the HMO insurance industry.⁶ In New York Empire Blue Cross in the early 1990s was experiencing mounting losses and depletion of its reserves, possibly as a result of its own mismanagement (Best 1998). At the time it was argued that Empire was at a competitive disadvantage because of the requirement that it price its non-group and small group insurance products using community rating while its competitors were under no such obligation and were consequently accused of “cherry-picking” enrollees (Best 1998). In an effort to “level the playing field,” more in Empire’s favor evidently, all carriers in the state were required to employ pure community rating and guaranteed issue. Subsequent premium increases and insurer defections from the non-group market were evident almost immediately and continued throughout the decade (Hall 2000a).

Also in 1993, Vermont implemented adjusted community rating that initially allowed plans the ability to vary premiums by +/- 40% for demographic factors (though not health status); two years later the allowed variation in premiums was reduced to +/-20% (Hall 2000b). In 1999 the 20% variation provision in Vermont was eliminated and the regulation became pure community rating. The story behind Vermont’s regulations is similar to New York’s: mounting losses in the Blue Cross plan associated with a commitment in the non-group and small group markets to community rate products with open enrollment (guaranteed issue) (Hall 2000b). As with New York State, rate increases and insurance company defections ensued (Hall 2000b), culminating in Vermont’s Blue Cross plan (rather ironically) leaving the non-group market.

⁶ Pauly (1970), in discussing the history of community rating, mentions that community rating was likely chosen by Blue Cross because the non-for-profit hospital industry, which originally organized the Blue Cross plans, “felt that it was best suited to gain community support for their plans and the preferred (tax-exempt) status accorded in most places to both hospitals and their plans” (p. 408). It is not without some degree of irony that the original market distortion of favorable tax treatment in turn led to a commitment (often a binding legal one) to maintain a money-losing practice, which itself led to the sanctioning of further market distortion through community rating legislation in the hopes of correcting the financial problem.

In 1993 New Jersey implemented what was arguably the most aggressive regulatory regime that had been seen to date (and likely since): pure community rating for five standardized indemnity plans and one HMO plan (Swartz and Garnick 2000). In 2003 additional high-deductible plans (termed by the state “basic and essential” plans) were allowed by the state mainly because the premiums on the six standard plans were increasing so dramatically. In a break with previous policy, insurers are allowed to adjust premium rating for the new high-deductible plans based on age, gender, and geography. Despite the somewhat improbably optimistic early reviews of New Jersey’s regulations (see Swartz and Garnick 1999, 2000), more recent evidence appears to suggest that the non-group market in New Jersey “is heading for collapse” (Monheit et al. 2004, p. 168). Monheit et al. (2004) document declining enrollment and continually increasing premiums, the very definition of an adverse selection death spiral in progress. According to the most recently available data⁷, enrollment in the non-group market in New Jersey has finally begun to increase above its nadir, reached at the end of 2003 at roughly 77,000 enrollees (enrollment declined steadily since peaking at 220,000 at the end of 1995). Since that time, enrollment has increased to slightly over 85,000 in the first quarter of 2007, but this is almost completely owing to the increases in enrollment in the high-deductible basic and essential plans that were allowed in 2003: enrollment in this plan type increased from 2800 at the end of 2004 to nearly 21,000 in the first quarter of 2007.

Maine implemented modified community rating in 1993 that allowed premiums to vary by +/- 20% of the community rate for age, smoking status, occupation, industry, and geographic areas (Maine Bureau of Insurance 2001). By 2001 only one of the five insurers operating in 1994 was still offering products in the non-group market, and premium increases were very large (Maine Bureau of Insurance 2001). Even the Bureau of Insurance commented in 2001 that, “the

⁷ Data available at <http://www.state.nj.us/dobi/reform.htm>.

market for individual HMO coverage does now appear to be in a death spiral” (Maine Bureau of Insurance 2001, p. 4). Undeterred by the apparent lack of success with previous regulatory efforts, Maine has since gone farther in regulating its non-group market through the passage of the controversial Dirigo Health Reform Act in 2003, which essentially created a state-sanctioned, state-subsidized monopoly for Anthem Blue Cross. Perhaps not surprisingly, though it apparently was a surprise to state officials, interest in the plan was considerably lower than anticipated (Wachenheim and Leida 2007). A recent survey of the non-group market in Maine revealed that roughly half of enrollees had plans with \$5000 deductibles, and the average premium paid was \$237 per member per month (PMPM), with paid claims averaging \$214 PMPM and individual out of pocket payments averaging \$143 PMPM (Gorman Actuarial 2007).

Washington State implemented adjusted community rating as part of its aggressive and pervasive reform effort aimed at eliminating uninsurance in the state, the Health Services Act in 1993 (Kirk 2000). Much of the law ended up being struck down in court, but the community rating and guaranteed issue components for the non-group and small group markets remained. A number of insurers stopped issuing non-group policies in the state immediately, and the largest insurers, Premera Blue Cross, Regence Blue Shield, and Group Health, stopped selling new policies by 1999. Subsequently, in 2000 the regulations were scaled back thus allowing some risk-based underwriting and limits on coverage for pre-existing conditions, among other changes.

Massachusetts implemented adjusted community rating in 1996 that allowed non-group premium variation by age, geographic region, and family composition of no more than +/- 33% of the base premium (Kirk 2000). Similar to insurance markets in a number of other states, the Blue Cross plan in Massachusetts was a legally mandated “insurance provider of last resort” with community rating and guaranteed issue requirements. The small group market had already been

subjected to increased regulation in 1991. State law initially dictated three standard plan designs for the non-group market: an HMO, a PPO, and an indemnity plan with generous floors placed on benefit coverage. By 1999 virtually all enrollees were in HMO products (Kirk 2000). Interestingly, Kirk (2000) reported that in 1999 neither the Massachusetts Division of Insurance nor any insurer was actively marketing non-group policies. Needless to say, a reluctance by insurers to sell products to would-be customers is not a sign of a healthy, functioning insurance market. Massachusetts has achieved a great deal of attention for its recent universal health insurance coverage proposal; quite tellingly, what little remained of the non-group market was simply folded into the small group market as part of the legislation.

New Hampshire's adjusted community rating began in 1995. Premiums could vary by age by a 3:1 ratio, but not by health status (GAO 1996, Feldvebel and Sky 2000). As with other state regulatory initiatives in the non-group and small group markets, a key motivation in New Hampshire appeared to be the mounting losses of the state's community-rated Blue Cross plan when facing greater competition. New Hampshire's Blue Cross plan abandoned strict community rating in 1993, but also began lobbying for new rules to "level the playing field" (Feldvebel and Sky 2000, p. 198), leading to the passage of the community rating and guaranteed issue legislation in the small-group and non-group markets. Interestingly, Blue Cross was unable to attract significant new entrants to its non-group policies even without serious competition from other insurers and decided in 1997 to exit the non-group market (Feldvebel and Sky 2000). Efforts to repair the market began shortly thereafter, which ultimately culminated in the repeal of community rating and guaranteed issue in non-group and small-group markets by 2003. In another policy twist, adjusted community rating was reinstated in the small-group market in 2005

because of concern about premium increases for older, less healthy groups that resulted from the 2003 legislation (New Hampshire Insurance Department 2005).

Kentucky's experience with adjusted community rating is a particularly poignant one. When implemented in 1995, rating was originally allowed to vary by a ratio of 3:1 based on age, geography, and family composition, but not by health status or claims experience (Kirk 2000). A year later in 1996 legislation altered the law to allow premium variation by a ratio of 5:1 and differential rating for gender was allowed, but the premiums could not vary for gender by greater than 50% (Kirk 2000). However, by 1997 virtually all of the insurers had left the state. Because of this non-group market implosion by 2000 the community rating and guaranteed issue regulations were repealed. As recent as May 2007, seven insurers were now offering non-group policies in the state (Wachenheim and Leida 2007).

4. Previous Research

A number of studies have examined aspects of the non-group and small-group regulations enacted in the 1990s. Lo Sasso and Lurie (2007) examined how state community rating regulations combined with guaranteed issue laws affected the purchase of non-group insurance by different risk groups and how the composition of the risk pool changed as a result of the regulations. The authors also examined the extent to which insurance products changed as a result of community rating. Their results suggest that community rating of the non-group health insurance market was associated with a significant change in the risk composition of the non-group market. Using data from large, national surveys the authors found strong evidence, consistent with the theoretical work (described above) advanced nearly four decades ago by Pauly (1970), that community rating made healthy people less likely to be insured by non-group

health insurance. They also found less consistent evidence that healthy people were more likely to be uninsured as a result of community rating, though this was certainly the case for some young and healthy individuals. Unhealthy individuals were more likely to be insured through non-group policies yet the authors only found limited evidence suggesting that uninsurance decreased among the unhealthy. On balance the effects on either tail of the distribution canceled each other out so that no overall effect on coverage was evident. The results regarding non-group insurance market compositional changes were further supported by examining the impact of community rating on the health status and health care utilization of persons with non-group insurance before and after community rating in a subset of states, which suggests that enrollees as a group were sicker as a result of the community rating laws. Finally, the authors also found evidence that HMO penetration in the non-group market increased disproportionately in states that implemented community rating relative to states that did not implement community rating.

Herring and Pauly (2006) used a clever combination of different data sets and techniques to tease out an estimate of (a) how much risk pooling there is in the non-group market and (b) the effect of community rating and guaranteed issue regulations on premiums and purchase decisions. There are a number of potentially weak links in the chain of logic, but in general the analysis is a strong one. The first key finding is that doubling a household's health condition related expected expenditures leads to only a 15 percent increase in non-group premiums, which would appear to imply significant risk pooling in the non-group market. There is, however, an inherent difficulty in predicting health expenditures based on observable characteristics leading to measurement error and in turn a downward bias in the estimated effect of expected expenditures on premiums; hence, the true level of risk pooling is most likely lower than the authors claim, though how much lower is unclear. The other key finding is that community

rating and guaranteed issue regulations do lead to lower coverage among healthier people and higher coverage among unhealthy people, but the effect is quite small. They conclude that premiums under community rating and guaranteed issue are predicted to be 12-15 percent higher than in the absence of these regulations. However, one may legitimately question the validity of the 12-15 percent figure when examining actual premium offers from insurers in regulated and unregulated markets in the next section.

Congdon, Kowalski, and Showalter (2006) used data acquired from the web-based distributor of health insurance, eHealthInsurance. The authors acquired aggregated information on over 32,000 policies sold through eHealthInsurance in 2003 across 42 states. The authors related characteristics of the policies sold, notably premiums, to characteristics of the state policy environment in which the policies were sold, including the number of mandated benefits, any willing provider mandates, community rating, and guaranteed issue requirements. Unfortunately a number of key community rated states are not included (New York, Maine, Vermont, New Hampshire, Massachusetts among them). The only heavily regulated state in their data set is New Jersey. Premiums in New Jersey policies were over 100% higher than premiums in the rest of the country, with significantly less generous coverage likely owing to individuals purchasing newly allowed basic and essential plans. Community rating in the absence of the guaranteed issue regulations is associated with 20% higher premiums.

Marquis et al. (2006) conducted a detailed case study of the non-group market in California. The study makes use of data on premiums, enrollment, benefit levels, and basic demographics from the three largest non-group insurers in the state of California over the period 1998-2003, comprising 80% of all policies written in the state. The authors then conducted a survey of enrollees and supplemented their analysis with information from Census data sets.

Among the key findings from the study is that non-group enrollees take advantage of the wide variation in health insurance policies available in the non-group market. One surprising finding, at least relative to the conventional wisdom, is that the bulk of non-group policies sold are not merely for short-term coverage. The authors found that 60 percent of new policies involved coverage for more than one year while 30 percent involved coverage for more than three years. Confirming prior findings (see Glied et al. 2002), the authors found that enrollment in non-group plans is relatively price insensitive. However, they also found, confirming other work (see Cutler and Reber 1998), that, conditional on purchasing insurance, consumers were quite sensitive to premiums across plans. In general the authors present a portrait of a dynamic market offering affordable coverage to relatively large numbers of beneficiaries for both short-term and long-term coverage.

Zuckerman and Rajan (1999) used data from the Current Population Survey (CPS), a large national data set collected annually by the Census Bureau, aggregated to the state-level to examine the impact of small- and non-group regulations. The authors found that non-group market regulations, which were aggregated into “packages” of large and small regulations, resulted in higher uninsurance levels and lower levels of non-group coverage. The authors conclude that their findings are consistent with the view that people chose to wait until they needed health insurance or that there was a decrease in the number of carriers willing to offer non-group policies in the regulated markets. A shortcoming of this aggregate work is that the approach does not allow the authors to distinguish compositional changes within the pool of those covered by non-group policies after implementation of the regulations.

Percy (2000) also used data from the CPS to examine the impact of state regulations in the small group and non-group markets. Like Zuckerman and Rajan, the author aggregated

regulations into strong and weak regulation types; strong regulations are considered any state rating restriction combined with guaranteed issue provisions. The CPS prior to 1996 does not contain health status indicators, thus it is difficult to judge the risk associated with individuals. However, Percy stratifies between high and low risk by using predicted expenditures based on a regression of health care expenditures on age, gender, and race using the National Medical Expenditure Survey. Because no personal health status information enters the equation the stratification is not significantly different from simply stratifying by age. In a model that further stratifies by income, Percy finds that strong non-group regulations were associated with less private coverage for low-income groups.

In another study, Sloan and Conover (1998) used CPS data to examine the effect of community rating in the non-group market among other policy variables. They found that non-group community rating did not impact uninsurance using age as a risk status proxy, though they did find that for persons over 55 years of age community rating was associated with a higher rate of group health insurance coverage. However, the authors found that community rating in the non-group market was associated with a lower rate of private coverage, which they speculate could be the result of a decreased supply of insurance.

In addition to these studies of the non-group regulations, a number of other studies have examined the small group market regulations. Kosali Simon's work (2005) remains the best work to date on the effects of small group regulations. Using data from the CPS she found that in states with "heavy" small group regulations, which included at least modified community rating and guaranteed issue rules, individuals employed by small firms (less than 25 workers) experienced decreases in health insurance coverage relative to states with comparatively minor

regulations. The effect was particularly pronounced among younger, unmarried men, a finding similar in spirit to Lo Sasso and Lurie (2007).

Simon's findings are somewhat at odds with the highly cited paper by Buchmueller and DiNardo (2002) published in the economics profession's flagship journal, the *American Economic Review*, which concluded that community rating in New York State had no significant effect on non-group and small-group coverage relative to the largely unregulated market in Pennsylvania. To Simon's credit, she re-estimated her main regression model including only the states examined by Buchmueller and DiNardo and did not find a statistically significant effect. Of course lack of a statistically significant effect does not lead one to conclude there was no effect; it merely means that if there was an effect it is not detectable given the data, sampling frame, and statistical methodology. It should also be noted that Buchmueller and DiNardo's data only went through 1996, just three years into the regulations, and important effects could have manifested later.

Other recent efforts to clarify the effects of the small group regulations have generally only muddied the waters. A case in point is Davidoff, Blumberg, and Nichols (2005), who attempted to refine estimates of the effect of small group regulations by using a data set with better information on health status (the National Health Interview Survey). The authors found that guaranteed issue and rating regulations in the small group market led to a 4.5 percentage point increase in employer-sponsored health insurance coverage for high-risk individuals and a "small" 1.7 percentage point decrease in employer-sponsored health insurance coverage for low-risk individuals. The work is not without its problems⁸, most seriously the authors do not

⁸ The conclusions from the paper are based on three statistically significant coefficient estimates from a table consisting of an additional 51 statistically insignificant coefficient estimates (which incidentally is precisely the number one would predict to be "significantly" different from zero if 54 numbers were randomly generated from a

acknowledge that the percentage point gain in insurance coverage for the sick and the loss of insurance coverage for the healthy are measured relative to vastly different population bases. The percentage point change for the sick is relative to the small group market while the percentage point change for the healthy is relative to the healthy members of small *and* large groups, implying that the loss in coverage in absolute numbers is likely far greater than any gain experienced by the unhealthy, an implication not drawn out by the authors.

Despite the large amount of work examining the small-group regulations, it is difficult to draw conclusive inferences from studies of the small group regulations because the studies have typically not been able to compare small employers who were likely to benefit from small group regulations (such as firms employing a number of older, sicker individuals) to small employers who were likely to be hurt by the regulations (such as firms that employ younger, healthier individuals). Consequently, the estimates might aggregate across the positive and negative effects, thus it is not surprising that the studies have uncovered modest or no effects of the regulations. In many ways the non-group market offers a much cleaner “experimental” setting in which to evaluate the impact of insurance regulations.

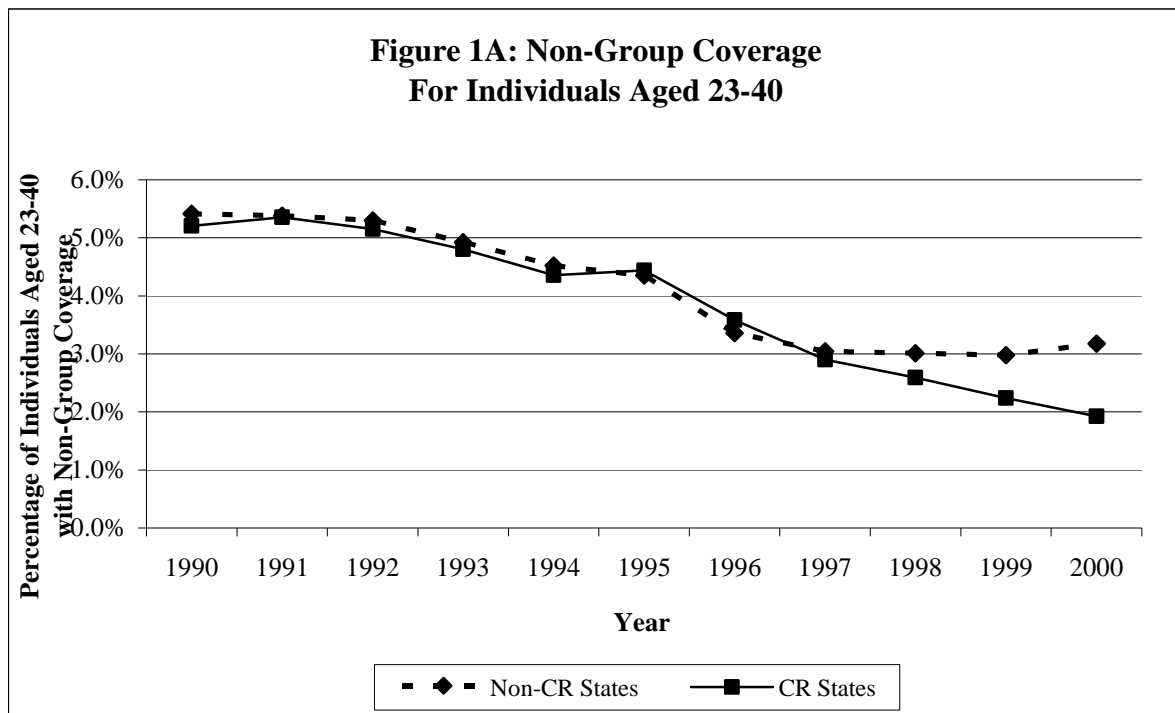
5. Further Analysis

Figures 1A and 1B display the trends in non-group health insurance coverage over the period 1990 through 2000 for adults below 40 years of age and adults over 40 years of age in states with and without community rating and guaranteed issue regulations, using data from the Survey of Income and Program Participation (SIPP), a large data set collected by the Census

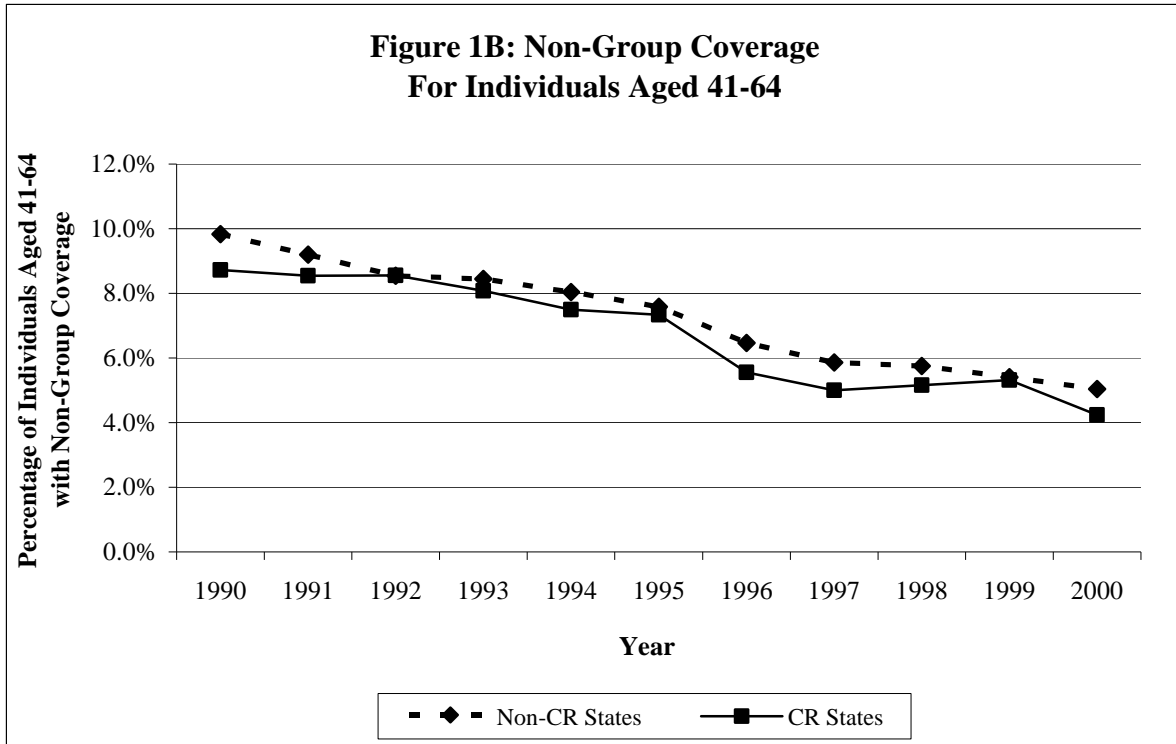
normal distribution). In addition, the results curiously suggest that “medium” state regulations should have stronger effects on coverage than do “strong” state regulations.

Bureau.⁹ In both graphs the trend in non-group coverage conforms to the well-documented secular decline in non-group coverage observed in other data sets such as the CPS (Mills 2000).

Figure 1A indicates that, among younger individuals, non-group coverage was similar across states that would eventually implement community rating and states that would not. However, in the period after all of the former group of states had implemented community rating (after 1996), a clear divergent trend in non-group coverage begins to emerge among younger individuals, suggesting lower rates of non-group coverage in community-rated states. Figure 1B suggests that



⁹ Successive waves of SIPP data from 1990, 1991, 1992, 1993, and 1996 are used to construct the estimates. Community rated states are New York, New Jersey, Massachusetts, Washington, Kentucky, and New Hampshire. Sample size prevented the inclusion of Vermont and Maine.



there was no such divergence apparent among the older members of the population. The differential response by potential risk status is precisely consistent with the anticipated effect of community rating. More specifically, while not conclusive, the figures suggest that increasing premiums for younger and presumably healthier individuals are met with reductions in coverage as the premiums must implicitly subsidize older and presumably unhealthier individuals. It is interesting that there is not a corresponding increase in coverage among older individuals in community rated states, which suggests that the community rated policies may not be such a deal for the majority of older individuals as well.

The aggregate trends appear to suggest that the overall effect of community rating is somewhat slow to manifest, but some degree of divergence is evident among younger individuals. The divergent trend in coverage for younger individuals suggests that their premiums for available policies were increasing, which is certainly consistent with the anecdotal

evidence reported above. However, premium information on non-group and small group policies is one of the most difficult to obtain items of information, which explains why much of the published work on the issue discussed in the previous section uses “reduced form,” quasi-experimental approaches to inference, measuring behavioral change following the policy change relative to a control group that did not experience the policy change and attributing the difference to increasing premiums.

While far from scientific, lessons about access and affordability of the individual and small group health insurance markets can be inferred from the popular website www.ehealthinsurance.com. eHealthInsurance is a company that markets individual and small group health insurance policies on the internet. A consumer interested in potentially purchasing a health insurance policy that he or she has found through the website is referred to a broker to facilitate the transaction. There are limitations to the use of the website for even modest research purposes. First, the website provides no information on how frequently the policies are actually purchased. Hence attempting to infer what individuals actually paid for purchased policies is not possible from the website, though it is plausible to treat the listed policies produced by the website as a good representation of the array of options available to most would-be purchasers. The qualifier “most” in the previous sentence raises the second concern about the interpretation of plan details—particularly premium and coverage information—from the eHealthInsurance website. Namely, the premiums presented on website represent a credible representation of what a *healthy* person would likely pay for a health insurance policy, at least in states without community rating and guaranteed issue requirements. This is because typical insurers will use underwriting to adjust premiums for potential health care expenditure risk factors; underwriting might also determine that the insurer does not want to risk insuring the individual at all. A

commonly cited figure in the industry is that 80% of policies sold are not underwritten. Of course in community-rated guaranteed issue states, the displayed premiums represent what both the healthy and the sick would pay for the policy. A third concern is that not all insurers in a given market may contract with eHealthInsurance to have their policies marketed in this manner. However, in competitive insurance markets with several insurers it is unlikely that other insurance companies not listed on the eHealthInsurance website would offer policies too far out of line with those presented on the website.

Using data obtained from the eHealthInsurance website, information on non-group health insurance policies is presented in Table 1 for hypothetical applicants in a select group of states. Two states are currently community rated with guaranteed issue (New York and New Jersey), two states currently are neither community rated nor have guaranteed issue but are contemplating such regulations (California and Pennsylvania), and one state is community rated without guaranteed issue (Oregon). Information is summarized on the breadth of policies available, including the number of insurers providing information to eHealthInsurance, and their premiums and basic policy characteristics for hypothetical 25- and 60-year-old single male applicants.

A number of salient facts are readily apparent from the information presented in Table 1. First, there are far fewer plans and insurance companies presented in the community-rated guaranteed issue states: only 10 plans from three companies in New York and 12 plans from two companies in New Jersey. This might be potentially misleading as the highly regulated insurance markets of New York and New Jersey might create incentives for even those few insurers, perversely, to avoid marketing their products to consumers. For example, the New Jersey Department of Banking and Insurance website lists seven insurers from whom non-group policies can be purchased. New Jersey requires insurers who write policies in the large group

market to also offer policies in the small- and non-group markets or pay a share of losses incurred by insurers operating in these markets (Swartz and Garnick 2000). Clearly, however, there are many challenges when it comes to the efficacy of mandating that an insurer “participate” in a market: an insurer might technically be participating in a market but not actively marketing insurance products.

The other obvious point to be drawn is that premiums for the 25-year-olds are considerably higher in New York and New Jersey relative to the other states sampled. The premiums for the most expensive plans listed for a 25-year-old in New York and New Jersey are roughly double those observed in the other three states; in the case of New Jersey, the most expensive plan offered would at best be considered a high-deductible plan with a \$5000 deductible and \$10,000 out-of-pocket annual maximum. As mentioned above, New Jersey has recently allowed the sale of cheaper, limited-benefit policies such as the \$155/month policy that covers office visits up to \$700 per year. While the plan does include coverage for hospitalization, there is no cap on the out-of-pocket spending that could result from exceeding benefit limits. As seen earlier, these basic and essential plans have been attracting enrollment from consumers in New Jersey. While it is reasonable to assume that the purchasers of the limited-benefit policies are healthier than average non-group enrollees in New Jersey, one must wonder whether they would prefer the far cheaper policies on the low end of the coverage spectrum evident when examining policies available in Pennsylvania and California.

Table 1: eHealthInsurance.com Health Plan Availability Summary for Selected States

| <i>State/Individual</i> | <i>Num Plans</i> | <i>Num Insurers</i> | <i>Median Premium and Plan Summary</i> | <i>Lowest Premium and Plan Summary</i> | <i>Highest Premium and Plan Summary</i> |
|--------------------------|------------------|---------------------|---|---|---|
| Oregon/25 year old | 110 | 8 | \$101/month PPO HSA \$2500 deductible 20% coinsurance \$5000 OOP max | \$35/month PPO \$10,000 deductible 50% coinsurance \$20,000 OOP max | \$339/month HMO \$0 deductible 0% coinsurance/ \$15 office copay \$3000 OOP max |
| Oregon/60 year old | 110 | 8 | \$309/month PPO HSA \$1500 deductible 20% coinsurance \$5000 OOP max | \$106/month PPO \$10,000 deductible 50% coinsurance \$20,000 OOP max | \$960/month HMO \$0 deductible 0% coinsurance/ \$15 office copay \$3000 OOP max |
| New York/25 year old | 10 | 3 | \$306/month HMO* HSA \$2000 deductible 0% coinsurance \$2000 OOP max | \$262/month HMO* \$0 deductible 0% coinsurance \$20 office copay No OOP max | \$651/month HMO \$0 deductible 0% coinsurance \$20 office copay \$1500 OOP max |
| New York/60 year old | 10 | 3 | \$306/month HMO* HSA \$2000 deductible 0% coinsurance \$2000 OOP max | \$262/month HMO* \$0 deductible 0% coinsurance \$20 office copay No OOP max | \$651/month HMO \$0 deductible 0% coinsurance \$20 office copay \$1500 OOP max |
| New Jersey/25 year old | 12 | 2 | \$429/month Indemnity \$10,000 deductible 50% coinsurance \$15,000 OOP max | \$155/month EPO** \$0 deductible Up to \$700 in OP cvg No OOP max | \$658/month Indemnity \$5000 deductible 50% coinsurance \$10,000 OOP max |
| New Jersey/60 year old | 12 | 2 | \$476/month HMO \$0 deductible 0% coinsurance/ \$30 office copay No OOP max | \$296/month HMO \$2500 deductible 50% coinsurance/ \$40 office copay \$5000 OOP max | \$658/month Indemnity \$5000 deductible 50% coinsurance \$10,000 OOP max |
| Pennsylvania/25 year old | 76 | 6 | \$90/month PPO \$2500 deductible 20% coinsurance/ \$30 office copay \$5000 OOP max | \$40/month PPO \$5000 deductible 20% coinsurance No OP coverage \$8000 OOP max | \$312/month PPO \$500 deductible 20% coinsurance \$1500 OOP max |
| Pennsylvania/60 year old | 76 | 6 | \$464/month PPO HSA \$3000 deductible 20% coinsurance \$5000 OOP max | \$184/month PPO \$5000 deductible 20% coinsurance No OP coverage \$8000 OOP max | \$1593/month PPO \$500 deductible 20% coinsurance \$1500 OOP max |
| California/25 year old | 109 | 8 | \$112/month PPO \$1000 deductible 30% coinsurance/ \$30 office copay \$5500 OOP max | \$47/month PPO \$5000 deductible 30% coinsurance \$7500 OOP max | \$331/month HMO \$1000 deductible 0% coinsurance/ \$15 office copay \$3000 OOP max |
| California/60 year old | 109 | 8 | \$508/month PPO \$2500 deductible 20% coinsurance/ \$30 office copay \$4500 OOP max | \$238/month PPO \$5000 deductible 30% coinsurance \$7500 OOP max | \$1631/month PPO \$500 deductible 25% coinsurance/ \$30 office copay \$4000 OOP max |

Notes: * Policy only available to self-employed and sole proprietors. ** EPO signifies exclusive provider organization, coverage only available for in-network providers. Data retrieved from www.ehealthinsurance.com on July 26, 2007.

In New York the cheapest policy is nearly 7, and 1.5, times the premiums of the cheapest policies available for a 25-year-old and a 60-year-old in Pennsylvania, respectively, though with admittedly greater coverage in New York. However, the relatively inexpensive (“cheapest”) New York policies claim to be only for the self-employed and sole proprietors, which would appear to represent a means of selecting potentially healthier enrollees, given that individuals actively employed are likely to be healthier than persons who are not employed.

Another interesting point is that in the adjusted community rating without guaranteed issue environment of Oregon, premium variation and breadth of policies offered appear strikingly similar to conditions in neighboring non-community-rated California. One would assume that the insurers in Oregon make more aggressive use of the denial of coverage option than states without community rating. The unfortunate yet predictable by-product of this policy regime is that moderately unhealthy individuals who would be willing to pay a higher, underwritten premium in order to have some health insurance coverage will be more likely to *not* be offered a policy at all in Oregon.

The information compiled from eHealthInsurance is certainly suggestive of important differences in the premiums and availability of health insurance policies between states with and without strong non-group and small group market health insurance regulations. Yet there could be numerous other factors at play in the premium differences between states, including regional variation in health care costs, health care infrastructure, industrial composition, and consumer preferences. As a result, it is difficult to draw conclusive findings about the effect of regulations from a cross-sectional “snapshot” of policies available.

6. Concluding Remarks

The information compiled and presented here provide a compelling portrait of the predictable distortions that can result from regulations aimed at improving perceived deficiencies in the non-group and small group health insurance markets. The predictions from economic theory are unambiguous and the bulk of the scholarly literature consistently point to decreases in coverage for young and healthy individuals and (with less regularity) increases in coverage for older and unhealthier individuals. A common sense look at the premiums for non-group health insurance policies in regulated and unregulated markets suggests that regulated markets offer only limited options for the healthy and still quite expensive options for the unhealthy.

There are at least two wildcards to consider for state policy makers envisioning reform efforts. The first is the potential efficacy of individual insurance purchase mandates to increase, through admittedly heavy-handed methods, the take-up of health insurance. We will probably get our first inkling on how successful such an approach is as the Massachusetts experiment rolls forward. The second wildcard is the potential role of high-deductible health savings accounts in making insurance more attractive or at least more affordable to an expanded spectrum of the country. Although the downstream effects of greater consumerism in health care are difficult to predict, it could potentially augur greater transparency in prices for medical care services and even some modest competition among providers as more health care dollars transition from third-party insurer payers to first-party consumer payers armed with a tax-preferred vehicle to save for future individual and family health care needs.

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