

# **AN EVALUATION OF HEALTH INSURANCE MARKET REFORMS**

## **Summary of Findings**

**Wake Forest University School of Medicine**

Mark A. Hall, J.D., Principal Investigator

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**Contact author at:  
Department of Public Health Sciences  
Wake Forest University School of Medicine  
Medical Center Boulevard  
Winston-Salem, NC 27157-1063  
336-716-9807**

mhall@law.wfu.edu  
[www.phs.wfubmc.edu/insure/](http://www.phs.wfubmc.edu/insure/)

This is a brief summary of the major findings, abstracted across the multiple states in which this study was conducted. These findings characterize the dominant impression across these states, but there are significant exceptions to some of these findings in some states. For more information and explanation, consult the full reports on this web site.

## Generally

- Reforms to the small-group market are more successful than those in the individual market, and the effects of reform must be analyzed separately in each market segment.
- Different versions of small-group reform do not vary dramatically in how they perform based on the components of the reform law. States with stringent, medium, and lenient versions of small-group reform have had similar results.

## Enrollment and Availability

- Both small-group and individual market reforms have enabled high risk (older or sicker) people to obtain coverage, if they can afford it. In an actual market test performed by a small employer with three workers, one of whom has a serious illness, little or no difficulty was encountered in finding coverage in states with insurance market reforms. Agents were more responsive and indicated less difficulty finding coverage in states with more stringent reforms.
- Small-group reforms have not substantially increased or decreased the percentage of small-group employees with private health insurance. Some states report substantial increases in the total number of small employers offering insurance or the total number of workers in small firms with coverage. However, these data sources are not entirely reliable, and they fail to account for the growth in the number of small firms or improvement in general economic conditions that occurred independently of these reforms.
- Small-group reform laws have had a significant positive impact on the ability of very small "micro" groups of 5 or fewer workers to obtain group coverage. However, most insurers continue to resist selling to groups this size because of greater administrative costs and adverse selection concerns.
- Although more small employers may be offering health insurance to their workers now than prior to market reforms, more employees are declining coverage or are opting not to pay for dependent coverage because of increased cost-sharing requirements.
- Enrollment in the individual market has dropped in response to reforms that impose guaranteed issue of all products and pure community rating. However, these reforms have not created an adverse selection "death spiral" nor have they caused the collapse of the individual market. Instead, these reforms tend to create an individual market that resembles a large high risk pool, one with widespread and substantial enrollment but in which it is more difficult for younger, healthier people to find affordable coverage.
- The "whole group," portability, and renewability features of the small-group reforms have been highly successful and are the most popular features among insurers and agents.

Restricting pre-existing condition exclusions to 12 months has not caused any noticeable problems.

- In the small-group market, the move from guaranteed issue of some products to guaranteed issue of all products has not been highly problematic or controversial. However, in states that allow rating flexibility, insurers such as HMOs and Blue Cross that previously engaged in community rating on a voluntary basis have begun to use medical underwriting in their rating decisions much more aggressively, in response to having to guarantee issue all of their products.
- Insurers have responded to guaranteed issue by increasing their requirements for employer contributions and employee participation, that is, by requiring that employers contribute a higher portion of the premium and that a higher percentage of eligible employees enroll. Insurers also screen these eligibility requirements more aggressively than before, and use these requirements in place of medical underwriting.
- States' efforts to standardize health insurance products have not succeeded. Standardized benefit plans that states require insurers to offer have sold very poorly in most states. For a variety of reasons, insurers and agents do not like these plans and so have not actively marketed them. Insurers and agents resist these plans because they see the covered benefits as inferior, or excessive. For a while, some states required only these plans to be guaranteed issue, and so they were expected to attract higher risks. Also, insurers complain about the administrative burden required to adapt their claims processing and computerized systems to reflect the differences in structure and content between their favored plans and these standardized plans.
- Insurers use various techniques to encourage agents to avoid high risk subscribers. Where allowed, insurers pay lower commissions on less desirable business. Also, insurers select and manage their agents in a manner that encourages loyalty and favoritism.
- The techniques just mentioned, especially lower commissions, have some impact on agents' willingness to sell coverage to higher risk subscribers. However, because most agents are independent of insurers and are paid by commission, they are well positioned and well motivated to promote coverage for both low and high risks, and they resist insurers' efforts to manipulate them. Agents as a whole are very much in favor of small-group market reforms and play a critical role in the success of these reforms.

### **Prices, Competition, and Rating Restrictions**

- Price increases remained remarkably low in the small-group market in most states during the first few years following reform. This is especially true for managed care products such as HMOs, and less true for traditional indemnity products. In 1997 and 1998, small-group rates increased more steeply for all products. These price trends appear to be independent of the reform law and driven by more systemic market conditions.
- Small-group markets remain highly competitive, both in price and in product offerings.

Some insurers left some or all states partly because of small-group reforms, but mainly for other strategic reasons. A number of new insurers entered small-group markets or became more aggressively competitive following the reform law. Most notably, the portion of the small-group market going to HMO plans increased very rapidly following enactment of reforms.

- These competitive conditions and the shift to managed care are thought by many informed observers to be independent of the reform law, but there are a number of plausible explanations for why the reform law might have precipitated or facilitated these conditions. In any event, it is clear that small-group reforms have not dampened competition.
- Product diversity and innovation in the small-group market remains active following market reforms. There is little indication that insurers' product design decisions are being driven by risk selection strategies in the small-group market; rather, they are mostly responsive to market-wide demands for better coverage, lower prices, or more choice. However, in the individual market, pure community rating has caused insurers to reduce benefits and eliminate more comprehensive indemnity offerings in order to avoid attracting the worst risks.
- Indemnity insurers believe, with some justification, that both individual and small-group market reforms create a set of market rules that favors managed care, because of natural selection patterns that tend to result in established indemnity insurers attracting higher risks. This concern is greater when rating rules do not allow some adjustment for health status.
- Where rating rules do allow health status adjustment, many insurers use this flexibility to full advantage by issuing standard coverage at the bottom of the allowable range rather than at the middle, in order to have maximum room to increase rates for higher risks. This greatly restricts the ability, however, to offer discounts to the healthiest subscribers, and it results in rate increases for higher risks that are much larger than first appears possible. Thus, for instance, a +/- 25 percent rating flexibility, which many states allow, permits insurers to charge the highest risks 67 percent more than the lowest risks (1.25 vs. .75). In addition, insurers in these states are usually allowed to make full adjustment for the risks associated with age, gender, family composition, and geographic location. This results in a possible range in rates of 10-fold or more for the same coverage.
- Most insurers are hostile to pure community rating, and many insurers are hostile to adjusted community rating. However, in the small-group market, we did not observe consistent and substantial market performance differences between states with different rating rules. There are some indications, however, that pure community rating causes somewhat greater market-wide price increases and adverse selection against indemnity plans than do other rating rules. These effects are not nearly as large and potentially destabilizing, though, as they are in the individual market.
- In the individual market, the stringency of rating restrictions has a dramatic effect on the

willingness of insurers to remain in the market and on adverse selection effects against the market. States that have adopted pure community rating in the individual market have experienced significantly worse problems, although some states have adapted better to pure community rating than have others.

- Pure community rating in the individual market prompts insurers to adopt various risk avoidance techniques much more aggressively. Among these is trying not to have the most comprehensive benefits or the most attractive price, since these features tend to attract more higher risk subscribers. This can create a perverse market dynamic in which insurers compete by trying to avoid attracting subscribers. To mitigate these tendencies, states with pure community rating in the individual market must set minimum benefit standards and require prior approval for significant rate increases.
- If prior rate approval is perceived by insurers to be onerous, this can have a more damaging effect on insurer participation than community rating. Insurers are sometimes willing to stay in a market, even though they oppose restrictions on risk rating, if they believe they can increase their average rates as needed to keep up with increasing claims. If they lack this confidence due to prior rate approval processes that take too long or are seen as unfair or excessively politicized, then insurers are much more inclined to leave a market, regardless of the leniency or stringency of the rating rules.
- Competition (in both the small-group and the individual market segments) still focuses to a considerable extent on risk selection strategies and effects, and on product differentiation. Even among managed care plans, there is almost no competitive focus on quality of care offered by competing networks. Price is the dominant focus of competition, but because benefits are not standardized, it is still difficult for consumers to make apples-to-apples comparisons.
- Purchasing cooperatives have functioned effectively in some states, but not in others. In states where they are effective, however, they have only a small market share. Their greatest perceived advantage is offering greater choice to employees who previously were offered only a single plan. Purchasing cooperatives have not significantly lowered prices through bargaining power, however. In some states, this is prohibited. In others where this might be allowed, most insurers and agents do not aggressively seek business through purchasing cooperatives and so a strong competitive dynamic has not taken hold. This resistance is due to a number of factors, but the most prominent among agents is the sense that the purpose or eventual effect of purchasing cooperatives is to make agents superfluous. Insurers are also concerned that some purchasing cooperatives tend to attract higher risk groups.

### **Administration and Enforcement**

- Health insurance market reforms have been relatively easy to administer. Insurers are well-motivated, and basic compliance within the industry is widespread. These laws have not required a large investment of enforcement or oversight resources by state regulators. Insurers, however, complain that it consumes a substantial amount of their administrative

resources to keep up with the multitude of differences across 50 states and the numerous and rapid amendments to these laws.

- Most states do not conduct detailed audits of insurers' practices under these laws. Therefore, some misinterpretation or circumvention may be going undetected. For instance, compliance with complex rating rules is typically determined only through an actuarial certification filed by each insurer, which contains only a broad and general assurance that actuarial and underwriting practices meet the legal requirements. This creates leeway for insurers to interpret and apply these rules in ways that are most favorable to them but that may not accurately capture legislative intent or regulatory policy.
- An important example of the point just made relates to adjusting rates to reflect differences in covered benefits. Such rate adjustments are supposed to reflect *risk-neutral* differences in benefits, but because some benefit packages are more attractive than others to subscribers of different risks, it is possible for these actuarial adjustments to capture health status factors as well. If allowed to do so, insurers could engage in risk segmentation and risk rating to a greater extent than intended by rating rules. Most regulators, however, do not collect sufficient information to audit these practices. Accordingly, we observed several instances where insurers were charging substantially more for plans with leaner benefits because these plans are purchased by higher risk subscribers.
- Other enforcement or circumvention problems are also of a comparatively minor nature, but are still noticeable in some states and for some insurers. These include: selling less-regulated individual products to small-group employees; selling individual insurance as if it is group insurance, to avoid individual market reforms; and purchasers falsely claiming to be small employers or falsely including people in the group who are not actual employees.
- In most states, there is no significant trend to small groups opting for self-insured arrangements in order to avoid the small-group laws. This is happening, however, in some states where the law allows the sale of high-deductible plans as if they were self-funded arrangements with low stop-loss levels.
- The reinsurance mechanisms that many states established to help shelter insurers from a disproportionate share of high risks have functioned smoothly, but they have had little impact. Insurers have used these mechanisms much less than anticipated, and the insurers with the largest market shares have opted not to participate. Very few insurers said that reinsurance was important to their decision to remain in a market. Other risk adjustment mechanisms are viewed as too primitive to be fully effective.