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THE COMPETITIVE IMPACT OF SMALL GROUP HEALTH INSURANCE REFORM LAWS

Mark A. Hall*

This Article reports on findings from an extensive study of small group health insurance market reforms in seven states, enacted during the early 1990s. After summarizing the content and purpose of these reforms, this evaluation focuses on the impact these reforms have had on the nature and degree of market competition. The principal findings are: (1) small group health insurance markets are highly competitive, both in price and in product innovation and diversity; (2) although some insurers have left some or all of these states in part because of these reforms, an ample number of active competitors remain, even in heavily regulated states; (3) in some of the more heavily regulated states, competition is very thin in less populated areas, especially for indemnity insurance; (4) the rapid growth in managed care in the small group market may have been precipitated by these reforms; (5) standardized benefit plans have not achieved their objectives; and (6) competitive forces still focus to a considerable extent on risk selection techniques and hardly at all on the quality of care.

INTRODUCTION AND METHODOLOGY

This study evaluates how small group health insurance reform laws have affected the nature and extent of competition among insurers.¹ The study focuses primarily on selected state laws

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1. As we begin, a word or two is required about terminology. Health insurance, like any other industry, has a specialized vocabulary with terms of art that sometimes differ from common understandings and that often are used inconsistently within the industry, due in part to regulatory differences among the states. For our present purposes, simplicity is valued over precision, so this Article will use a lay vocabulary that glosses over many of the distinctions that are important within the industry. Thus, "insurer" includes, generically, both indemnity and HMO plans. "Managed care" refers primarily to HMO plans, including point-of-service plans. In contrast, "indemnity" means both traditional unconstrained fee-for-service plans as well as more managed forms of indemnity such as preferred provider organizations (PPOs). "Insurance agents" refers mainly to independent agents, sometimes

enacted in the early 1990s, but this research also provides some preliminary evaluation of small group portions of the federal Health Insurance Portability and Accountability Act² which took effect in 1997. This study looks at various small group market reforms in seven states: Colorado, Florida, Iowa, New York, North Carolina, Ohio, and Vermont. The principal reforms studied are: (1) guaranteed issue and open enrollment, (2) renewability and portability, (3) rating bands and community rating, (4) restrictions on underwriting practices such as risk selection and pre-existing condition exclusions, (5) purchasing cooperatives, and (6) reinsurance and risk adjustment.

This intensive case study was conducted primarily through more than 100 semi-structured in-depth interviews in 1997 and 1998. The primary sources of information in each state were insurance regulators, insurers (commercial, nonprofit, and HMOs), agents/brokers, public and private purchasing cooperatives, reinsurance pool administrators, and trade associations.³ Also, extensive documentary data and information sources were collected through multiple sources, including insurers, regulators, agents, and newspapers and other academic and public policy studies. Finally, a market testing study was conducted to determine the ability of an actual small employer and unhealthy individual to obtain insurance. These multiple sources of information and data were analyzed using both qualitative and quantitative techniques.⁴

Part I reviews the history, purpose, content, and logic of these reforms and summarizes the concerns raised by opponents. Part II presents the study's findings with respect to the impact of these reforms on market competition. Part II first addresses market

called brokers. The terms "premium," "price," and "rate" are used interchangeably to refer to the cost of insurance. Finally, "health insurance" means comprehensive major medical policies, in contrast with more limited or specialized coverage. Other, more technical terms will be defined later in the context in which they are important.

2. Pub. L. No. 104-191, 110 Stat. 1936 (1996).

3. Interviews lasted approximately one to two hours each and were based on an interview guide, but the discussions were free-ranging and the interviewers covered a variety of topics. Interviews were conducted primarily by the author, who is the principal investigator, and by Elliot Wicks, Ph.D., who is a consultant to the project, with the assistance of Janice Lawlor, M.P.H., project manager. Most interviews were in person and one-on-one, but a number were over the phone and in groups of two to five subjects. See Mark A. Hall, *An Evaluation of Health Insurance Reform Laws: The Views of National Insurers* (last modified Apr. 6, 1999) <<http://www.phs.wfubmc.edu/insure/NatIns/>> (on file with the *University of Michigan Journal of Law Reform*).

4. See Mark A. Hall & Janice Lawlor, *Wake Forest University Health Insurance Market Reform Study* (last modified Apr. 21, 1999) <<http://www.phs.wfubmc.edu/insure/reports.html>> (on file with the *University of Michigan Journal of Law Reform*) (providing the full collection of lengthy research reports, each focusing on a specific state).

structure in terms of the concentration of firms involved in the movement to managed care. Next, Part II separately examines the key dimensions of competition—price, product design, and quality. Part II concludes with a look at the continuing role that risk selection plays in the competitive dynamic.

I. HEALTH INSURANCE MARKET REFORMS

A. The Impetus for Reform

Health insurance market reforms were enacted across the country in the early 1990s in response to growing concerns that the market for individual and small groups was rapidly disintegrating and that market behavior was undermining the social objective of universal coverage.⁵ Problems first began to appear in the individual market for insurance sold outside the workplace. This end of the market has always been plagued by fairly severe adverse selection. Younger, healthier individuals often decline to purchase insurance until they or a family member anticipate significant expenses such as the birth of a child or the onset of a chronic disease. Those who purchase individually, therefore, tend to be at significantly greater risk for health care costs than those insured through employer groups. This raises the price to a level that many individuals cannot afford or are not willing to pay unless they know they are likely to use the benefits. Similar problems have also begun to spread to the small group market: that portion composed of smaller employers, where the group size creates the same problems of biased selection. At first, these problems affected only employers with ten or fewer workers, but significant selection problems have begun to affect firms of twenty-five and more.

To counteract adverse selection and to offer more attractive prices, insurers have long used a number of practices, known generically as medical underwriting, which limit the availability of health insurance. First, they have rated applicants according to

5. See generally MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE (1994) [hereinafter HALL, REFORMING HEALTH INSURANCE]; Mark A. Hall, *Reforming the Health Insurance Market for Small Businesses*, 326 NEW ENG. J. MED. 565 (1992) (discussing the purposes of reforms in the small-group market and the likely effects of the reforms); Mark A. Hall, *The Political Economics of Health Insurance Market Reform*, HEALTH AFF., Summer 1992 (discussing the purpose and likely effects of reforms in the small-group market). See also Linda Blumberg & Len Nichols, *First, Do No Harm: Developing Health Insurance Market Reform Packages*, HEALTH AFF., Fall 1996 (presenting four health insurance reform packages that could improve insurance market performance without aggravating risk selection problems).

their individual age and health status, which can price insurance out of the reach of older or chronically ill people. Second, to discourage subscribers from enrolling only when they are ill, insurers have imposed pre-existing illness provisions that offer insurance but do not cover for a defined period those health conditions that existed any time during the prior six to twelve months before enrollment. This makes health insurance much less attractive to subscribers who are sick or have sick family members. Still, many would choose to pay the premiums for a year or more in order to be covered thereafter. Insurers, therefore, have declined to cover high-risk individuals or groups or they have excluded altogether a designated set of health problems, such as cancer or asthma, a practice known as "ridering out."

A second problem created by pre-existing exclusion clauses is that once employees have fulfilled the waiting requirements, they are reluctant to switch to a new employer with another insurer and start all over. This can create a condition of "job-lock" in which mildly but chronically ill employees, or those with sick family members, are frozen into their present positions by the fear of losing insurance benefits if they switch jobs.

Some health insurers were also accused of "churning." This is the practice of offering deep discounts to new subscribers after extensive medical underwriting, based on their initial good health profiles, and then imposing extreme price increases of 50 to 100% or more after a year or two of coverage, or refusing to renew altogether. Frequently, these price increases or terminations were not based on any actual adverse claims history but instead reflected the "wearing off" of the predictive power of the initial screening. Medical underwriting tends to wear off by virtue of the statistical phenomenon known as "regression to the mean," according to which unusually good risks tend over time to become normal risks simply by the operation of the law of averages. Claims costs also rise over time simply because the initial pre-existing condition periods expire. After failing to anticipate these increased costs in their initial pricing, some insurers were offering unrealistically low prices at the outset and then imposing steep price increases on renewal, forcing many subscribers to search elsewhere for affordable coverage.

In sum, in the late 1980s and early 1990s, we witnessed what some have characterized as a not-so-gradual unraveling of the private market, beginning at its smallest (individual subscribers and very small employer groups) and progressing to medium-sized firms and larger. The task that state and federal lawmakers faced

was how best to weave these frayed ends of the health insurance rope back together at the same time that they were seeking to create mechanisms that would restrain health care costs.

Out of these multiple concerns and objectives arose a barrage of state legislation attempting to shore up the market for private health insurance. Between 1991 and 1996, all but four states enacted significant legislation that affects the pricing or marketing of private health insurance. This was followed in 1996 by the federal law known as the Health Insurance Portability and Accountability Act (HIPAA).⁶ This Article focuses on the aspects of these laws that apply to the small group market, which is typically defined as employers with fifty or fewer workers. This somewhat restricted focus is essential because the structure and economics of the individual and group markets are fundamentally different.⁷ The individual market is much smaller (accounting for less than 10% of private health insurance), individual insurance is not subsidized by employers, and it does not receive the same favorable tax treatment as employer-based insurance. Most importantly, the economics operate much differently when insurance is purchased by groups because this greatly minimizes the tendency (known as "adverse selection") for people to buy health insurance only when they expect to use it, and group purchase improves bargaining power and economies of scale.

B. The Logic and Content of Reforms

1. The Purpose of Reform—Health insurance reforms have multiple purposes, but they all tend to converge on one central goal: to create a market dynamic that will both promote health insurance coverage and limit health insurance costs. This broad objective has a number of subsidiary components, which include increasing insurance availability and affordability, reducing risk selection and

6. 110 Stat. at 1936. HIPAA standardized many aspects of state small group reform laws by setting uniform requirements for guaranteed issue, renewability, and portability for small groups. It also required states to adopt some mechanism that enables subscribers leaving group coverage to maintain individual coverage.

7. See U.S. GENERAL ACCOUNTING OFFICE, PUB. NO. HEHS-97-8, PRIVATE HEALTH INSURANCE: MILLIONS RELYING ON INDIVIDUAL MARKET FACE COST AND COVERAGE TRADE-OFFS 6 (1996) (noting that individual and employer sponsored markets differ substantially); Deborah J. Chollet & Adele M. Kirk, Understanding Individual Health Insurance Markets (Mar. 1998) (unpublished manuscript, on file with the *University of Michigan Journal of Law Reform*) (noting the differences in consumer entry in and exit from individual versus group insurance markets).

medical underwriting, “leveling the playing field” among insurers of different types, and stabilizing the market. Others view the purposes of reforms in political terms, as a means to improve the functioning of the private market to lessen the threat of a complete government takeover, or in some instances to force other members of the industry to compete on their terms.

Thus, there is no single, cohesive view that characterizes all insurance reform efforts. Some reformers view the existing market structures and practices as generally acceptable and socially responsible, except for certain excesses that give the industry a bad name. This view tends to prevail among smaller, indemnity-based insurers. Other reformers, however, have more sweeping goals. Such reformers feel that private insurers are dissipating too much of their competitive energies in socially unproductive or counterproductive efforts to screen, select, and measure individual health risks. These reformers think that the private health insurance market would serve its best social function if insurers would quit competing on the basis of risk selection and begin competing on the basis of risk management. This viewpoint is obviously more sympathetic to larger, managed care insurers.

According to this second viewpoint, risk selection has its strongest economic function where insurance behaves in the classic fashion of reducing risk by pooling large numbers of subscribers with similar risk profiles. Risk selection has its strongest social purpose when the risk in question is controllable, so that the cost of insurance motivates efforts to reduce the risk. These are some, but not the central, functions of health insurance. Health insurance pools not only attempt to enhance statistical predictability of uncertain events through the law of large numbers, but also to pool the known costs of predictable health risk through health insurance spread across a heterogeneous pool of both healthy and sick people, for both routine and catastrophic expenses. Health insurance has thus become in large part a pre-paid financing mechanism for predictable health care expenses. Moreover, many of the genetic and environmental factors that influence health risk are not controllable by individuals, so it is seen as unfair and unproductive to vary insurance cost by risk status. The more fundamental reformers, therefore, believe that insurers serve their most useful social function by covering as many people as possible and by setting prices to reflect their ability to control the underlying costs of treatment rather than their ability to accurately measure and project those costs. Reforms enacted with this mindset were intended, in part, to harness the energies that private

insurers previously applied to assessing individual health status (medical underwriting) and redirect them toward managing the costs of treatment. The purpose of this Article is to assess whether these reforms have achieved this particular set of purposes and whether they have improved or hampered the degree of competition in general.

The details of insurance market reforms vary considerably but the reforms share four essential components: (1) guaranteed issue and continuity of coverage, (2) rating bands and community rating, (3) purchasing cooperatives, and (4) administered reinsurance or risk adjustment. These laws also vary in their scope: most states define small groups as employers with two to fifty workers, but a significant number cover a hybrid category between small groups and non-groups known somewhat paradoxically as "one-life" groups. These are self-employed individuals who purchase insurance through their businesses. The following overview is based on the common features of this set of laws across all fifty states.

2. *Guaranteed Issue and Continuity of Coverage*—The starting point of reform is to make sure that any willing purchaser has access to insurance and can retain that insurance through subsequent renewal periods. "Guaranteed issue," also known as open enrollment, requires all insurers who participate in the small group or individual markets to accept any applicant.⁸ An important distinction exists between states that require only designated policies to be guaranteed issued and those that require this of all policies. Prior to HIPAA, only fifteen states had imposed the broader requirement, but since 1997 states have conformed their laws to HIPAA, which requires all small group policies to be guaranteed issued.⁹ HIPAA, however, applies only to groups of two to fifty employees, and many states retain the limited guaranteed issue requirement for the self-employed.

Where guaranteed issue applies only to some policies, it is usually to one or more standardized plans with benefits set by a government committee. Typically, these so-called "state-mandated" plans come in a very basic version or with a standard or common benefits package. Versions of each often exist for both indemnity and HMO products.

8. Guaranteed issue describes a continuous open enrollment requirement. Open enrollment usually describes a limited period of guaranteed issue. See HALL, *REFORMING HEALTH INSURANCE*, *supra* note 5, at 35.

9. For a more extensive discussion, see Jack A. Rovner, *Federal Regulation Comes to Private Health Care Financing: The Group Health Insurance Provisions of the Health Insurance Portability and Accountability Act of 1996*, 7 *ANNALS HEALTH L.* 183 (1998).

Enabling any group to obtain insurance is coupled with a "whole group" concept, which requires the employer to offer coverage to all individuals within a group. This prevents employers from angling for lower cost policies by excluding sicker individuals in the group and minimizes the selection problems that result if healthier individuals are allowed to drop out of the risk pool and purchase individual insurance.

Continuity of coverage once varied considerably among the states, but it is now mostly uniform for small groups as a result of HIPAA. Individual states, however, are still permitted to impose requirements that are more demanding than the federal law. As a result, insurance market reform laws promote continuity of coverage in three ways. First, insurers are prohibited from refusing to renew insurance except for fraud, nonpayment, or similar malfeasance. Insurance theory tells us that, once good and bad risks are pooled together randomly and remain together and a fair premium is set, actuarial soundness does not require that insurers be able to drop the bad risks as claims accrue. Moreover, if insurance does not remain available when the need for it arises, it is not attractive either to the sick or to the healthy.

The second aspect of continuity is the regulation of pre-existing condition exclusion clauses. Insurers are prohibited from riding out specific health conditions altogether. Under HIPAA, they are allowed for small group insurance to place only an initial twelve month pre-existing exclusion on any condition manifested within six months before the date of coverage. This restriction recognizes that some form of pre-existing exclusion is necessary in a market where the purchase of insurance remains voluntary. The pre-existing exclusion counteracts the tendency of subscribers to delay purchase until they are sick.

Third, these reforms address the problem of job-lock that arises when employees are afraid to change jobs for fear of having to undergo an additional exclusion period. The reforms promote the portability or continuity of coverage by requiring that subscribers, once enrolled, be permitted to transfer coverage to a new insurer without undergoing a new exclusion period, so long as the gap in coverage does not exceed two months.

Again, the logic is that of adverse selection. If insurance is acquired in a setting that is demonstrably not driven by selection concerns, such as a change of job, risks should distribute themselves evenly and predictably, and therefore no special protection against adverse selection is required. Insurers should be able to cover their risks simply by setting an appropriate initial premium.

Also, easing the ability to switch is critical to allowing insurers to compete on the basis of price and service quality.

3. *Rating Restrictions*—Guaranteed issue and continuity of coverage eliminate the worst effects of medical underwriting—denial of coverage, job lock, and churning. Standing alone, however, they would increase price variations and fluctuations by forcing insurers to take on the most extreme risks and allowing them to price their policies accordingly. Therefore, the second component of the reforms is to construct a variety of rating restrictions that compress the degree of price variation among subscribers. HIPAA purposefully does not impose rate restrictions, leaving this to state law. States have adopted various restrictions that compress the range of prices an insurer can charge across its entire book of small-group business at any point in time.

States use three basic approaches to rating restrictions: rating bands, adjusted community rating, and pure community rating. While each requires successively greater degrees of rate compression, the key distinguishing factor of each approach is the extent to which insurers may incorporate health characteristics in their rates, in addition to other allowable “case characteristics” such as age and gender. Rating bands allow insurance companies to consider health status when setting rates, but only to a defined extent above or below the mid-points. States originally allowed ranges of plus or minus 25 to 35%, but many have since tightened the range to plus or minus 10 to 20%. Prohibiting rate variation based on individual health status is called “modified community rating.” This is “modified” or “adjusted,” rather than pure, community rating because full or substantial adjustment is still allowed for age and sometimes gender factors. These states also sometimes permit adjustments for other factors such as the employer’s industry or whether employees smoke.

Pure community rating eliminates most of these other factors (including age/gender factors) and retains only location and family size as rating factors. Some states with this form of community rating are not totally “pure,” to the extent that they allow some small additional rate variation. The critical distinction is whether a state greatly constrains age and gender factors because these can result in rate variations of five-fold or more, even if individual health status is entirely removed. As a consequence, considerable rating flexibility remains even in states with modified community rating or tight rating bands. Because each allowable factor can be added to each of the others, and because demographic factors can be large, at the extreme these restrictions still allow more than a

ten-fold difference in the rates charged groups at either end of the possible combinations of risk factors. On the other hand, these distant outliers might be very rare.

4. *Purchasing Cooperatives*—As a partial solution to many of the inefficiencies in the small group market, states have created public purchasing cooperatives or have authorized varying forms of private purchasing groups. These purchasing cooperatives contract with insurers who agree to abide by certain marketing and pricing rules. The core idea is to streamline the marketing function and to form a larger risk pool in a fashion that creates for small groups the same bargaining clout, administrative expertise, and employee choice that are typically available to large employers. This Article will touch only briefly on this aspect of the reform laws.

5. *Reinsurance or Risk Adjustment*—The final component of these laws is an administered reinsurance mechanism that allows insurers to reinsure any risks that are expected to generate costs exceeding the prices that they may charge. Reinsurance encourages insurers to willingly accept all applicants by allowing them to pass their worst risks over to an industry-funded reinsurance pool. This outlet suppresses the incentive to engage in risk selection in various indirect and surreptitious ways such as targeted marketing, gerrymandered benefit packages, selective poor service, or field underwriting (informal screening by agents). This administered reinsurance mechanism differs from conventional, private market reinsurance because it is used selectively for groups or individuals that are expected to be higher risks than the allowable premium reflects. In contrast, conventional reinsurance covers all of an insurer's risk pool for the unpredictable chance that an actuarially accurate premium will not be sufficient.¹⁰ Commercial reinsurance also does not have a redistributive funding mechanism to spread the excess loss across the industry through a market-share based assessment.

An alternative approach is a system of mandatory, administered risk adjustment in which insurers with lower risk pools make transfer payments to those with higher risks, according to a specified, objective measure of risk. In theory, this approach is more accurate and fine-grained than reinsurance, but the techniques for making the required measurements are relatively undeveloped and untested, so risk adjustment is used only on a limited basis in a few states.

10. For an insightful discussion that makes many of these same points, see Randall R. Bovbjerg, *Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?*, 29 INQUIRY 158 (1992).

6. *Summary of Small Group Laws*—There is wide variation across the states in how to combine different versions of these dimensions of insurance market reform. This Article reports on findings from seven states, which reflect a range in the stringency of these laws. This chart summarizes the core features in each state prior to HIPAA, in decreasing order of stringency.

STATE	GUARANTEED ISSUE	RATING
<i>New York</i>	All products, 3–50 Groups of 1–2 can be sold either as groups or individuals	Pure community rating
<i>Vermont</i>	All products, 1–50	Nearly pure community rating
<i>Florida</i>	All products, 1–50	Modified community rating
<i>Colorado</i>	Statutory plans, 2–50	Rate band of +/-20%, phased down to 0% (modified community rating)
<i>N. Carolina</i>	Statutory plans, 1–50	Rate band of +/-20%
<i>Iowa</i>	Statutory plans, 2–50	Rate band of +/-25%
<i>Ohio</i>	Limited open enrollment, 2–25; 1 month/year for HMOs, and .5% of book of business for indemnity	Rate band of +/-35%

Colorado, Florida and North Carolina have state-wide public purchasing cooperatives, and New York and Ohio have localized private purchasing cooperatives. Colorado, Florida, Iowa, North Carolina, and Ohio have reinsurance pools, and New York uses a risk adjustment mechanism.

C. The Dangers of Reform

These reforms have attracted some vocal critics who warn about possible adverse consequences and a number of quieter voices who warn against setting hopes too high. The greatest fear is that these

reforms will be counterproductive because they could increase prices and decrease coverage. These reforms may raise prices because they make insurance most attractive to the highest risk subscribers by holding prices to less than the policy's actuarial value. The excess is built into the premiums paid by all purchasers, which will inevitably drive an undetermined number of lower risk purchasers out of the market, thus further raising the average price. This phenomenon is known as adverse selection against the market as a whole. This potential exists because the decision to purchase insurance remains voluntary and existing purchasers are thought to be highly price sensitive.

Critics most vehemently oppose pure community rating because it has the most severe rate compression, and therefore, has the greatest potential to drive out younger, healthier subscribers. Pure community rating, critics fear, will result in not simply a one-time loss in coverage, but an escalating, destabilizing dynamic that may cripple the market. When the first round of subscribers drops out, the community rate increases, forcing still more cycles of subscriber drop outs and subsequent price increases, setting into effect an adverse selection spiral that eventually would result in insurance so expensive that almost no one would buy it.

A related concern is that adverse selection will occur *among* insurers. Even if the market as a whole does not lose enrollment, some insurers, either by luck of the draw or due to systemic or strategic patterns, could suffer a greater loss of subscribers or attract higher risks, resulting in some insurers going out of business. This loss of enrollment affects not only their private welfare, but could compromise market competition if too many insurers fold or withdraw. This form of biased selection can occur because good and bad risks do not always sort themselves randomly among competing insurers. Instead, attributes of some insurers' plans attract healthier patients and other attributes attract sicker patients. For instance, patients who have strong ties with their physicians because of their medical histories may be more hostile to the restrictions in choice of providers imposed by managed care plans such as HMOs. Conversely, younger and healthier patients with no established physician relationships, or without anticipated heavy use of medical services, find these restrictions to be less of an inconvenience. On the other hand, patients who anticipate larger medical expenditures might prefer the lower deductibles and co-payments that are typical of HMOs. Therefore, there is considerable debate over the extent to which indemnity plans systematically attract riskier patients than do HMOs. Similarly, subscribers who have

mental illness will naturally gravitate toward plans with this coverage, and patients with chronic illness will be more attracted to packages that offer generous pharmacy benefits.

Insurers are able to engage in countless techniques to encourage this strategic behavior to their benefit. Some are devious and improper, using strategies such as poor claims service for sicker patients, or what is known as field underwriting—tacit encouragement of field agents to keep high-risk applications from ever reaching the home office. Other techniques are quite innocuous. Well-baby visits and an ample supply of pediatric specialists tend to attract young subscribers, and specialists in sports medicine may attract healthy subscribers. Lesser coverage of prescription drugs discourages very sick patients, and deleting from an HMO's drug formulary certain very expensive specialty drugs used to treat rare conditions will obviously deter subscribers who suffer from those conditions. Simply choosing one advertising medium over another or marketing more aggressively in one geographic area over another is likely to produce a varied mix of age and health status. Similarly, the managed care plan's location strongly influences the plan's attractiveness to different populations' choice of treatment facilities.

In sum, biased selection can occur both naturally, through patients' choice among different benefit packages, and artificially through insurers' calculated use of covert selection devices. Insurance reforms heighten this potential because they prevent insurers from accurately pricing according to anticipated medical costs. This is worrisome behavior that, at a relatively low level, may need to be policed. If it occurs on a larger scale, certain insurers may be forced artificially to leave the market or certain desirable insurance products and benefits packages may be withdrawn. Part II evaluates the extent to which these various beneficial purposes and potential harms have in fact occurred.

II. THE EFFECTS OF SMALL GROUP MARKET REFORMS

The following assessment of the law's impact begins with an overview of the general impact of small group market reforms on market structure. It then examines the movement to HMOs, and the impact on price competition. Non-price competition is discussed next, in terms of both standardization versus diversification in product offerings, and a focus on quality of care. This assessment concludes with a look at which risk selection techniques

survive reform and whether insurers have found tactics for circumventing these laws.

A. General Competitiveness and Market Concentration

The small group health insurance market in each of these states has been highly competitive over the past several years, as evidenced in a number of ways. First, numerous interview subjects held the nearly uniform opinion that these markets have been highly competitive. Most insurers see the market as offering good opportunities for increased sales but believe that they face stiff competition. Insurance agents are also enthusiastic about the impact of the law on their business because guaranteed issue makes it easier for them to sell insurance. This holds true even in New York, which has the most stringent law. Favorable comments include a statement by a New York agent that the law has been “a real boon to [our] business. . . . I’d venture to say our business has increased 50% to 60% at least. It was wild.” Another said the law

helped us tremendously because we were able to bring our rates down. Everybody said that [community rating] would put people like us out of business . . . because people didn’t need us and this and that and the other thing. I hate to tell you our business has quadrupled. . . . I saw it as a marketing opportunity because I think a lot of people fell asleep and really didn’t keep on top of what was going on. So there was a lot of opportunity for businesses throughout most of Manhattan because it’s right here on our fingertips to go in and explain what was going on with community rating, explain what the options were [to purchase insurance at uniform rates, regardless of age or health status].

Small group reforms have been especially successful in expanding market options for micro-sized groups (groups of five or fewer employees) extending down to self-employed individuals. Prior to reforms, many insurers never sold to micro-sized groups, or offered only individual coverage. Micro-sized groups are seen by insurers as inherently less desirable due to greater marketing and administrative expense and greater adverse selection. Following reform, market options have “improved tremendously” for groups under ten, and especially for those under five. Some insurers attribute much of their recent enrollment growth to these micro-sized groups. Evidence of

this can be seen in the fact that average group size has dropped sharply for a number of insurers. Nationwide, enrollment growth has been the strongest for groups under ten.¹¹

Market competitiveness can be measured structurally in terms of the number of competitors and the degree of market concentration. While there has been some degree of market consolidation in most of these states because a number of insurers have dropped entirely out of the small group market or have ceased actively soliciting new business, the number of insurers that remains is ample to produce a strong competitive dynamic. In most of the study states, the portion of the market held by the top three to five insurers has remained about the same following reform. Although the largest insurers (usually Blue Cross plans) have remained at or near the top, significant movement into and out of the top ranks has occurred, indicating that the market is fluid.¹²

In many states, we heard or observed that there are fewer competitors now than a few years ago, especially among indemnity insurers and in rural areas. New York, for instance, saw an "exodus" of dozens of insurers when reform was enacted, and Florida and Vermont each lost a dozen or more. We solicited views on why the number of insurers has diminished. Several subjects explained that two forces are at work. First, a wave of consolidations and mergers

11. See Gail A. Jensen & Michael A. Morrissey, *Small Group Reform and Insurance Provision by Small Firms 1989-1995*, 36 INQUIRY 176 (1999); see also Thomas C. Buchmueller & Gail A. Jensen, *Small Group Reform in a Competitive Managed Care Market: The Case of California 1993 to 1995*, 34 INQUIRY 249, 257 (1997); Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan./Feb. 1997, at 131 (finding that point-of-service plans, defined as all HMOs, PPOs, and managed care plans have recently become the dominant form of health insurance provided by both small and large employers).

12. For example, in North Carolina, the total number of insurers registered to sell small group insurance grew from 60 in 1992-1993, to 73 in 1996-1997. See Mark A. Hall, *An Evaluation of North Carolina's Small-Group Health Insurance Reform Laws* (last modified Feb. 1999) <http://www.phs.wfubmc.edu/insure/north_carolina/index.html> (on file with the *University of Michigan Journal of Law Reform*) [hereinafter Hall, *North Carolina Evaluation*]. Over this time, market concentration has remained virtually the same. In 1992, the top 10 insurers had 77% of the market and the top three had 55%, compared with 73% and 53% in 1997. See *id.* Only four companies have stayed consistently in the top 10, although the top two companies have remained unchanged. See *id.*

This is not the case in all markets, however. For instance, in Florida, although there are a large number of insurers registered to do business, market concentration has increased following reform. See Mark A. Hall & Elliot Wicks, *An Evaluation of Florida's Small-Group Health Insurance Reform Laws* (last modified Dec. 1998) <<http://www.phs.wfubmc.edu/insure/florida/index.html>> (on file with the *University of Michigan Journal of Law Reform*) [hereinafter Hall & Wicks, *Florida Evaluation*]. In 1993 about 50% of the Florida small-group market was held by the four largest insurers. See *id.* In 1998, however, the top half of the market was composed of only two firms, and only five insurers had more than 5% of the market. See *id.*

has taken place among insurers, mostly HMOs.¹³ Second, national insurers have become more selective of markets on which to concentrate. This is especially true for indemnity insurers. The first of these forces appears unrelated to the reform laws. Our subjects believe the second force, however, is partially related to these laws.

Several indemnity insurers explained that, prior to reform, they considered themselves to be national companies and so would market in virtually every state, even if they had very small market shares. Following reform, these insurers gave up this "mile wide and inch deep" philosophy in favor of selecting those states and regions within states where they believed they could compete most effectively. This concentration occurred partly in reaction to increasing competition from HMOs and an increasing amount of capital resources necessary to develop managed care networks. This strategy, however, also resulted from experience under the reform laws. As explained below, indemnity insurers found that they could compete more effectively under some versions of these laws than under others. Although few insurers said that there are any versions of the small group reforms they are completely unwilling to accept, most insurers said that the regulatory environment is one factor they now consider in deciding whether or not to remain or become active in a state. Thus, insurers view states as having both regulatory and business risks and opportunities.

One insurer who specializes in small group insurance first said it would withdraw from New York because of pure community rating, but then decided to remain.¹⁴ The primary reason was a clarification about the impact of the law on its one-to-two life groups, which allowed it to keep its existing subscribers in these micro-sized groups without having to write new business for this group size. Similarly, one indemnity insurer told us that guaranteed issue for groups as small as self-insured individuals was one of several factors in its decision to withdraw from the Florida market. Another indemnity insurer explained that it initially embraced small group reforms in a proactive manner, even in the toughest states, with the philosophy that it had to learn to compete against the re-

13. See Janet Corrigan et al., *Trends Toward a National Health Care Marketplace*, 34 INQUIRY 11, 18 (1997).

14. This insurer is headquartered in New York and has a significant block of business, so it would "take an act of God" for the carrier to have to leave the market. The only alteration in the legal environment this insurer could easily imagine that would change its mind would be an "all-markets" law like the one in New Jersey and the one in New York that applies to HMOs, which requires all group insurers to sell in the individual market. See Mark A. Hall, *An Evaluation of New York's Health Insurance Reform Laws* (last modified Mar. 25, 1999) <http://www.phs.wfubmc.edu/insure/new_york/index.html> (on file with the *University of Michigan Journal of Law Reform*) [hereinafter Hall, *New York Evaluation*].

forms in order to survive. But it found after about two years that its losses in some states were unacceptably high, and it began a concerted effort to determine which regulatory environments were more accommodating.

Few insurers, however, placed primary blame on the small group laws for their decisions to withdraw from any of the study states. One small group insurer that withdrew from New York attributed this decision in part to the law, but also to its lack of a good agent network and the fact that its existing block of business was perceived as having problems. Also, this is an indemnity company that was consolidating and withdrawing from small group markets in other parts of the country in response to increased competition from managed care. Another insurer, one with both indemnity and HMO products, remained in New York but withdrew from Vermont and Kentucky, states with similar laws, because the market potential in New York was so much greater and constituted such a large portion of the insurer's existing business. The three largest insurers we spoke to continue to compete in most states regardless of how the small group laws are constructed.

This degree of consolidation does not necessarily undermine competition. Much of the attrition of insurers comes from those with very tiny market shares who were not "committed" to the market,¹⁵ so that the competition among those who remain is much fiercer. According to one Florida agent:

[Small group reform] really took a lot of the players out of Florida. A lot of the insurance companies that were writing small groups from one to fifty lives in Florida decided that they didn't want to abide by all these regulations and be controlled by the state. Therefore they pulled their product out or they pulled out of the state of Florida completely. So over

15. All of these study states except Vermont have over 50 insurers in the market, and some have over 100, but in most of these states, only a dozen or so insurers have more than a few thousand covered lives. See Mark A. Hall, *An Evaluation of Colorado's Small-Group Health Insurance Reform Laws* (last modified Dec. 1998) <<http://www.phs.wfubmc.edu/insure/colorado/index.html>> (on file with the *University of Michigan Journal of Law Reform*) [hereinafter Hall, *Colorado Evaluation*]; Mark A. Hall, *An Evaluation of Ohio's Small-Group Health Insurance Reform Laws* (last modified Dec. 1998) <<http://www.phs.wfubmc.edu/insure/ohio/index.html>> (on file with the *University of Michigan Journal of Law Reform*) [hereinafter Hall, *Ohio Evaluation*]; Mark A. Hall, *An Evaluation of Vermont's Health Insurance Reform Laws* (last modified Dec. 1998) <<http://www.phs.wfubmc.edu/insure/vermont/index.html>> (on file with the *University of Michigan Journal of Law Reform*); Hall, *North Carolina Evaluation*, *supra* note 12; Hall, *New York Evaluation*, *supra* note 14; Hall & Wicks, *Florida Evaluation*, *supra* note 12. For instance, in 1994 the Ohio small group market was composed of 83 insurers, although only 20 had more than 2500 covered lives.

the last three years we're really getting down to the cream of the crop. The ones that are really going to stay in it for the long haul. . . .

An article in a New York business journal recounted one year after reform:

As for the fear that New Yorkers would be trampled by insurance carriers running for the state line, the stampede isn't even a minor traffic jam. "The massive exit from the market didn't happen," reports [an Insurance Department researcher]. . . . "All the major players are still here."

Despite these generally competitive conditions, there are other indications that reform laws may have dampened competition. Although a large number of insurers remain in the market in each state, some insurers do so only marginally, in order to keep the business of renewing subscribers, but they do not offer rates that attract new subscribers. Rating rules limit the extent to which insurers can set lower rates for new versus renewing business. If an insurer cannot offer a competitive community rate, then it faces the choice of either canceling all of its small group business and leaving the state entirely, or keeping its renewing subscribers and setting rates high enough to anticipate the adverse selection that inevitably affects a block of business that is not attracting new subscribers. The consequence is that many insurers technically in these markets do not effectively contribute to price competitiveness or diversity in product offerings.

A further limitation is that, with the market consolidation that has occurred in recent years, insurers are focusing their marketing efforts more selectively among metropolitan or rural areas. Although indemnity insurers are usually licensed to sell anywhere in the state, they make strategic decisions about which cities or counties justify the costs of developing agent networks. Moreover, HMOs are usually licensed only in those portions of the state in which they have developed provider networks. Because of the large capital investment required to develop provider networks, HMOs are even more selective than indemnity plans.

As a consequence, the level of effective competition in one area of a state may be much less than in others and may not be accurately conveyed by the total number of registered insurers. In New York, for instance, there are forty insurers selling in the mid-Hudson region of the state, but only twenty-six selling in the Buffalo area. Some

Ohio agents said they are getting quotes for small groups from only three to four insurers compared with eight to ten in the past. One Florida agent explained:

[I]n Tallahassee [the reform law has] had a very adverse effect. We had numerous carriers who would write business here [before the law], and [now] we're down to just a hand full of carriers that will even do business in Tallahassee or that are even competitive. . . . Principal is the only one [left] that is a large name carrier. The rest of them are smaller carriers not as highly rated on Best ratings.

These perceptions may be due in part to agents' preferences for indemnity versus managed care. The agent just quoted, for example, appears to be speaking primarily of indemnity offerings and does not address the fact that there are several new HMOs competing in the Tallahassee market. Others do not view the reduction in effective competition as a response to the reform law but instead as a consequence of market consolidation driven by other economic forces, including the rapid movement to managed care, the topic to which we next turn.

B. Managed Care

There are several possible reasons the law might have helped to precipitate the move to managed care and the resulting price-competitiveness. First, HMOs are accustomed to offering open enrollment and modified community rating; reform laws helped to level the playing field by requiring indemnity insurers to do business on the same terms as managed care. Second, to the extent reform laws cause any rate shock effect, they may have provoked subscribers to look around for alternatives more quickly than if prices had climbed more gradually.¹⁶ Third, employers' ability to switch insurers is attributable in part to the portability provisions in the law.

These speculations were confirmed by several interview subjects and sources of data. As discussed more below, indemnity prices indeed rose steeply in states with more stringent reforms, at least for some insurers. Some insurers with HMO products said the

16. A rate shock might exist for a substantial portion of the market even if average rates did not increase, because community rating has offsetting effects at the high- and low-risk ends of the market.

reform law was directly responsible for making the small group market a “major target” for their HMO products or for their HMO competitors by focusing more attention on this market segment, which previously had been largely overlooked. According to one New York agent

[y]ou could have almost foretold the eventual movement toward the HMOs and PPOs because there was no other way to go. In that respect perhaps [the disruptive effects of the law were] good. It financially forced everyone to go toward managed care where everyone was basically trying to fight managed care.

On the face of things, then, the small group reform laws have been a great success in terms of reorienting the market toward competition based on managing costs rather than selecting risks. Risk selection has been largely eliminated by requiring guaranteed issue and prohibiting most forms of risk rating. Whether this appearance reflects reality will be explored more below. Also, whether these are positive or negative developments depends in large part on one’s view of managed care. A negative view, held both by many consumers and many indemnity insurers, is that insurers should not be in the business of making medical decisions and thus competitive forces should not focus primarily on success in containing medical costs. Regardless of one’s views, it is very clear that, following the enactment of these laws, managed care has become a dominant force in the small group market. According to one industry source in Florida, “[t]he whole game has changed. It used to be underwriting, risk selection and claims investigation; now it’s networks and managed care.” In most of our study states, HMO market share doubled or tripled in just two or three years following reform, and most of these states have seen a noticeable growth in smaller, new HMOs serving local markets.

It is debatable whether the reform law is responsible for the movement to managed care. Most interview subjects opined that it is not because this movement occurred in states with and without reforms. A study based on a representative national sample of approximately 2000 employers found that managed care plans (HMOs, PPOs, and point-of-service) tripled their share of the small group market in two years, increasing from 22 to 69% between 1993 and 1995.¹⁷ These researchers concluded, based on a regres-

17. See Jensen et al., *supra* note 11, at 127 (“In firms with fewer than fifty workers the percentage of insured workers with conventional coverage fell from 78 to 31% from 1993

sion analysis, that this movement was unrelated to the reform laws but instead was due to the growing presence of managed care in the large group market and the price advantage offered by managed care over indemnity. Similarly, in our study states with low managed care penetration—Iowa and Vermont—the greater success of indemnity products appears unrelated to the structure of the reform law and to be determined more by inherent market conditions. Both states lack large urban concentrations and have significant populations in rural areas that do not easily support competing managed care networks.

The view that reform laws did not precipitate the movement to managed care is confirmed by the market testing study described above, in which an actual small employer contacted eighteen agents in each of the study states to inquire about the availability of health insurance, using a designed scenario.¹⁸ The market testing firm recorded whether the agents offered or recommended traditional indemnity or managed care products. Grouping these responses by the intensity of insurance market reforms in each state,¹⁹ there are no statistically significant differences in the proportion of agents offering or recommending managed care products, as displayed in the following table. In states with the lightest regulation, however, agents were more than twice as likely to offer only indemnity insurance, although only a small portion of agents did so (15% versus 6%). This provides some support for the view of insurer subjects, discussed below, who said that looser rating rules are more accommodating to indemnity insurance. The small sample sizes involved in this study, however, kept even this difference from being statistically significant.

and 1995."); see also Michael A. Morrisey & Gail A. Jensen, *Switching to Managed Care in the Small Employer Market*, 34 INQUIRY 237 (1997).

18. This type of actual market testing is an established form of evaluation that provides powerful insight into actual commercial behavior. Its weakness in this instance is that, due to concerns over insurance fraud laws and the lack of funds to make actual purchases of insurance, the market tester was able only to inquire about the availability of coverage and was not able to submit an application. See Hall, *Colorado Evaluation*, *supra* note 15.

19. New York and Vermont are classified as heavy regulation states, Iowa and Ohio as light regulation states, and the remaining states (except North Carolina, which was not included) as medium regulation. In this portion of the study, Minnesota and New Mexico are also included, and are classified as medium regulation states. See Hall, *supra* note 3 (classifying states into categories of "strong," "medium," and "weaker" based on the strength of their reform laws).

AGENTS' PREFERENCE FOR MANAGED CARE OVER INDEMNITY, BY INTENSITY OF REFORM			
	INTENSITY OF INSURANCE MARKET REFORMS ²⁰		
	HEAVY	MEDIUM	LIGHT
Agents Recommending Managed Care Products	81%	83%	71%
Agents Offering Only Managed Care Products	14%	23%	12%
Agents Offering Only Indemnity Products	6%	6%	15%

The finding that high managed care penetration is unrelated to the degree of small group regulation is confirmed by most of our interview subjects, who viewed the small group market as simply the next logical place for HMOs to look for sales growth after the large group market became saturated.²¹ The struggle for a foothold in the market led to fierce price competition. There are other indications, however, that reform laws have facilitated or precipitated competitive conditions. Small employers' embrace of HMOs largely coincides with nationwide market reform laws. Although the nationwide regression analysis mentioned above did not show a statistically significant correlation with these laws, it did show a positive relationship between insurance reform and managed care growth, and these researchers speculated that these laws might have "set the stage" for managed care growth.²²

20. See Hall, *supra* note 3.

21. Also, there are other, more technical explanations relating to unique regulatory conditions. For example, one interview subject made a forceful argument that HMOs are desperate for market share because they must increase their private enrollment in order to take on more Medicare and Medicaid enrollees under a rule no longer in effect that required at least 50% private enrollment. This subject attributed the intensified HMO competition in the market directly to this motivation, because the larger group market was much more saturated with managed care than the small group segment. See Hall & Wicks, *Florida Evaluation*, *supra* note 12. In New York, the increase in HMO enrollment might be attributed to a unique regulatory treatment that HMOs received for a time with respect to negotiating hospital discounts. New York maintained all-payor rate regulation through 1995, which required indemnity insurers to pay regulated hospital rates; only HMOs negotiate discounts, giving them a competitive advantage. See Hall, *New York Evaluation*, *supra* note 14.

22. See Morrisey & Gail, *supra* note 17, at 237.

C. Price Competition

1. *Price Trends*—Across all of these states, we saw similar, but not identical, price trends. Between 1993 and 1996, HMO prices increased very little, or actually declined, but indemnity-based products increased at high single-digit or low double-digit rates. In 1999, however, rates for HMOs and indemnity-based products increased dramatically.²³

Precise quantitative description of market-wide prices is difficult because premiums vary by so many factors that there is no easy or accepted way to average across all the different products and risk groupings for even a single insurer, let alone the entire market. Also, most states do not systematically collect or report rate information, so even if such a calculation were possible, the data do not exist. In several states, therefore, simpler proxy indicators of price must be used, depending on the information available.²⁴ In some states (Colorado, New York, and Vermont), good data was available for actual median prices for representative products from all insurers. In all study states, we also collected subjective views about prices from agents and actuaries, whose expertise is acutely sensitive to trends in prices.

Health insurance premiums for small employers held remarkably steady during the first few years of reform, especially compared with the double-digit increases that were common in the late 1980s. For example, Colorado reported market-wide rate decreases or increases in the low single digits during the first two years of reform, and in New York rates for most insurers increased only in the mid-single digits from 1994 to 1996. One Florida agent commented that “it seemed like when health care reform came in . . . the pricing [became] very, very favorable and still is.” One indicator of price competition is the high loss ratios that many market leaders experience for small group business. New York law, for instance, encourages insurers to maintain substantial loss ratios by

23. See Michael Meyer, *Oh No, Here We Go Again*, NEWSWEEK, Dec. 14, 1998, at 46 (stating that in 1999, medical insurance rates will increase from about 8% on average, to 20% or more).

24. Typically, the closest proxy is to calculate the average premium per employee for several years following reform. This is an average across all small groups and all products for each insurer. The median figure among the top insurers is a good indication of market trends. See Hall, *supra* note 3. It is important to stress that these premium figures are not adjusted for any changes in benefits. Average premiums might hold steady only because benefits are being pared back, such as by increasing deductibles or lowering coverage for prescription drugs. In our interviews, we heard that some of this is occurring, but we also heard that some insurers were increasing benefits. See Hall, *Ohio Evaluation*, *supra* note 15.

waiving rate review hearings if loss ratios exceed 75%. This regulatory impetus is largely unnecessary at present, however, because price competition has forced loss ratios for most insurers into the high seventies or low eighties.

These changing trends may be due to the rapid increase of HMO enrollment in the small group market, which may have produced adverse selection against indemnity plans. The increase in HMO enrollment resulted in large increases for indemnity plans, while fierce competition for HMO market share may have held prices artificially low for HMOs. Many subjects spoke of HMOs "buying market share" in the mid-1990s, meaning they were pricing at or below expected costs in order to build the subscriber bases needed to establish new managed care networks. These subjects explained that steeper increases in the late 1990s have been necessary to maintain long-term profitability.

Nevertheless, most subjects, including agents, confirmed that the small group market is highly price competitive. The rates of leading insurers "are all right in line with each other." In most states, most of the market share among top insurers was held by those insurers whose average premiums were near or below the median for the top insurers. The overall impression, then, is that the small group market is competitive and rational with respect to price. One pricing actuary commented that he is "constantly amazed" at how small a price difference can induce employers to switch insurers; some will switch for as little as one dollar per employee per month.

Whether this achievement is due to the reform law is still debatable. It is clear that these laws did not cause the premium spirals that many critics warned were possible because of adverse selection against the market. Some degree of adverse selection may have occurred, but moderate price increases indicate that it has been minimal and easily absorbed without adding noticeably to the price of the leading insurance products. According to one Florida agent:

[E]verybody was afraid that their rates really were going to go up and they didn't. In fact, they stayed the same or went down. Because what was happening at the time was managed care was becoming more and more popular and . . . managed care [had] provisions that made it much more cost effective, and that was passed on to the consumer. And so, if there was any increase because of the new guidelines, it was washed out because of the market change.

This raises the possibility, however, that the full effects of small group reforms have not yet been felt. Now that steeper price increases are being imposed, adverse selection might begin to take its toll more noticeably.

2. *Price Shopping and Market Volatility*—There is some debate over whether or not this degree of price competitiveness is positive. Some subjects believe that reform, in combination with other factors, has produced an unhealthy degree of market volatility. Others, however, think that occasional price wars can be good for consumers. Whichever view is correct, it is clear that, since these laws have been enacted, there is a much greater degree of market activity among both consumers and producers.

On the consumer side, most insurers report that retention (or persistence) rates (the percentage of subscribers that renew, or the length of time they stay with the insurer) have dropped significantly since the enactment of reform laws. This tends to undermine the incentive for managed care plans to invest in preventative health and health maintenance for chronic illness. For instance, one large national insurer reports that over 50% of its small group subscribers turn over each year in most of our study states, compared to normal industry averages of 15 to 25%.²⁵ In New York, pooled data obtained from nine large, primarily indemnity insurers shows that, in the year following reform, the portion of each insurer's existing subscribers who terminated coverage jumped from 22% to 31%, at the same time that the number of subscribers new to each company leapt up 170%, resulting in essentially no gain in net enrollment. Although the number of new subscribers roughly equaled the number of terminating subscribers during the three years preceding reform and in the year after, the volume of market activity roughly doubled for these nine insurers the year after reform.

25. Similarly, in North Carolina, the number of newly insured groups throughout the market increased 65% from 1994 to 1996 at the same time that the total number of insured groups has increased only 13%. See Hall, *North Carolina Evaluation*, *supra* note 12. Also, 39% of covered groups in 1996 were new to the insurer but only 22% were previously uninsured. See *id.* This indicates that most new business comes from groups that switch insurers. The same is true in Florida, where, on average, for every 10 new subscribers that small group insurers attracted in 1995, they lost approximately seven or eight existing subscribers. See Hall & Wicks, *Florida Evaluation*, *supra* note 12. There are a few contrary indications, however. Most Ohio subjects felt that volatility was not a major concern in their market. See Hall, *Ohio Evaluation*, *supra* note 15. One Ohio actuary told us that, as a marketing strategy, his company issues "a three-year guarantee that groups will receive the new business rates," and they found this to be "a huge success in attracting new business and in lowering the lapse rate." Hall, *Ohio Evaluation*, *supra* note 15.

Signs of volatility also exist on the producer side, where some insurers' small group business has fluctuated dramatically. Most states show substantial shifts in market share among top insurers following enactment of the small group laws, although in most states the same insurer remains the market leader each year. These large and sudden swings in market share can result from mistaken pricing decisions, usually when prices are too low. We heard from several different sources in Florida that in 1994, the first year of market-wide guaranteed issue and modified community rating, a number of indemnity insurers kept their rate increases very low, expecting that others were doing the same, and later found out that they had underpriced. As a result, these companies attracted too many high risk enrollees. In order to offset significant losses, they increased rates steeply, severely hurting their new enrollment in the subsequent year, and leaving them trapped in a position from which they might not ever be able to recover. Under different rating and regulatory rules, they might be able to close off a block of bad business by not selling existing policies to new subscribers, and then creating new policies that are slightly different and priced attractively in order to gain new enrollment. Nevertheless, guaranteed renewal and portability, coupled with the modified community rating rules, effectively keep insurers from segregating their bad risk pools in this fashion, a common practice before regulation. The law was intended to have this result because some insurers were using more flexible rating rules to aggressively "churn" their accounts. Eliminating this flexibility, however, also has the effect of keeping insurers with bad risk pools from competing effectively for new business.²⁶ As a result, one actuary explained

26. One Florida agent explains the result in the market:

A: I remember [just before] January 1, 1994 [when guarantee issue took effect], one carrier that I obtained a quote from in November, this is an eight or ten life case, and actually the rate that I got for a December 1 effective date was about 15% higher than the one in January on a guaranteed issued basis. So different companies use different philosophies as far as getting into the market. I think the quality carriers, and this particular carrier is a first class company, they took the attitude, well we're going to use Group Insurance 101 from the CLU [certified life underwriters] course and we're going to try and get as many lives on the books as we can. We know we're going to get some of the bad, but we want as many of the good that we can. Unfortunately what happened to them is that it blew them out of the water and they're still really not in the marketplace from a price standpoint as a result of the losses experienced in the eighteen months that they were really aggressively seeking marketing share.

that "one year's genius can be next year's bozo," because a great new business rate that attracts lots of business will end up locking the insurer into a rate structure that cannot sustain increased claims without pricing the insurer out of the market for new business in succeeding years.

We heard the same story from or in regard to three other Florida insurers, one New York insurer, and one North Carolina insurer, each with mostly or entirely indemnity policies.²⁷ The Florida insurers attributed their inability to recover not only to the rating rules designed to eliminate churning, but also to the fact that Florida, apart from the small group laws, requires prior approval by the Department of Insurance for increases in average rates, which many other states do not. These insurers complained that rate review authority has been used to ratchet down their requests for rate increases, keeping them from recouping their full losses even when their requests are actuarially justified. Of these four Florida insurers, two have either officially or effectively withdrawn from the market, and two are still struggling to maintain market position, although they indicate that the "jury is still out" on whether they will remain active in the Florida market.

Other interview subjects did not view this pricing behavior as mistaken underpricing but instead as strategic "low-balling" or "buying market share." They observed that new market entrants are inherently able to offer lower premiums because, all things being equal, newer risk pools are healthier than older ones. New subscribers are lower risks for three reasons: they are subject to pre-existing condition exclusions; freshly underwritten groups are uniformly healthier than a pool that contains groups that have renewed over a number of years; and people with health problems are reluctant to switch insurance in the midst of treatment. As a consequence of these advantages, new market entrants can quickly gain market share by pricing aggressively. This opportunity is

Q: Okay. So they underpriced and then they ended up getting some bad business.

A: They got nailed.

Hall & Wicks, *Florida Evaluation*, *supra* note 12.

27. One of the Florida insurers explained that "we tried like crazy" to stay in the market with guaranteed issue and modified community rating, but it "severely underpriced" in 1994, with rate increases of only 4%, because it thought others were doing the same and it wanted to remain. But, when claims started to come in, it found that it had "really screwed up." The company had targeted a 72% loss ratio and ended up with 92%. "Once you make this kind of mistake, you can't ever recover." Hall & Wicks, *Florida Evaluation*, *supra* note 12. Similar examples were seen in New York and North Carolina. See Hall, *North Carolina Evaluation*, *supra* note 12; Hall, *New York Evaluation*, *supra* note 14.

especially tempting for indemnity insurers since they do not face the same capital costs of expansion that are required to build managed care networks.

The severity of this problem is debatable. Undoubtedly, some insurers are hit harder than others, which is unfair and undermines the goal for using competitive forces to promote true economic efficiency. On the other hand, the effects of initial underwriting wear off rather rapidly, and new insurers often find that they have to raise their rates steeply after just a year or two, especially if they underpriced initially relative to the risks they received. If so, their enrollment will deteriorate rapidly because existing healthy subscribers will leave and the insurers will not attract new enrollees. Moreover, rate flexibility allowed by some rating bands means that existing insurers can respond by offering preferred rates, so long as their normal pricing is in the middle of the bands (which may be impossible due to other strategic concerns mentioned above). Most insurers realize that they have limited leeway to impose rate increases greater than the trend in new business rates and so they are reluctant to engage in low-balling strategies to gain an artificial advantage from new business. It is also notable that most subjects did not report this issue in New York and Ohio, which respectively have the most and the least stringent versions of the reform laws, yet volatility was a concern in North Carolina and Vermont, two states that are also at near-polar extremes in their reform stringency. It does not appear, therefore, that the pattern of market volatility matches the pattern of restriction in the reform laws across states, suggesting that the volatility that exists is precipitated by the market conditions unique to each state.

Nevertheless, the reform law appears to facilitate high levels of market activity. Portability makes it easier for subscribers to switch insurers in order to save a few dollars. Guaranteed renewability ensures that unhealthy subscribers can keep their coverage, thereby magnifying the difference between newly-enrolled and renewal subscriber pools. Rating restrictions also limit the extent to which insurers can establish different rates for different risk pools if the benefits are the same, which prevents existing insurers from competing directly with new market entrants by offering lower rates for newer business.

D. Standardized Benefits

The reform law might promote price competition by creating standardized benefit packages that make price comparisons easier, or that serve as reference prices for insurers' other products. Historically, one problem with price shopping is that intricacies in benefit packages make it extremely difficult to evaluate comparable products. Seemingly minor differences in benefits can account for significant differences in price. One intended advantage of requiring insurers to offer standardized (or "statutory") benefits plans is to eliminate such confusion over price. Alternatively, if the plans do not sell successfully, they might at least serve as a barometer of each insurer's relative price competitiveness so purchasers have some idea of whether the non-standard plans are a good value.

The reform laws have not served this purpose effectively, for a variety of reasons. First, insurers are reluctant to sell standardized benefits, and therefore do not put much effort into the market or service of such plans. We inquired into the source of this unpopularity, and found that, to some degree, it is simple philosophical antipathy to government intervention in the market. Of course, the government alone does not construct the benefit package in most states; this work is usually done by a committee composed mainly of insurers and agents. The government, however, does impose the mandate, so the plans carry an ideological taint for some agents, who describe them to their clients as "state-mandated" plans²⁸ designed for "inferior" or "substandard" groups as "coverage of last resort."

28. One Florida agent explained:

A: Usually when you mention to a client, "Listen we have this available through the state of Florida," I don't know how or why but when it comes to being provided by a government agency, people seem to be turned off by that and [would] rather purchase health insurance through the private sector.

Q: OK, now, help me with [understanding] that a little bit because my understanding was that . . . the state actually has nothing to do with that plan?

A: Yeah, but as long as people think that, perception is reality.

Q: But do you tell them that it's a state plan?

A: No, no, absolutely. I just say it is the basic and standard plans that are provided through, I'm not saying that it's the state, but it's really provided because the state has made them available.

Another Florida agent stated the point in this manner:

Another explanation for antipathy to these plans is that both insurers and purchasers like to individualize their benefit packages. Crafting benefit packages is a way for insurers to express their product and corporate identity and to attempt to distinguish themselves from their competitors. Finally, we were told that administering the statutory plans is difficult and expensive for insurers. When insurers create and modify their own benefit packages, they make systems changes that help to automate rating and claims processing decisions. System changes incur costs, but without such changes, rating and claims processing is much more time consuming.²⁹

These explanations from insurers compare with a more obvious reason to disfavor the statutory plans in states such as North Carolina, Iowa, and Florida. Until 1997, statutory plans were the only plans that were required to be guaranteed issue, yet they were subject to the same rating bands as medically underwritten plans, so they were bound to attract higher-risk individuals.

For these reasons, insurers take a number of steps to keep a low profile in the market with respect to these plans. First, insurers do not actively market or advertise these plans. They have none of the usual slick color brochures to describe them. The examples collected in this study were mostly plain, single-page summaries of benefits. Sometimes insurers send nothing at all, leaving to the agent the task of explaining the plan contents.³⁰

As a result of the “planned lack of response” to state-mandated plans, one North Carolina agent observed that, from an agent’s

A lot of times when we get called by people, a lot of people already have an idea of what they want. And so, you know, you are going to give them what they want and not try to sell them what they don’t want. . . . You know some of that has to do with marketing. I mean you’re talking the ‘basic and the standard’ plan with the state of Florida. If they called it the Flamingo Plan like they do for Lotto, maybe people would flock to it, I don’t know, but, because it is very mundane—‘basic and standard’—I just don’t think it has a whole lot of appeal.

Hall & Wicks, *Florida Evaluation*, *supra* note 12.

29. Being forced to add another benefit plan, however minor the differences, adds to the systems costs, not simply because it is yet another variation, but because the benefit structure may be incompatible with the insurer’s system. For instance, hospital benefits might be structured by days, dollar amounts, or diagnosis. A system designed for one structure does not adapt well to a different structure in benefits. We did not observe, however, that inconsistencies in benefits structures are widespread or significant. *See* Hall, *supra* note 3.

30. Ironically, some of the same tactics may also affect an insurer’s favored products. One Ohio insurer said that the move to market-wide guaranteed issue under HIPAA caused them not to advertise the fact that their rate increase last year was less than 1% because they want to “keep their head down” to avoid attracting bad risks. We did not hear this attitude elsewhere in the small group market. *See* Hall, *Ohio Evaluation*, *supra* note 15.

perspective, "it's as if these plans don't exist." In Florida, several agents we spoke to who specialized in small group insurance had not sold a single standardized plan. One of these agents actually served on the committee that formulated the statutory benefits packages. In both Florida and North Carolina, the statutory plans account for less than 5% of new small group sales. The basic plan is especially unattractive, accounting for 1/10 of 1% of new sales, in other words, one out of a thousand new subscribers in Florida. In North Carolina, only 282 basic plans have sold over a five-year period. One large national insurer had only thirty-two of these plans in effect in twenty-three states at the end of 1996. Another insurer, who specializes in small group coverage and is active nationally, had only about two dozen groups enrolled in these plans in eighteen states.

Standardized plans are also hampered in their ability to serve a reference pricing function that indicates an insurer's overall competitiveness. First, in some states it is difficult to learn what insurers' rates are for these or any other plans without contacting each insurer individually. Most states do not collect and disseminate rate information systematically (Colorado is the notable exception among the study states). Comparative price information is available through the state-wide purchasing cooperatives in each state, which are sometimes used by agents to determine price competitiveness for sales outside the cooperatives. In North Carolina, however, this is hampered by rating rules that allow these statutory plans to be priced much differently than non-standard plans. Also, as discussed below, insurers have adopted a variety of rating strategies that allow them to reflect the relative health risks of the different pools of subscribers for their different products in ways that were not intended by the reform law. Consequently, an insurer's rate for a standardized product may not reveal very much about its rates for more popular plans.³¹

31. It is useful to contrast this experience with that under the Medigap reform laws, which require standardization of the insurance policies that supplement Medicare coverage. In this context, benefits standardization has successfully promoted price competition. See Thomas Rice et al., *The Impact of Policy Standardization on the Medigap Market*, 34 *INQUIRY* 106, 114 (1997). There, however, the law allows *only* standardized benefit plans to be sold, and so insurers must focus their marketing efforts on those plans.

E. Non-Price Competition

1. *Product Offerings*—Several forms of non-price competition will now be discussed to determine whether small group reforms enhance the quality and range of choice in product offerings. One public policy argument against standardized benefit plans is that, even though they enhance price competition, mandatory plans suppress competition and innovation in product choice and benefits design and fail to reflect the diversity of consumer tastes. On the other hand, changes and differences in benefit designs might be used strategically to engage in covert risk selection, by adding or subtracting benefits that are more or less attractive to groups with different risk profiles. It is an ongoing and probably unresolvable debate whether and which benefit design strategies partake of either these positive or negative features. Nevertheless, it is helpful to document and describe the variety of benefits innovations that exist and to consider their connection with the small group laws.

Noted above is the pronounced movement to HMOs in the small group market. This development is generally seen as efficiency-enhancing, but some commentators maintain that HMOs accentuate adverse selection against indemnity plans, possibly effectively pricing such plans out of the market. Several indemnity insurers argued forcefully that, under tight rating restrictions, they cannot adequately guard against adverse selection from HMOs. They contend, with some justification, that on average sicker people prefer indemnity and PPO products because they impose fewer restrictions on choice of physician and covered prescriptions. If these insurers are allowed to reflect this increased health risk only in their average rates, then they cannot offer a competitive price to healthier subscribers. This has the potential, the insurers claim, to price indemnity-based products out of the market (except for higher risks), even though there are lower risk candidates willing to pay extra for increased choice and coverage.

The extent to which these claims are true will have to be resolved through more quantitative and direct empirical measures. A significant reduction in the number of indemnity insurers after the reform indicates that the claims are true. Although to some extent this may be due simply to indemnity's lack of cost controls and subscribers' willingness to switch to managed care, the extent to which indemnity coverage has lost favor suggests that something more is occurring. Traditional indemnity products have all but disappeared from several of the more tightly regulated small group

markets. Although PPO products, which are a hybrid between indemnity and managed care, are still widely available, even in tightly regulated small group markets, their prices are increasing significantly faster than HMO products. The market testing study discussed above shows that indemnity products are somewhat more favored by agents in states with lighter versions of the reform laws. Also, traditional indemnity products are virtually nonexistent in the state-wide purchasing cooperatives. These cooperatives do, however, offer PPO and point-of-service HMO products.

There are various strategies that insurers might adopt to counteract adverse selection. One is to make benefit packages less attractive to people with health problems by increasing deductibles or decreasing drug benefits. According to one Florida agent, “[y]ou don’t see a \$100 deductible anymore. You don’t see, or hardly ever see, a \$200 or \$250 deductible. . . . The deductibles are up to \$300, \$500. I’ve got them as high as \$1,000.”³² A North Carolina agent complained bitterly of another benefits tactic the agent viewed as unfair: offering good coverage for very attractive prices, but only to the extent of the insurer’s limited fee schedule, which the agent thought was not adequately disclosed to subscribers, thus leaving them exposed to much greater payment liability than they realized.

Naturally, these trends and tactics might also be driven by purchasers’ desire for more affordable coverage and by insurers’ concern about controlling moral hazard. Indeed, most insurers and agents said that reductions and changes in benefits are in response to market forces, especially employers’ desire to reduce costs. Several subjects noted that a good array of benefit options is available, and insurers continually try to innovate different and hybrid managed care structures in an effort to determine the optimal mix between choice and cost controls. One prominent example is the adoption by some HMOs of an “open network” design which eliminates the requirement that patients receive permission from primary care “gatekeepers” before seeking care from specialists within the network.

On the other hand, the move to guaranteed issue of all small group products prompted insurers to weed out many benefit plans that were failing to sell on this basis or were no longer actively marketed. Even insurers who continue to pride themselves on offering “gourmet” benefit plans are setting limits on particularly

32. These views are partially contradicted by a nationwide sampling of employers that found that “average deductibles declined in small firms but grew in large firms.” Jensen et al., *supra* note 11, at 132.

high cost items such as in vitro fertilization and designer drugs that insurers believe form the basis for adverse selection. One insurer said it is reluctant to try out new benefit structures, such as medical savings accounts and disease management programs, in states where rating rules are less forgiving of possible pricing mistakes because it is difficult to know for certain what impact these changes will have on costs and on purchasers' selection decisions.

From another perspective, one might conclude there is too much choice in benefit packages, leading to confusion and market segmentation. An examination of a large number of sales brochures reveals that much of insurers' strategic market positioning is focused on minor differences in benefit packages. Insurers tout a dizzying array of ways to mix and match various components of coverage such as deductibles, copayment levels, maximum payouts, and various riders for prescription drug benefits or mental health coverage. Again, this might be a procompetitive response to varying consumer tastes, or a strategic attempt to frustrate price comparison to generate favorable selection by offering benefits that have greater or lesser appeal to different risk groups. Most agents took the benign view, but others spoke of "little gimmicks that [insurers] can put in the contract." One example, which we heard about or witnessed in several states, is offering health club membership as a way to attract health-conscious subscribers. Another possible example of this tactic is the highly visible decision by Oxford Health Plan to offer coverage for alternative or holistic therapies. Both these examples, however, are subject to the benign interpretation as well.³³ Also, a number of other agents thought that differences in benefits packages had narrowed since reform.

2. *Quality Competition*—So far, we have seen that price and product competition appear to be thriving in the small group market. Noticeably absent is any form of competition based on outcome measures of quality, measured through criteria such as

33. One New York agent, for instance, attributed Oxford's decision to a savvy marketing strategy to appeal to diverse ethnic groups:

I think Oxford has been very intelligent. As of late . . . they have gone to alternative medicines. So they are starting to say we are willing to cover and promote coverage by chiropractors or acupuncturists who are properly licensed and so forth. It's an incredibly smart move, I think especially given the multiplicity of ethnic makeup of the New York area. . . . So that kind of diversity is very crucial to their marketing plan, and by Oxford going to alternative medicines, it's recognizing that there are other forms of medicine in other parts of the world that are very common and popular and they want to be including those in their realm.

Hall, *New York Evaluation*, *supra* note 14.

patient satisfaction, recovery times, and overall health status following treatment. Naturally, this is relevant only to HMOs because indemnity insurers are not in a position to monitor or influence the quality of care, and one of the selling points of indemnity coverage is that subscribers are free to make their own decisions about which are the best providers. Given the penetration of HMOs, however, one might expect at least some competitive focus on quality of care measures. We reviewed HMOs' sales literature targeted to the small group market and found almost no reference to outcome measures of quality such as those developed by National Committee on Quality Assurance, even though the committee accredits HMOs. At most, there were passing generic references to the quality of providers in the network. The focus of the sales literature is on the particulars of the benefit packages, and for HMOs, on the composition of the network. In the vocabulary of most agents, "quality" refers to the quality of the benefits, that is, how comprehensive they are, and to the quality of the insurers' claims service, that is, how promptly and easily they pay claims, not to the quality of care delivered.

The same is true for the most part even within the purchasing cooperatives. Purchasing cooperatives are supposed to embody the pure form of managed competition that focuses competition precisely on the trade-off between price and outcomes-based quality. Yet, the cooperatives in each of the study states, which are among the largest and most sophisticated in the country, have only recently considered the possibility of using simple patient satisfaction measures. The use of more detailed outcomes measures is still a topic to be studied for implementation at an undefined future point.³⁴

We inquired of agents about the lack of emphasis on objective measures of quality and received the following explanations. First, with employers making the decision, cost is still the critical issue. Employers are satisfied with quality if their personal physician is in the network; other than that, the quality of the network overall is

34. In one instance, the purchasing cooperative in Cleveland asked one insurer to drop a hospital from its network based on outcomes and cost information, and this coop is collecting this information from other hospitals, but this information is being used only to formulate the provider network, not to assist employers and employees in choosing insurance. See Hall, *Ohio Evaluation*, *supra* note 15. A purchasing cooperative administrator in Florida expressed his disappointment that he came to the job thinking he would be a reformer and innovator, working with techniques such as outcomes measurement of quality, but he quickly discovered that his main job is to sell as much insurance as possible and to leave the high-minded ideals for a future time when there are sufficient enrollees to justify the effort. See Hall & Wicks, *Florida Evaluation*, *supra* note 12.

not their central concern.³⁵ These views are not dissimilar to those expressed by benefits managers for large employers, despite their greater resources and sophistication.³⁶ These factors are also essentially the same ones that employees indicate (through focus groups) are the most important when they choose among multiple options.³⁷ Therefore, the small group market may be efficiently producing the type of information that consumers actually want, even if it is not producing the information some reformers seek.

The absence of overt use of objective quality measures in small group marketing literature and employers' decisions does not mean this information does not shape insurers' behavior. This information increasingly exists in the large group market and in the public domain, and insurers are acutely sensitive and responsive to it, even though few purchasers are demonstrably influenced by it.³⁸ Economic theory postulates that quality or price information affects competitive behavior if even only a few, sophisticated market leaders use it in their purchasing decisions. Also, as a matter of corporate pride or identity, insurers naturally do not want to be ranked below their competitors, so they work hard to improve their rankings, even if they do not actively use the rankings in their marketing schemes.

35. This was one agent's explanation:

Q: Academic theorists would like to see the competitive focus on pure outcomes measures and patient satisfaction and stuff like that. You know, "We're not only cheaper but we're better in terms of quality of care, or we may be a little bit more expensive but it's worth it because if you come here you'll end up living longer and feeling better." Do you see that kind of focus emerging in the small group market?

A: I think that's what they'll say. . . . In theory that's wonderful. I don't think it's going to be reality though. Carriers, in my opinion, are really looking at bottom line. How much does it cost to give . . . quality care. Quality care is defined by them how inexpensively can we do it for them. . . . Another thing that people look at is, when they get onto a plan, I think the first thing that most people do is check to see if their doctor is on the plan. Otherwise they kind of hem and haw a little bit. And in group plans it's the old adage, he who has the gold, makes the rules. The first thing that the decision maker is going to do is see if his or her doctor is on the plan and if not they might look at somebody else.

Hall, *New York Evaluation*, *supra* note 14.

36. See Judith H. Hibbard et al., *Choosing a Health Plan: Do Large Employers Use the Data?*, HEALTH AFF., Nov./Dec. 1997, at 172, 177 (finding that cost measures may outweigh the more vague quality measures in the decision-making process of large scale purchasers).

37. See JACK A. MEYER ET AL., ECON. AND SOC. RESEARCH INST., REPORT ON REPORT CARDS: INITIATIVES OF HEALTH COALITIONS AND STATE GOVERNMENT EMPLOYERS TO REPORT ON HEALTH PLAN PERFORMANCE AND USE FINANCIAL INCENTIVES 3 (1998).

38. See *id.* at 2.

The small group laws, however, create a potential barrier to aggressive quality competition by encouraging insurers to keep a low profile with respect to higher risk subscribers in a guaranteed issue environment. According to a New York agent:

I think the [insurance] companies are in a quandary. Here they are, they are forced to offer health insurance. If their service is great and their named reputation and all that is wonderful, everyone who is ill is going to go to them. If their service is lousy, they're not going to get the clients and therefore their rate is going to be even higher because they don't have enough client base to support.

Similarly, the possibility that quality advertising might be used against plans in litigation over errors in treatment could deter plans from promoting themselves based on quality records.

F. Rating Games and Risk Selection

The following picture emerges from the analysis so far: although small group market reforms have been successful on a number of fronts, they have not produced the economic ideal envisioned by some reformers. Even though insurers do not use risk selection to the same extent as before, virtually all of our interview subjects contend that risk selection remains an important, and perhaps the most important, factor in determining insurers' profitability. This clouds, to a considerable extent, the ability of consumers to determine from a plan's price the underlying efficiency in the form of insurance or the delivery of medical care.

There are strong indications that price differences in the small group market are still determined by differences in risk pools. Risk differentials can be seen in statistics on average claims per enrollee. Although differences among insurers *in any one year* in average claims per enrollee reflect in part differences in benefit packages, *trends* in average claims from year to year *for a given insurer* more clearly point to changes in the composition of the risk pool. In most states, we observed substantial differences in these trends, with some insurers increasing much more rapidly than others. This is confirmed by an analysis performed by the Lewin Group, which surveyed twenty small group insurers in Florida to determine the extent of risk differentials. Using the risk adjustment methodology from the California purchasing cooperative, these researchers

determined, based on 1995 information, that among the dozen Florida insurers they surveyed (which are not the same as the top dozen in the market), differences in risk factors were three times greater than what are accounted for in the modified community rating factors.

Differences of this magnitude exist despite the risk adjustment and reinsurance mechanisms that companies use in each of these states. These mechanisms are intended to smooth out risk differentials and counteract incentives to engage in risk selection, but for reasons that are beyond the scope of this paper, they do not appear to be having their full intended effect.

Large differences in risk pools continue to exist for a variety of possible reasons. First, insurers entered the reformed market with lower or higher risk pools and these historical patterns may have persisted. Second, insurers have available a number of covert risk selection techniques which may result in some companies systematically attracting better risks. Some of these techniques are perfectly legitimate, such as crafting benefit packages to appeal to healthier subscribers; others are not legitimate or are of questionable legality, such as field underwriting. Third, risk differentials may exist by virtue of subscribers' natural preferences, such as the tendency of sicker people to prefer one kind of plan or set of benefits over another, or the reluctance of sicker subscribers to switch insurers, with a resulting advantage for newer market entrants. There is no rigorous way to disentangle these possibilities, but to a notable extent, insurers are still able to engage in purposeful risk selection strategies. One industry source stated that regulators "can't hold a candle" to the creative abilities of insurers to encourage risk selection.

Insurers still compete considerably on their medical underwriting abilities, despite the efforts of reforms to minimize medical underwriting. First, until 1997 a number of states still allowed insurers to decline coverage for their primary plans. Even following HIPAA, which requires that all small group plans be guaranteed issue, risk rating still occurs in states with rating bands to almost the same extent as before reforms because of the considerable medical underwriting that is required to make full use of the flexibility in the rating bands. A number of HMO and Blue Cross plans told us that they started using their rating flexibility much more aggressively once HIPAA required them to guarantee issue all of their plans, so that now they devote more focus to making fine-grained distinctions through medical underwriting than they did

before these reforms.³⁹ Underwriting expertise is also required to determine whether to reinsure. Accuracy in these endeavors still determines profitability to a considerable extent.

Moreover, insurers have developed a number of techniques that allow them to engage in a greater degree of risk rating than is apparent from the rating bands. Rating bands that allow a +/- spread based on health risk or claims experience suggest that rates for one plan could never be more than the stated percentage higher than average rates, but that is not the case. In order to make maximum use of the allowable spread between high and low risks, many actuaries rate standard-risk applicants near the bottom end of the spread, not the middle, thereby allowing almost twice as much increase for poor health status than appears allowable from the bands.⁴⁰

We also heard that insurers have been able to manipulate the rating factors for benefits differences to produce greater health risk differentials than the rating rules allow. Valuing benefit differences among plans requires an exercise of actuarial judgment for which there are different techniques. One technique is to declare simply that benefits are worth the claims costs they generate, so that different benefit packages are rated according to the claims experience for the pool of subscribers to each package. The problem with this approach is that the differences in benefits are measured by the health risk of the populations that purchase them. If some plans are more attractive to healthier or sicker populations, then the claims experience will reflect underlying health risk as well as benefit differences. Using simple claims experience can result in anomalies such as placing a higher actuarial value on a benefits package that objectively is less rich. For instance, if two plans are identical except that Plan B offers free membership in a health club, Plan B should be more expensive but, measured by

39. One Ohio agent expressed frustration that insurers issue quotes at preferred rates based on perfect risks but then revert to higher standard rates once underwriting is completed: "They come in with a proposal that is too good to be true and in most cases it is. And the only way to qualify for it is that you have to be Jesus Christ yourself and then they would probably look hard at holes in the hands and all that." See Hall, *Ohio Evaluation*, *supra* note 15.

40. For example, with +/- 20% bands, one might think that a rate of \$100 for standard-risk subscribers would yield a spread of rates from \$80 to \$120 for low and high risk subscribers. However, if an insurer uses \$100 as its lowest rate by refusing to issue any preferred rates, it could set its mid-point at \$125 and charge high risks up to \$150, 50% more than standard, for identical coverage and demographics. See Hall, *supra* note 3 (describing how insurers can influence rating bands in order to increase rates). Even more extreme possibilities exist in Ohio, where bands are +/- 35%, producing a total potential spread of 108% (1.35/.65) based on individual health risk, in addition to demographic and benefits factors. See Hall, *Ohio Evaluation*, *supra* note 15.

claims experience, this difference will likely be muted, or reversed, since health-conscious subscribers will likely gravitate toward the free membership. Used in a different manner, claims-based measures of benefits differences can be used to exaggerate the actuarial value of different deductible levels. A plan with a \$100 deductible is worth more than an identical one with a \$500 deductible, but the difference is certainly not more than \$400. However, measured purely by claims experience, the low-deductible plan might in fact produce an actuarial measure greater than the difference in the deductibles because higher risks gravitate toward richer benefits. The same technique could be used in states where only some plans are guaranteed issue to price those plans considerably higher than medically underwritten plans.

We in fact observed actuarial anomalies of this nature in several states.⁴¹ For instance, one New York actuary admitted their point-of-service HMO plan costs more than a PPO indemnity plan, whereas the pure benefits effect should be the opposite. Other actuaries said that they do not rate benefit differences according to product-specific claims experience because this is improper, contrary to the law, or prohibited by regulators. It does not appear, however, that insurance regulators closely scrutinize rate filings or actuarial certifications in this regard. Actuarial certifications verify compliance with the rating rules only in general terms and do not specify how the actuaries derive or support various rating factors. We found no indication that the regulators request or scrutinize the data and actuarial theories that underlie these certifications. One regulator conceded that his agency is “willing to take almost anything” based on this actuarial certification.

Insurers are also able to engage in risk selection through a variety of techniques known as “field underwriting.” This term refers to a practice of encouraging agents rather than insurers to screen out applicants they know or suspect are higher risks. This is a legitimate practice in many parts of the insurance industry such as property, casualty, and life, but for health insurance in a guaranteed issue environment, field underwriting of this sort is not legitimate and violates the statutory requirement of fair marketing.

41. For instance, the rates for the statutory plans in North Carolina, which provide somewhat leaner benefits than most insurers' medically underwritten plans, nevertheless were priced higher than the underwritten coverage for many insurers. The rate differences were sometimes dramatic. One insurer charged \$209 for the standard statutory plan but only \$71 for its underwritten plan with more generous benefits. For another, the rates were \$145 for standard benefits versus \$70 for the more generous underwritten plan, and there were several other examples of a similar magnitude. See Hall, *North Carolina Evaluation*, *supra* note 12.

Nevertheless, interview subjects in every state confirmed that field underwriting occurs to some degree, largely through subtle suggestions and pressure on agents rather than through more overt means. This makes it difficult to detect with the resources available to regulators. Moreover, in some states, notably Ohio and Florida, regulators allow insurers to influence agents directly by adjusting their commission levels according to the attractiveness of the business generated by different agents.

Most agents claimed these tactics do not influence their judgment regarding where to send high risk applicants. Nevertheless, whether through agents, through selective marketing, or simply through chance, the distribution of high risk cases is highly uneven among insurers. This can be seen in Ohio, for instance, where prior to HIPAA small group indemnity insurers accepted open enrollment applicants only until they filled a quota based on their market share of underwritten plans. In 1995, one insurer reached 61% of its open enrollment quota, another one reached 12%, and a third reached only 1%. The remaining several dozen insurers sold no open enrollment policies at all that year. Similarly, in North Carolina, statutory plan (guaranteed issue) enrollees in 1996 accounted for almost 7% of one HMO's small group enrollment and more than 2% of two other insurers' small group enrollment, but all of the other top insurers had less than half of 1% of their enrollment in guaranteed issue plans.

CONCLUSION

How concerned should we be that competition in the small group market does not fit the model of economic efficiency intended by some reformers? Answers to that question obviously vary widely depending on one's social and economic ideology. Those who favor unconstrained competition or who oppose managed care can be glad that market reforms allow competition based on risk selection. For those who favor nationalized health insurance or mandated purchase of insurance, these findings may supply considerable ammunition against the current voluntary private system. It is also possible, however, to view these findings from a middle ground that sees their moderated virtues. The movement toward managed care represents a profound shift in the nature of competition in the small group market, and methods of competing based on risk selection are now greatly reduced in some states. Also, the small group market in all states remains vibrantly price competitive

and innovative in product development, despite rather intensive regulatory intervention.

The matter of most concern is the considerable number of techniques that insurers still use to engage in strategic risk selection or to avoid adverse selection. It is naive to think that the incentives for risk selection will ever be fully controlled within a competitive insurance market. Although this is a goal of some market reformers, others take a more moderate approach to the social and economic merits of risk selection. Under this contrary view, some degree of risk selection may be desirable because this generates price signals about the costs of unhealthy behavior and lifestyle choices. Risk selection also helps to lubricate the moving parts of the market machinery by counteracting adverse selection. The micro-management of insurers' and agents' strategic decisions and interactions required to eliminate risk selection would overwhelm regulators and impose a huge administrative cost, as well as suppress valuable forms of competitive innovation.⁴²

Dilemmas like this confront us at every turn. Portability facilitates price and product competition but undermines insurers' incentive to invest in their subscribers' long-term health. Standardizing coverage promotes price comparability but suppresses product innovation. Guaranteed issue and community rating reduce available risk selection techniques at the same time they amplify the incentive to engage in risk selection. Purchasing cooperatives bring to small employers some of the sophistication and bargaining clout enjoyed by large employers but they threaten to undermine the valued role that insurance agents play in assisting purchasers. If there is one thing this study clearly establishes, it is that finding the optimal balance among these and other competing objectives is a demanding endeavor, one that reformers have initiated with some success but that is far from complete.

42. For instance, the large purchasing cooperative in Cleveland is dominated by one insurer because the coop administrators are afraid that letting in others would create too much administrative policing, resulting in risk-selection behavior as insurers "ate each other's lunch chasing after the good accounts." Hall, *Ohio Evaluation*, *supra* note 15.