STATE REGULATION AND INITIATIVES TO EXPAND SMALL GROUP COVERAGE

Testimony submitted by

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In every state, workers in small businesses are the least likely to have employer-based coverage and the most likely to be uninsured. This situation has driven concern about the affordability of small-group coverage in every state. Many states have significant efforts underway to address problems of affordability in this market and maintain access to necessary health care services.

This testimony reviews the impetus for state regulation to address the affordability of coverage and summarizes specific efforts to improve small-group coverage in selected states—including Arizona, Maine, Maryland, Massachusetts, Minnesota, New Jersey, and New York. The states that have developed programs to encourage greater coverage rely heavily on the commercial small-group market accepting and retaining significant risk.

Several of these states (Maine, New York, and—anticipating enactment—Massachusetts) have developed programs to subsidize low-income workers and encourage employers to offer coverage. If higher-risk groups were forced out of the commercial market and systematically gravitated toward these programs, they probably would be too costly for the states to operate. In turn, many high-risk individuals who lost group coverage would turn to individual coverage or to Medicaid and SCHIP in greater numbers, disrupting the individual market and adding enrollment and cost to federal- and state-financed programs.[1] By ensuring that insurers pool risk more broadly, these states are able to make the average cost of good coverage affordable to low-wage firms and low-income families.

THE IMPETUS FOR STATE REGULATION OF HEALTH INSURANCE RATES

The states' concern about access to and affordability of coverage spans nearly three decades. In a wave of state small-group reforms during the 1980s and early 1990s, many states required guaranteed issue and renewal in the small-group market. Many also acted to limit rate variation among small groups, especially with respect to health status and other group characteristics that contribute significantly to the volatility of premiums for small groups.

In 1994, the model act governing small-group coverage developed by the National Association of Insurance Commissioners called for modified community rating in the small

[1] SCHIP is the general acronym used to designate the State Children's Health Insurance Program in each state. Most states have folded SCHIP into their Medicaid program, developed a separate child health program, or combined these two approaches.

group market. The model act prohibits insurers from rating coverage to reflect health status, claims experience, or duration of coverage,[2] but allows adjustment in rates to reflect demographic characteristics (such as age) that are broadly correlated with medical cost.

The states that enacted restrictions on small-group rating did so to address real problems in their markets. Rating on health status was seen as an important contributor to unproductive churning—as small groups changed carriers and coverage, in effect to restart duration—and high administrative cost. Not only does churning add to the complexity and time commitment that small employers bear in order to offer coverage, it also burdens employees whose insurance coverage (and potentially also their providers) would change in the course of a serious illness. In addition, it adds significantly to insurers' already very high administrative costs for small-group coverage, as greater resources are devoted to underwriting, and disenrolling and enrolling small groups displaced from coverage by the illness of a worker or dependent.

Because small-group claims experience necessarily is more volatile than that of larger groups, health rating contributes to substantial premium volatility for small groups, causing some small employers to drop coverage and many not offer it at all.[3] A survey of small businesses conducted in 1993 found that about 12 percent of small employers had given up coverage in response to large premium increases—and 75 percent did not offer coverage because of uncertainty about increases in premiums (Christianson et al. 1994).

States that prohibited or narrowly limited health- or durational rating viewed broader risk pooling and, therefore, greater premium stability as essential to retaining and building small-employer coverage. By prohibiting health- and durational rating and requiring guaranteed issue, these states forced insurers to pool risk more broadly in order to stabilize rates. At present, at least 11 states require small-group carriers to use adjusted or pure community rating.[4] The states that have adopted pure community rating of small-group coverage—New York and Vermont—restrict carriers from varying rates on any characteristics of a small group other than family composition and geographic location.

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[2] Duration of coverage is a proxy for the rising incidence of health problems that emerge over time in any insured group. Most states, but not all, prohibit insurers from re-underwriting either or both small-group or individual coverage at renewal. However, durational rating encourages small groups to seek new coverage and, therefore, to submit to re-underwriting.

[3] Firms that are community rated are charged premiums that reflect the average claims experience of all small groups in their insurer’s book of business, not specifically based on the firm’s own claims experience. Community rates may vary by other factors as allowed or constrained in regulation. In contrast, larger groups have a greater number of workers over which to spread a few employees’ very high claims costs and, therefore, typically experience more stable premiums, even when their coverage is experience-rated.

[4] Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Vermont, and Washington. In addition, Michigan requires its Blue Cross and Blue Shield plan and all HMOs to use modified community rates. At present, the nonprofit Blue Cross and Blue Shield carriers and HMOs in Pennsylvania (accounting for about two-thirds of the market, but eroding) also use modified community rates.

IMPACTS OF HEALTH INSURANCE RATE REGULATION

No research has directly observed the effect of the states' rate regulation on small group rates. Instead, the research literature considers impacts on coverage, assuming that (all else being equal) lower rates of coverage correspond to higher premium levels and that some small employers and/or employees would drop coverage if regulation caused an increase in premiums.

Most early studies of rate regulation found little or no effect on overall coverage in the small group market (Monheit and Cantor 2004). However, more recent studies have looked for and found differences by risk group. These studies conclude that, in states with community rating, higher-risk individuals (for example, married women of childbearing years with children) may have gained coverage (Simon 2002). Similarly, high-risk workers are more likely to find or retain coverage in community-rated states, especially in states with narrow rate bands overall (Monheit and Schone 2004).[5]

However, community rating predictably increases premiums for healthier and younger groups, and may discourage employers from offering coverage to such groups, or (when employers require significant premium sharing) it may discourage lower-risk workers from taking coverage. Indeed, one study concluded that low-risk workers (for example, single men under age 36) in small firms might be more likely to become uninsured in states with narrow rate bands, although the effect was slight (Simon 2002).

These research findings highlight the choices that all states must make, either actively or passively, when health insurance coverage is voluntary. When small-group (and/or individual) rates vary widely with health status, it is more likely that individuals with health problems will be uninsured, especially if they are in low- or middle-income families. Conversely, with community rating and narrow rate bands overall, individuals with health problems are more likely to be insured—although some individuals who anticipate few medical needs may remain uninsured.

Whether the state restricts both the extremes of rate variation and the volatility of premium increases at renewal has important implications for population health status, as well as implications for financing throughout the health care system. By forcing the small group market to accept and hold greater risk, community rating and narrow overall rate bands help people with health care needs to afford coverage and access needed care. In turn, this probably minimizes reliance on Medicaid and SCHIP and also minimizes providers' burden for bad debt and charity care. All payers—including Medicare and large employer plans—ultimately finance medical bad debt and charity care in higher charges for insured care.

[5] A rate band is defined as the ratio of the highest to lowest rate offered to different small groups for the same product. States that regulate health insurance rates commonly set rate bands with respect to specific factors (such as health status or age), and they may also band rates for all factors taken together (called a comprehensive rate band).

STATE EFFORTS TO IMPROVE SMALL GROUP COVERAGE

A number of states have enacted programs to reduce the cost of small-group coverage and, therefore, encourage employers to offer it. Each of these programs also provides coverage for self-employed workers; many offer coverage to individuals as well. These states have taken alternative paths to subsidizing broad coverage for necessary services, as opposed to the less successful state efforts to develop less costly "bare bones" policies, stripped of most state-mandated benefits.[6]

These programs vary in their approaches, but all rely fundamentally on the small-group market holding substantial risk for health care costs. That is, these programs are feasible because they are likely to enroll groups with medical costs that are approximately at the population average. If carriers in the small group market were allowed to use health- or experience-rating, these programs would need also to health-rate coverage in the same way as carriers in the market. If they did not, they would become, in effect, high-risk pools, as groups that experienced a serious illness of a worker or dependent gravitated toward them to avoid experience rating. All of the programs that offer direct or indirect subsidies to small groups and/or individuals to encourage coverage probably would be forced to close if severe adverse selection accelerated their costs. The essential features of each program are summarized below:

- ***Arizona***. Arizona's Health Care Group (HCG) contracts with insurers to offer coverage to small firms and self-employed individuals; HCG reinsures that coverage, but does not directly subsidize premiums and eligibility is not based on income or wages. To protect the program against adverse selection, HCG requires that 80 to 100 percent of a firm's employees participate. HCG premiums are age-rated (as in the general market), but they are not health-rated; carriers in the general market may rate up as much as 60 percent for health status. Participating carriers must guarantee issue of coverage to all HCG applicants and, in return, HCG reinsures the highest costs. As of November 2005, HCG covered nearly 17,300 lives, of which about 70 percent were sole proprietors who are not guaranteed issue in the commercial market. The legislature appropriated $4 million per year for this program from 2004 through 2006 (Chollet 2004; Chollet and Watts 2005).
- ***Maine***. In mid-2003, Maine created the Dirigo Health Agency to design and administer a voluntary market-based health plan to help small businesses, the self-employed, and individuals afford health coverage. Called, DirigoChoice™, the health plan offers two high-quality health insurance options (distinguished only by the size of the deductible) through a private insurance carrier and competes with all products and carriers in the small group and individual markets (Rosenthal and Pernice 2004). It must comply with all insurance regulations—including guaranteed

[6] At least 11 states (Arkansas, Colorado, Florida, Maryland, Minnesota, Montana, New Jersey, North Dakota, Texas, Utah, and Washington) have considered or enacted legislation allowing insurers to sell limited-benefit policies to small groups. To date, these products have elicited very little employer interest and have not sold well. In contrast, low-income uninsured adults may be more likely to enroll in limited-benefit plans when offered through public programs and highly subsidized. For example, Maryland, Pennsylvania, and Utah sponsor limited-benefit plans for low-income adults that in some cases have hit their enrollment caps (Friedenzohn 2004).

issue and community rating adjusted only for age, geography, and industry within 1:5 rate bands. Employers must contribute at least 55 percent of the single premium for workers. Employees with family income less than 300 percent of the federal poverty level may approach the program for a reduced premium contribution and deductible, both calculated on a sliding scale relative to family income.[7] Otherwise, both DirigoChoice products are HSA-qualified. DirigoChoice opened enrollment in January 2005, and by December had enrolled more than 750 small groups. The claims experience of the program was generally comparable to industry norms in Maine, although inpatient hospital costs were somewhat higher than Anthem BCBS's commercially insured small groups. The anticipated cost of the program in 2006 is $43.7 million, financed as a 2.4 percent assessment on all paid claims in Maine [http://www.maine.gov/governor/baldacci/healthpolicy/news/11_22_05.htm].

- ***Maryland.*** Regulation in Maryland has standardized small-group products to facilitate comparison of small-group premiums among carriers and direct price competition, but it does not subsidize coverage. Carriers may offer only one small-group product, but they may offer riders to enhance the standard coverage. Most small employers in Maryland buy products that include one or more riders. Coverage must be offered without pre-existing condition exclusions, and it must be community rated, adjusted only for age and geography. The standard benefit is also subject to an affordability cap: the average annual premium for standard plans may not exceed 10 percent of the average annual wage in Maryland. A legislatively mandated evaluation of Maryland's small group regulation concluded that the cost of coverage, controlling for the benefits covered, was less expensive in Maryland than in all but one of six comparison states and 9 percent less expensive than the average. The standard benefit was generally comparable to that available in other states (Wicks 2002).

- ***Massachusetts.*** Legislation sent to Governor Romney for signature would require every Massachusetts resident to have health insurance by July 1, 2007. Those who do not get coverage would first lose their personal income tax exemption and eventually could face a yearly fee payable to the state and equal to half of the lowest-cost available insurance plan. Under the bill, the new insurance plans will be offered and run by private companies, but coverage for low-income families will be subsidized by the state. This strategy is likely to increase workers' demand for group coverage sharply, as a less costly way for individuals to meet their individual obligation to be covered. It is expected to cover an additional 215,000 people by creating incentives for insurers to offer low-cost products with fewer benefits and allowing individuals (like businesses) to purchase health insurance with pre-tax dollars. The premium subsidies are expected to result in coverage of an additional 207,500 people who will qualify for free or low-cost private insurance with sliding-scale premiums.[8] The plan calls for $58 million in new state spending through June 30, 2006, and $125 million per year in FY2007-2009. This bill was crafted in the context of strong small-group rate regulation and, therefore, market with relatively little premium volatility:

[7] Individuals who are not otherwise Medicaid eligible may also qualify for a reduced premium and deductible.

[8] In addition, the plan anticipates enrolling an additional 92,500 people in MassHealth (the state's Medicaid program) by expanding eligibility for children and enrolling all eligible adults.

Massachusetts requires small group carriers to community rate coverage, adjusted within 2:1 rate bands for age, industry, and group size.

- ***Minnesota.*** Minnesota has achieved the highest rate of voluntary health insurance coverage of any state, largely as a result of extensive participation in managed care, constraining health care costs, but also by sponsoring a series of public insurance programs available to individuals and families who cannot afford private coverage. Minnesota operates several programs that encourage coverage—including the Public Employees Insurance Program (which covers local government and school district employees and is operated by the state employee health plan), MinnesotaCare (a subsidized state program for low-income adults who do not qualify for Medicaid), and a uniquely large and affordable high-risk pool for individuals who are denied coverage in the individual market or quoted a high premium related to their health status (Chollet and Achman 2003). In a series of legislative initiatives since 2001, Minnesota relaxed its small group rating restrictions (including community rating) in response to the industry's argument more insurers would enter a deregulated market and that greater competition would drive down costs.[9] Since 2001, the small-group market has seen double-digit premium increases each year, despite significant growth in deductibles and other cost sharing for covered services, and the percentage of small-group workers covered by their own employer has dropped sharply.[10] Fewer people are now covered in the small group market, and insurer loss ratios have declined to the statutory minimum—suggesting that the small group market has in fact shed risk.[11] From 2000 to 2004, Minnesota (like other states) experienced significant growth in both Medicaid enrollment and the uninsured [www.statehealthfacts.org].[12] Enrollment in MinnesotaCare also accelerated sharply prior to cuts in the program (MDH 2006).

- ***New Jersey.*** Small-group carriers in New Jersey may offer any of four standard PPO products and one standard HMO plan. Each standard plans covers a comprehensive set of services, and they vary by co-insurance levels (ranging from 10 to 40 percent) and deductible options. Small group carriers must use modified community rating adjusted only for age, gender, and geography within overall rate bands of 2 to 1. At renewal, premiums may be adjusted for medical trend plus as much as 10 percent for health status, medical claims, or duration. In addition, New Jersey requires all small group carriers to meet or exceed a loss ratio of 75 percent. New Jersey estimates that

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[9] Currently, Minnesota insurers may rate for health claims, duration, and industry within rate bands of ± 25 percent (1.67 to 1); age within rate bands of ± 50 percent (3 to 1); as well as geographic area within rate bands of ± 20 percent (1.5 to 1)—cumulatively, rate bands of about 7.5 to 1.

[10] From 2001 to 2004, the percent of nonelderly workers in groups of 2 to 10 covered by their own employer declined from 34 percent to 28 percent; in groups of 11 to 50, the percentage declined from 60 percent to 50 percent. Coverage in other firm sizes also declined, but not as dramatically as in small groups. These changes were statistically significant (MDH 2006).

[11] A loss ratio is the ratio of medical claims incurred to insurance premiums earned by private health insurers. Minnesota requires the largest insurers to maintain a loss ratio of at least 80 percent in the small group market.

[12] The rate of uninsured increased from 12 percent in 2001 to 17 percent in 2004 among nonelderly adult workers employed in groups of 2 to 10; in groups of 11 to 50, the uninsured rate increased from 8 to 11 percent. These changes were statistically significant (MDH 2006).

it has caused carriers to return substantial funds to small employers during the years that it has been in effect (Sanders 2005).

- ***New York.*** Established in 2001, Healthy New York (NY) targets small employers (with 50 or fewer employees) as well as low-income sole proprietors and individuals. Healthy New York reinsures 90 percent of each enrollee's claims between $5,000 and $75,000 per year. Small groups may participate if at least 30 percent of employees earn less than $34,000 annually (indexed to inflation), and the employer did not offer or contribute substantially to comprehensive group coverage in the prior year.[13] To deter adverse selection in the program, at least half of eligible employees must participate and the employer must contribute at least half the premium. Uninsured sole proprietors and individuals may participate if they (or their spouse) are employed full- or part-time (or were employed some time in the prior year) and if their gross household income is 250 percent of the federal poverty level or less.[14] Healthy NY contracts only with HMOs; 24 currently participate. All are required to enroll all applicants and to community rate—consistent with New York's requirement that individual and small-group coverage throughout the state be guaranteed issue and pure community-rated.[15] Since the program began active marketing, enrollment has increased rapidly. In December 2005, Healthy New York was serving nearly 107,000 members. About one quarter of enrollees (26 percent) are small businesses (typically with 5 or fewer employees and having been in business 3 years or more), 18 percent were sole proprietors, and 56 percent were working individuals (EP&P 2005). In CY2004, Healthy New York spent $31.5 million—about 29 percent of participating plans' medical losses.[16] Premiums were 25 to 30 percent below market levels for Healthy New York products (United Hospital Fund 2005).

CONCLUDING COMMENTS

The states' efforts to encourage small group coverage fundamentally rely on a stable small-group market—and one that accepts and retains risk that is at least equal to population-wide average. In such markets, the uninsured population is expected to be at least as healthy as the insured population. Paradoxically, even state reinsurance programs—designed to cover the cost of unusually high-risk enrollees—are susceptible to adverse selection, if the market insures only the healthiest small groups and individuals.

[13] Small employers that provide coverage may be eligible for the program if they contributed less than $50 (or $75 if the business is located in the Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester counties) per month per employee.

[14] Individuals must have been uninsured during the past year, but may qualify if coverage during the past 12 months was terminated for such reasons as loss of employment, death of a family member or subscriber, change to a new employer without health insurance, change in residence, discontinuation of a group product, expiration or termination of continuation coverage (COBRA); change in marital status, loss of eligibility for group health insurance, or reaching the maximum age of dependency. Applicants with COBRA coverage or public program coverage in New York may enroll directly in Healthy NY (SCI 2005).

[15] In addition, participating carriers are required to set a single premium for small groups, sole proprietors, and individuals, regardless of enrollment category.

[16] New York finances the program from its tobacco trust fund.

When unregulated, health insurance carriers can shed or avoid risk by pricing and/or tailoring benefits to avoid specific medical costs. Both have precedent in the history of state health insurance markets. For example, if coverage cannot be denied (as under federal law in the small group market), it can be made unaffordable to groups that include workers or dependents with health problems. Carriers can use durational rating to force small groups to undergo re-underwriting, moving them into much higher rate classes. The potential for sharp increases in insurance premiums, in turn, discourages small employers from continuing coverage or offering it at all. Employees, when confronted with steep increases in their share of the premium, are less likely to accept coverage even when offered—especially if the plan's deductibles and copayments also are rising sharply.

In addition, unless required to offer some critical benefits, carriers can tailor benefit designs to avoid specific risks—for example, offering no or reduced coverage for maternity or mental health benefits, or for coverage of congenital problems in newborns, a benefit that every state currently mandates. Such latitude in developing insurance products presents at least two problems: By making benefits impossible to compare, it reduces price competition. In addition, it may in effect eliminate insurance for some benefits by breaking insurance pools into "puddles"; when the probability of using a benefit is very high in any insurance pool, the pool is in effect prepaying for care. Such prepayment schemes are unlikely to survive, and therefore the benefit they would cover is likely to disappear. State programs that work with the private market—such as those in Arizona, Maine, and New York—cannot offer good benefits with affordable premiums in an environment where carriers in the market do not do the same.

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