

# The Impact of Health Insurance Market Reforms on Market Competition

Mark A. Hall, JD

## **Abstract**

**Objectives:** To assess the impact of state and federal health insurance market reforms on the nature and extent of market competition.

**Study Design:** Qualitative, comparative case studies in 7 states.

**Methods:** Two rounds of in-depth interviews were conducted with over 100 key informants from the insurance industry. In each state, these sources included 2 to 4 regulators, 5 to 6 independent agents, and several sources at each of 4 to 5 of the top insurers. Extensive documentary data relating to market activity were also collected. These multiple sources of information and data were analyzed with both qualitative and quantitative techniques.

**Results:** (1) Small-group health insurance markets are highly competitive, both in price and in product innovation and diversity. (2) In some of the more heavily regulated states, there is very little competition in less-populated areas, especially for indemnity insurance. (3) The rapid growth of managed care in the small-group market may have been precipitated by these reforms. (4) Standardized benefit plans

have not achieved their objectives. (5) Competitive forces still focus to a considerable extent on risk selection techniques.

**Conclusion:** Small-group market reforms have not harmed market competition and may have improved competition in several respects. However, these reforms do not alter the fundamental orientation of competitive insurance markets, which is to focus on risk selection factors and techniques to the extent feasible.

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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.<sup>1,2</sup> Problems of affordability and availability of coverage emerged initially in the individual market (insurance sold outside the workplace) but then spread to the small-employers market—first, to groups of 10 and fewer and later to groups of 25 or more. Thus, in the late 1980s and early 1990s, there was a relatively swift unraveling of the private market, extending from individual subscribers and very small employer groups to medium-sized and larger firms. State and federal lawmakers faced the dual tasks of restoring the private health insurance market and restraining healthcare costs.

These multiple concerns and objectives led to rapid enactment of state laws aimed at stabilizing the market for private health insurance. Between 1991 and 1996, all but 4 states passed significant legislation that affected the pricing or marketing of pri-

From Wake Forest University School of Medicine, Winston-Salem, NC.

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Address correspondence to: Mark A. Hall, JD, Professor of Law and Public Health, Wake Forest University School of Medicine, Department of Public Health Sciences, Winston-Salem, NC 27157-1063.

vate health insurance. The federal law known as the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996.

The objective of this study was to assess the impact of small-group market reforms on the nature and extent of various competitive practices among insurers. In particular, we examined whether the reforms have led to a shift from competition based on health risk management to competition based on risk selection and measurement. This article focuses on legislation that applies to the small-group market (typically defined as employers with 50 or fewer workers) rather than on the individual market.

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... BACKGROUND ...

### The Purpose of Reform

Health insurance reforms have multiple purposes, but they all have one central aim: to create a market dynamic that will both promote health insurance coverage and restrain health insurance costs. This broad objective has a number of subsidiary components, which include increasing insurance availability, increasing its affordability, reducing risk selection and medical underwriting, allowing fair competition among insurers of different types, and stabilizing the market.

No single, cohesive vision characterized all insurance reform efforts. A prevailing view, especially among smaller, indemnity-based insurers, was that existing market structures and practices were mostly acceptable and socially responsible, except for certain excesses that were giving the industry a bad name. Other reformers, however, had more sweeping goals and felt that private insurers were dissipating too much competitive energy in socially unproductive or counterproductive efforts to screen, select, and measure individual health risks. This viewpoint, obviously more sympathetic to larger managed care insurers, held that the private health insurance market would serve its social function best if insurers began competing on the basis of risk management rather than risk selection.

According to this second viewpoint, risk selection serves its social purpose best when the risk in question is controllable, so that the cost of insurance motivates efforts to reduce the risk. Because many of the genetic and environmental factors that influence health risk are uncontrollable, however, varying insurance cost by risk status was considered unfair and unproductive. These more fundamental reformers believed, therefore, that insurers served

their most useful social function by covering as many people as possible and by setting their 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 underlying premise were intended, in part, to harness the resources that had previously been applied to assessing individual health status (medical underwriting) and redirect them toward managing the costs of treatment.

### The Logic and Content of Reforms

Insurance market reforms vary considerably in the details but they share 4 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. The following overview is based on the common features of this set of laws across all the states.<sup>1,2</sup>

*Guaranteed Issue and Continuity of Coverage.* Access of all purchasers to insurance and ability to renew that insurance were the starting goals of reform. “Guaranteed-issue” legislation requires all insurers who participate in the small-group or individual market to accept any applicant. An important distinction exists between states that (prior to HIPAA) required only designated policies to be guaranteed issue and those that required this of all policies. Since 1997, HIPAA requires all small-group policies to be guaranteed issue, but because HIPAA applies only to groups of 2 to 50 employees, many states retain the limited guaranteed-issue requirement for the self-employed.

In states where guaranteed issue applied only to some policies, it was usually to one or more standardized plans whose benefits were set by a government committee. Two versions of these “state-mandated” plans were typically offered—a basic version, and a more standard benefits package, with versions of each for both indemnity and HMO products.

Continuity of coverage is promoted in 3 ways: (1) Insurers are prohibited from refusing to renew insurance except for fraud, nonpayment, or similar malfeasance. (2) Insurers may not use riders that exclude specific health conditions, and under HIPAA, small-group insurers may place only an initial 12-month preexisting exclusion on any condition manifested within 6 months before the date of coverage. (3) “Portability” is promoted by allowing enrolled subscribers to transfer coverage to a new insurer (either by changing jobs or changing insurers within the same workplace) without undergoing

a new exclusion period, so long as the gap in coverage does not exceed 2 months. This provision addresses the problem of "job lock" that occurs when employees are afraid to change jobs for fear of having to undergo an additional exclusion period.

*Rating Bands and Community Rating.* Although guaranteed issue and continuity of coverage eliminate the worst effects of medical underwriting, standing alone they would have increased price variations and fluctuations by forcing insurers to accept high-risk subscribers and allowing them to price their policies accordingly. A second component of the reforms was, therefore, to construct a variety of rating restrictions that compress the range of prices an insurer may charge across all of its small-group businesses.

The 3 basic approaches to price compression are rating bands, adjusted community rating, and pure community rating. Each approach requires successively greater degrees of rate compression, the key distinguishing factor being the extent to which insurers can reflect health characteristics in their rates, in addition to other allowable "case characteristics" such as age and gender. Rating bands allow health status to affect rates, but only to a defined extent (eg,  $\pm$  20%). "Modified community rating" does not allow rate variation based on individual health status; however, in contrast to pure community rating, full or substantial adjustment is still allowed for age and sometimes for gender under the "modified" or "adjusted" community rating. Because age and gender can cause rates to vary 5-fold or more, even if individual health status is not a factor, considerable rating flexibility remains even in states with modified community rating or tight rating bands.

*Purchasing Cooperatives.* As a partial solution to many of the inefficiencies in the small-group market, several states created public purchasing cooperatives or authorized private purchasing groups in a number of different forms. These purchasing cooperatives contract with insurers who agree to abide by certain marketing and pricing rules. The core idea is to streamline marketing function and to form a larger risk pool so that small groups have the same bargaining clout, administrative expertise, and employee choice as large employers.

*Administered Reinsurance or Risk Adjustment.* The final component of the health insurance reform laws is an administered reinsurance mechanism that allows insurers to reinsure any risks that are expected to generate costs that exceed the prices charged. Reinsurance encourages insurers to accept

all applicants by allowing them to pass their worst risks to an industry-funded reinsurance pool. This administered reinsurance mechanism differs from conventional private market reinsurance because it is used selectively for groups or individuals expected to be higher risks than reflected by the allowable premium. By contrast, conventional reinsurance covers all of an insurer's risk pool for the chance that an actuarially accurate premium is not sufficient.<sup>3</sup> Commercial reinsurance also does not have a redistributive funding mechanism that spreads 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-risk pools, according to a specified, objective measure of risk. In theory, this approach is more accurate and finely tuned than reinsurance, but the techniques for making the required measurements are as yet not well developed and remain untested; risk adjustment is thus being used only on a limited basis in a few states.

### **The Dangers of Reform**

The high expectations for health insurance market reforms must be tempered by the reality of possible adverse consequences. One fear is that these reforms could be counterproductive, since they have the potential to increase prices and decrease coverage. Prices may increase because holding prices to less than the policy's actuarial value will make insurance most attractive to higher-risk subscribers. Because the excess is built into the premiums paid by all purchasers, higher premiums will inevitably drive an undetermined number of lower-risk purchasers out of the market, further raising the average price. This phenomenon is known as adverse selection against the market as a whole. The potential for adverse selection always exists where insurance purchase is voluntary and insurers cannot accurately reflect actuarial risk.

A related, but different, concern is that adverse selection will occur among insurers. Even if the market as a whole does not lose enrollment, some insurers may be disproportionately hit by a loss of subscribers or by higher-risk subscribers, which will result in some insurers going out of business. This can not only affect their private welfare, but also compromise market competition if too many insurers fold or withdraw. This form of biased selection can occur because good and poor risks do not always sort themselves randomly among competing insur-

ers. Instead, attributes of some insurers' plans will be more attractive to healthier patients and other attributes more attractive to sicker patients. Thus, biased selection can occur both naturally, through patients' choice among different benefit packages, and through insurers' calculated use of covert selection tactics. Insurance reforms heighten this problem by preventing insurers from setting prices accurately according to anticipated medical costs.

... METHODS ...

Seven states were chosen for this intensive case study: Colorado, Florida, Iowa, New York, North Carolina, Ohio, and Vermont. These study states represent a range of stringency in the elements of reform, as summarized in the Table (in order of decreasing stringency).

The study was conducted through more than 100 semistructured in-depth interviews in 1997 and

1998 with insurance regulators, insurers (commercial, nonprofit, and health maintenance organizations [HMOs]), agents/brokers, public and private purchasing cooperatives, reinsurance pool administrators, and trade associations. In each state, we interviewed 2 to 4 regulators with the most knowledge of these laws, 5 to 6 independent agents who specialize in health insurance (except in North Carolina, where only 3 agents were interviewed), and actuaries, underwriters, marketers, product designers, or lawyers at 3 to 4 of the top insurers. We also interviewed 11 national insurers with business in some or all of these study states, often with small market shares.

Interviews lasted 1 to 2 hours each and were based on an interview guide, but the discussions were free-ranging with some variability in the topics covered. Interviews were conducted by 3 individuals knowledgeable of industry structures and practices. Most interviews were in person and one-on-one, but a few were over the phone and in

groups of 2 to 5 subjects. Extensive documentary data and information were also collected from multiple sources (insurers, regulators, agents, newspapers, and academic and public policy studies) and analyzed with qualitative and quantitative techniques.

For simplicity, this article uses a lay vocabulary, with terms such as "insurer," "agent," and "price" that gloss over many of the distinctions that are important within the industry. "Managed care" refers primarily to HMO plans, including point-of-service plans, in contrast to "indemnity," which refers to both traditional unconstrained fee-for-service plans, as well as more managed forms of indemnity such as preferred provider organizations (PPOs).

**Table.** Key Reform Elements in Each Study State in 1996 (pre-HIPAA), in Order of Stringency

State	Guaranteed Issue (Group Size)	Rating Restrictions	Other Components
New York	All products (3-50) Groups of 1-2 can be sold to either as groups or individuals	Pure community rating	Risk adjustment
Vermont	All products (1-50)	Nearly pure community rating	—
Florida	All products (1-50)	Modified community rating	Purchasing cooperative; reinsurance
Colorado	Statutory plans (2-50)	Rate band of $\pm 20\%$ , phased down to 0% (modified community rating)	Purchasing cooperative; reinsurance
North Carolina	Statutory plans (1-50)	Rate band of $\pm 20\%$	Purchasing cooperative; reinsurance
Iowa	Statutory plans (2-50)	Rate band of $\pm 25\%$	Purchasing cooperative; reinsurance
Ohio	Limited open enrollment (2-25) 1 month/year for HMOs, and 0.5 % of book of business for	Rate band of $\pm 35\%$	Reinsurance

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... RESULTS AND DISCUSSION ...

### General Competitiveness and Market Concentration

Several lines of evidence indicate that the small-group health insurance market in each of the 7 states have been highly competitive over the past several years. First, most interview subjects concurred with this opinion. Many insurers saw opportunities for increased sales in this market but believed they faced stiff competition. Insurance agents were also enthusiastic about the impact of the law on their business. Even in New York, which has the most stringent law, agents said that guaranteed issue made the sale of insurance easier. Representative of these views, one New York agent said the law had been “a real boon to [our] business...our business has increased 50% to 60% at least” and another said that the law “helped us tremendously because we were able to bring our rates down...I saw [community rating] as a marketing opportunity.”

Small-group reforms have been especially successful in expanding market options for microgroups (5 or fewer employees) and, in some states, for self-employed individuals. Before the reforms, many insurers either did not sell to microgroups or offered only individual coverage because higher marketing and administrative expense and greater adverse selection made these small groups inherently less desirable. After reform, market options “improved tremendously” for groups with less than 10 members and especially for those with fewer than 5 members. Some insurers attributed much of their recent enrollment growth to these smaller groups, in agreement with nationwide statistics showing the strongest enrollment growth after reform in groups of less than 10 individuals.<sup>4</sup>

Market competitiveness can be measured by the number of competitors and the degree of market concentration. Although there was some market consolidation in most of these states—a number of insurers dropped entirely out of the small-group market or ceased to actively solicit new business—enough insurers remained to allow strong competition. In most of the study states, the percentage of the market held by the top 3 to 5 insurers has remained stable following reform.

Competition, especially among indemnity insurers and in rural areas, has decreased in many states compared with past years. Some agents in Ohio and Florida, for instance, said they were getting quotes for small groups from only 3 to 4 insurers, compared

with 8 to 10 previously. Two reasons emerged for this diminishing number of insurers. First, a wave of consolidations and mergers among insurers, mostly HMOs, reduced the numbers of available insurers<sup>5</sup>; this trend appears unrelated to reform laws. A second trend, believed to be partially related to the laws, is the increasing selectiveness of national insurers, particularly indemnity insurers, in picking markets in which to concentrate their marketing efforts.

Several indemnity insurers explained that, before reform, they considered themselves national companies and would market in virtually every state, even if they had very small market shares. After reform, they gave up this “mile wide and inch deep” philosophy in favor of selecting states and regions within states where they believe they can compete the most effectively. This change in focus is partly a reaction to increased competition from HMOs and the need to redirect capital resources to develop managed care networks of their own, but also results from experience under the reform laws. As explained later, indemnity insurers found they can compete more effectively under some versions of these laws than others. Although no versions of the small-group reforms appeared to be completely unacceptable to insurers, most indicated that a decision to remain or become active in a state took into account both the regulatory environment and the business risks and opportunities.

Few insurers, however, placed primary blame on the small-group laws for their decision to withdraw from any of these study states. One small-group insurer that withdrew from New York attributed this decision in part to the law, but also to lack of a good agent network and problems with the insurer’s existing block of business. (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, with both indemnity and HMO products, remained in New York but withdrew from Vermont and Kentucky, which have laws similar to New York’s, because of the higher market potential in New York and because it constituted a large portion of its existing business. Three other, larger insurers decided to continue competing in most states, regardless of how the small-group laws were constructed.

Despite these generally competitive conditions, there were some indications that reform laws may have dampened competition somewhat. Although a large number of insurers remained in the market in each state, the extent of effective competition may

vary considerably among different areas of a state because recent market consolidation has led insurers to be more selective in their marketing efforts. Moreover, some insurers are in the market only to renew existing subscribers and do not offer rates that attract new subscribers. For instance, in 1994, the Ohio small-group market consisted of 83 insurers, although only 20 covered more than 2500 individuals.

Rating rules limit the extent to which insurers can set lower rates for new versus renewing subscribers. An insurer who is unable to offer a competitive community rate faces the choice of either canceling 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. Consequently, many of the insurers that are technically in these markets do not effectively contribute to price competitiveness or diversity in product offerings.

Overall, the consolidation that has occurred in the small-group market has not undermined competition. Much of the attrition in insurers stemmed from insurers with very tiny market shares who were not "committed" to the market, so that the competition among those who remain is, in the words of one insurer, "much fiercer." The reduction in effective competition that occurred in some markets was not generally attributed to the reform law; rather, the subjects considered this a consequence of market consolidation driven by other economic forces, including the rapid movement to managed care.

### Managed Care

The small-group reform laws appear to be successful in reorienting the market toward competition based on managing costs rather than selecting risks. Risk selection has been reduced by requiring guaranteed issue and by prohibiting most forms of risk rating. Regardless of whether these developments are viewed positively or negatively, it is clear that managed care became a dominant force in the small-group market following the enactment of reform. According to one industry source in Florida, "The 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 among small groups doubled or tripled in just 2 or 3 years following reform, and most of these states also had a noticeable growth in smaller, new HMOs serving more local markets.

Most interview subjects did not attribute this change to the reform law, because the movement to managed care was occurring nationwide. Rather, they contended, the small-group market was the logical place for HMOs to turn for sales growth after the large-group market had become saturated. This was confirmed by a study, based on a representative national sample of approximately 3000 employers, which found that managed care plans (HMOs, PPOs, and point-of-service) tripled their share of the small-group market in 2 years, increasing from 22% to 69% between 1993 and 1995.<sup>4,6</sup> The conclusion, based on a regression analysis, was that this movement was unrelated to the reform laws and occurred because managed care had become established in the large-group market and offered a price advantage over indemnity. Similarly, in our study states with low managed care penetration—Iowa and Vermont—the greater success of indemnity products was unrelated to the structure of the reform law, but was determined more by inherent market conditions. Both states lack large urban concentrations and have large rural populations that do not easily support competing managed care networks.

Other indicators, however, suggest that the reform laws may have facilitated or precipitated these competitive conditions. The movement by small employers to HMOs largely coincided with these laws, and the laws were nationwide. Although the regression analysis mentioned earlier did not show a statistically significant correlation with these laws, it did show a positive relationship between insurance reform and growth of managed care, suggesting that these laws paved the way for this growth.<sup>4,6</sup>

Several possibilities may explain why the laws triggered the move to managed care and the resulting price competitiveness. First, HMOs were accustomed to offering open enrollment and modified community rating; these laws may have helped HMOs compete by requiring indemnity insurers to do business on the same terms. Second, the laws may have led to a rate shock effect and provoked subscribers to search for alternatives more quickly than if prices had increased more gradually. Third, employers' ability to switch insurers was aided by the portability provisions in the law.

These speculations were confirmed by several of the subjects and by existing data. Indemnity prices indeed rose steeply in states with more stringent reforms, at least for a few insurers. Some insurers with HMO products said the reform law was directly responsible for making the small-group market a

“major target” by focusing more attention on this market segment, which previously had been largely overlooked. According to one New York agent, “you could have almost foretold the eventual movement toward the HMOs and PPOs because there was no other way to go...[The reform law] financially forced everyone to go toward managed care [whereas before] everyone was basically trying to fight managed care.”

### Price Competition

The generally competitive conditions that prevailed after the enactment of small-group reforms and the push for market share by managed care firms led to intense price competition in the study states. Health insurance premiums for small employers held remarkably steady during the first few years of reform (1993 to 1996), especially when compared with the double-digit increases that were common in the late 1980s. A precise quantitative description of marketwide prices was difficult because premiums vary according to so many factors that there is no easy or accepted way to average across all of the different products and risk groupings for even a single insurer, let alone for the entire market. Also, most states do not systematically collect and report rate information, so even if such a calculation were possible, the data do not exist. Therefore, simpler proxy indicators of price were used in several states, depending on the information available. In some states (Colorado, New York, and Vermont), good data were available for actual median prices for representative products from all insurers.

We saw similar, but not identical, price trends across all the states. 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. 1997 and 1998, however, saw steeper increases for both types of insurance. HMO rate hikes escalated into the 8% to 15% range; indemnity products increased even more, by 15% to 25%. The large increase in rates for indemnity products may have been the result of adverse selection against indemnity plans arising from the rapid increase of HMO enrollment in the small-group market, whereas prices for HMOs may have been held artificially low by fierce competition for HMO market share. Many subjects spoke of HMOs “buying market share” in the early or mid-1990s, meaning they were pricing at or below expected costs in order to build the subscriber base needed to establish new managed care networks. These subjects explained that steeper

increases in the late 1990s were necessary to maintain long-term profitability.

Nevertheless, most subjects, including agents, confirmed that the small group market remains 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 insurers whose average premiums were near or below the median for the top insurers. Overall, agents and insurers considered the small-group market competitive and rational with respect to price. One pricing actuary commented that he was “constantly amazed” at how small a price difference it took for employers to switch insurers; some would switch for as little as \$1 per employee per month.

Regardless of whether the reforms can be credited with increasing pricing competitiveness, it is clear the laws did not lead to adverse selection against the market and cause the premium spirals that critics had warned about. Any adverse selection has been minimal and easily absorbed and has not added noticeably to the price of the leading insurance products. According to one Florida agent, “everybody 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.” Some subjects, however, warned that the full effects of small-group reforms had not yet been felt. With the imposition of steeper price increases, adverse selection might take a more noticeable toll.

### Benefit Packages

*Standardized Benefits.* One way the reform law may have promoted price competition is by creating standardized benefit packages that make price comparisons easier or that serve as reference prices for insurers’ other products. Our examination of a large number of sales brochures revealed that much of insurers’ strategic market positioning is focused on minor differences in benefit packages. Insurers present dizzying combinations of various components of coverage such as deductibles, copayments, maximum payouts, and riders for prescription drug benefits or mental health coverage. This makes price comparisons difficult and leads to risk segmentation through biased selection. To counter these tenden-

cies, some states required insurers to sell one or some types of standardized benefit plans.

The standardized plans have not sold well, for a variety of reasons: (1) Insurers were reluctant to sell standardized benefits, and therefore did not market or service them very well. To some extent this reluctance arose from simple philosophical antipathy to government intervention in the market. Although the benefit package was usually constructed by a committee of insurers and agents, it was the government that imposed the mandate, and so these plans carry an ideologic taint for some agents, who described them to their clients as “state-mandated” plans designed for “inferior” or “substandard” groups as “coverage of last resort.” (2) Another source of the unpopularity of these plans was that both insurers and purchasers like to individualize their benefit packages. For insurers, this is one way to express their product and corporate identity and to distinguish themselves from their competitors. (3) Administering the statutory plans was difficult and expensive for insurers. When insurers create and modify their own benefit packages, they make systems changes that help automate rating and claims processing decisions. Nonconforming benefit structures require more hands-on rating and claims processing.

A more obvious reason to disfavor the statutory plans in some states such as North Carolina, Iowa, and Florida was that, until 1997, they were the only plans that were required to be guaranteed issue, yet they were subject to the same rating bands as medically underwritten plans and hence, were bound to attract risks that were higher than the allowable premiums.

For these reasons, insurers maintain a low profile in the market with respect to standardized plans. The plans are not actively marketed or advertised and are usually offered as an alternative only after coverage was declined for an underwritten plan. The usual slick color brochures are absent, and, at best, a plain, single-page summary of benefits is sent; in some instances insurers send no literature at all and it is left to the agent to explain the plan features.

As a result of the “planned lack of response” to state-mandated plans, one North Carolina agent observed that, from an agent’s perspective, “it’s as if these plans don’t exist.” In Florida, several agents who specialized in small-group insurance had not sold a single standardized plan. One of these agents even served on the committee that formulated the statutory benefits packages. In both Florida and

North Carolina, the statutory plans accounted for less than 5% of new small-group sales. The basic plan was especially unattractive, accounting for only 0.1% of new sales in Florida. In North Carolina, only 282 basic plans were sold over a 5-year period. One large national insurer had only 32 of these plans in effect in 23 states at the end of 1996. Another insurer, who specialized in small-group coverage and was active nationally, had only about 2 dozen groups enrolled in these plans in 18 states. Colorado was the only state in this study where standardized plans have sold reasonably well, accounting for more than 10% of all small-group enrollment and more than 20% of HMO enrollment. The reason, according to insurers, was that in Colorado, the standard plan is as comprehensive as their regular plans, and regulations require insurers to actively market the standard plans along with the other plans.

Standardized plans in most states were also hampered in their ability to serve a reference pricing function that indicate an insurer’s overall competitiveness. In some states plan rates were difficult to obtain without contacting insurers individually. Most states did not collect and disseminate rate information systematically. (Colorado was the notable exception.) Comparative price information was available through the statewide purchasing cooperatives in each state, which were sometimes used by agents to determine price competitiveness for sales outside the cooperatives. In North Carolina, however, this was hampered by rating rules that allow statutory plans to be priced differently from nonstandard plans. Also, insurers adopted a variety of rating strategies that allow them to reflect the relative health risks of the various pools of subscribers for their different products in ways that are not clearly intended by the reform law. Thus the rate for a standardized product does not reveal much about rates for more popular plans.

This experience contrasts with that under the Medigap reform law, in which benefits standardization has been reported to promote price competition successfully for private insurance that supplements Medicare.<sup>7</sup> The Medigap law, however, allows *only* standardized benefit plans to be sold, and so insurers must focus their marketing efforts on those plans.

*Product Innovations.* An ongoing and probably unresolvable debate has centered around the favorable and harmful effects of innovative benefit design strategies. One reason public policymakers might not favor standardized benefit plans is that, despite enhancing price competition, these plans suppress

competition and innovation in product choice and benefits design and fail to reflect the diversity in consumer tastes. On the other hand, changes and differences in benefit designs may encourage covert risk selection, by allowing insurers to strategically tailor benefits to be more or less attractive to groups with different risk profiles. It is nevertheless helpful to document and describe the variety of innovations in benefits and to consider their connection with the small-group laws.

The pronounced movement to HMOs in the small-group market was generally thought to have enhanced product choice, although some interviewees maintained that HMOs, by accentuating adverse selection against indemnity plans, effectively priced them out of the market. Several indemnity insurers argued that, under tight rating restrictions, they can not adequately guard against adverse selection from HMOs because, on average, indemnity and PPO products (which impose fewer restrictions on choice of physician and covered prescriptions) are preferred by sicker people. If this increased health risk were reflected only in their average rates, however, insurers would be unable to offer a competitive price to healthier subscribers. This could price indemnity-based products out of the market except for high-risk individuals, even though those at lower risk would be willing to pay extra for increased choice and coverage.

The validity of these claims needs to be established through quantitative and direct empirical measures. Initial data indicate, however, that significantly fewer indemnity insurers remained in business after these reforms. Although PPO products are still widely available, even in tightly regulated small-group markets, their prices are increasing significantly faster than those of HMO products; pure indemnity products have almost disappeared from several of the more tightly regulated small-group markets. Notably, traditional indemnity products are rarely offered by the statewide purchasing cooperatives, although some of these cooperatives do provide PPO and point-of-service HMO products.

A strategy adopted by some insurers to counteract adverse selection is to make benefit packages less attractive to people with health problems, by increasing deductibles or decreasing drug benefits. According to one Florida agent, "You 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 or \$500. I've got them as high as \$1000." Another tactic agents viewed as unfair is to offer good coverage for very attractive

prices, but only to the extent of the insurer's limited fee schedule, which is not adequately disclosed to subscribers, thus exposing subscribers to a greater payment liability than they realize.

Rather than being a strategic attempt to frustrate price comparison and generate favorable selection, these trends and tactics might be driven by purchasers' desire for more affordable coverage and by insurers' concern about controlling utilization; or they might reflect a procompetitive response to varying consumer tastes. Most agents adopted the benign view, but others spoke of "little gimmicks that [insurers] can put in the contract," such as offering health club membership as a way to attract the health-conscious, or coverage for alternative or holistic therapies (although both these benefits can also be viewed benignly).

Some changes in benefits, however, are clearly related to market reforms. The move to guaranteed issue of all small-group products prompted insurers to weed out several benefit plans they were not willing to sell on this basis or were no longer marketing actively. Even insurers who continued to pride themselves on offering "gourmet" benefit plans set limits on particular high-cost items such as in vitro fertilization and "designer drugs" that could lead to adverse selection. One insurer was reluctant to try new benefit structures such as medical savings accounts and disease management programs in states where rating rules are less forgiving of possible pricing mistakes, since it is difficult to ascertain the impact of such changes on costs and purchasers' selection decisions. Nevertheless, most subjects agreed that a good array of benefit options is available. Although the differences in benefits packages were considered to have narrowed since reform, we observed that insurers were formulating different and hybrid managed care structures in their efforts to determine the optimal mix between choice and cost controls.

### **Rating Games and Risk Selection**

The picture emerging is that small-group market reforms have been successful on a number of fronts, but fall short of reaching the economic ideal envisioned by some reformers. Risk selection, although used less extensively, still remains an important, perhaps the most important, factor that determines insurers' profitability. Attaining homogeneous risk pools, however, is considered an unrealistic expectation. In fact, the interviewees felt that some differential among risk pools is perfectly acceptable and perhaps even desirable. Risk-pool differentials make

it difficult, however, for consumers to use price as the gauge of a plan's underlying efficiency, which weakens the motivation to compete on the basis of the quality and cost of medical care delivery.

There are strong indications that price differences in the small-group market are still determined to a great extent 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 the differences in benefit packages, the yearly *trends* in average claims *for a given insurer* more clearly point to changes in the composition of the risk pool. We noted substantial differences in these trends in most states, with some insurers' claim costs increasing much more rapidly than others. Notably, these differences existed despite the existence of risk adjustment and reinsurance mechanisms that were intended to smooth out risk differentials and counteract incentives to engage in risk selection.

Large differences in risk pools have persisted for a variety of reasons. First, insurers entered the reformed market with lower- or higher-risk pools, and these historical patterns may have endured. Second, the use of certain covert risk selection techniques may have resulted in some insurers systematically attracting better risks. Some of these techniques, such as crafting benefit packages to appeal to healthier subscribers, are perfectly legitimate; others, such as encouraging field underwriting, are not legitimate or of questionable legality (unpublished observations). Third, subscribers' preferences—the tendency of sicker people to prefer certain plans or sets of benefits or the reluctance of sicker subscribers to switch insurers—may have led to risk differentials, with a resulting advantage for newer market entrants. Regardless of the reason, purposeful risk-selection strategies are widespread. One industry source said that regulators “can't hold a candle” to the creative abilities of insurers to encourage risk selection.

Although the reforms were enacted to minimize medical underwriting, insurers still compete to a considerable extent on their medical underwriting abilities. Up to 1997, a number of states still allowed insurers to decline coverage for their primary plans. Even after enactment of HIPAA, risk rating in states with rating bands continued unabated because of the considerable flexibility in the rating bands. A number of HMO and Blue Cross plans began to use their rating flexibility more aggressively after HIPAA required guaranteed issue of all their plans

and to make increasing use of medical underwriting to draw fine distinctions among applicants. Underwriting expertise is also required for determining reinsurance of subscribers. To a considerable extent, profitability is still determined by the accuracy of these endeavors.

Many techniques developed by insurers allow them to engage in risk rating to a greater extent than that apparent from the rating bands. Rating bands that allow a spread based on health risk or claims experience suggest that the rate for a plan may not exceed the stated percentage over average rates, but that is not the case. 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, rather than in the middle, thereby allowing almost twice as much increase for poor health status than appears allowable from the bands.

Insurers also manipulate the rating factors for benefits differences to produce greater health-risk differentials than the rating rules allow. For instance, one New York actuary admitted the company's point-of-service HMO plan cost more than a PPO indemnity plan, whereas the pure benefits effect should be the opposite. In North Carolina, before enactment of HIPAA, the rates for the statutory plans, which contained somewhat leaner benefits than most insurers' medically underwritten plans, were priced higher than the underwritten coverage for many insurers. The rate differences were sometimes substantial. For example, one insurer charged \$209 for the standard statutory plan but only \$71 for its underwritten plan with more generous benefits; another charged \$145 for standard benefits compared with \$70 for the more generous underwritten plan.

Insurers also engage in risk selection through a variety of techniques known as “field underwriting.”<sup>8</sup> This term refers to a practice of encouraging agents to screen out higher-risk applicants. This is a legitimate practice in many other 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. Nevertheless, interview subjects in every state confirmed that field underwriting occurs to some degree, largely through subtle suggestions and pressure on agents, making the practice difficult to detect. Moreover, in some states, notably Ohio and Florida, insurers have influenced agents directly by adjusting their commission levels

according to the attractiveness of the business they generate.

Most agents claimed these tactics do not influence their advice to high-risk applicants. Nevertheless, whether through agents, selective marketing, or simply chance, the distribution of high-risk cases can be highly uneven among insurers. For instance, in Ohio, before 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 reached 12%, a third reached only 1%, and 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 2 other insurers' small-group enrollment, but the other top insurers had less than 0.5% 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? Proponents of unconstrained competition who oppose managed care can be pleased that market reforms have left in place a substantial ability to compete on the basis of risk selection. For those who favor nationalized health insurance or mandated purchase of insurance, these findings fuel the argument against the current voluntary private system. From a moderate viewpoint, methods of competing based on risk selection are now greatly reduced, and the movement toward managed care represents a profound shift in the nature of competition in the small-group market. The small-group market also remains vibrantly price competitive and innovative in product development, despite rather intensive regulatory intervention.

The techniques that insurers still use to engage in strategic risk selection or to avoid adverse selection raise considerable concern. It is naive to think that the incentives for risk selection will ever be fully controlled or counteracted within a competitive insurance market. Some degree of risk selection may be desirable because it generates economic signals about the costs of unhealthy behavior and lifestyle choices. Risk selection can also counteract the adverse selection that occurs when higher risks systematically choose one type of prod-

uct over another. Any effort to eliminate all forms of risk selection would require intensive micro-management of insurers' and agents' businesses and would overwhelm regulators, impose a huge administrative cost, and suppress valuable competitive innovation.

The proper balance between risk pooling and risk segmentation is only one of several dilemmas created by these reforms. Portability facilitates price and product competition but undermines incentives to invest in subscribers' long-term health. Standardizing coverage promotes price comparability but suppresses product innovation. Purchasing cooperatives bring to small employers some of the sophistication and bargaining clout enjoyed by large employers but threaten to undermine the valued role that insurance agents play in assisting purchasers. In sum, while these reforms have met with some success, the process is far from complete, and finding an optimal mix among competing objectives remains an ongoing challenge.

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