

Policy Forum

State Health Insurance Regulations: Implications for Illinois by Anthony T. Lo Sasso

At various times advocates, politicians, policy analysts, and concerned citizens have recommended reforms of state small-group and non-group (individual) health insurance markets. The early- to mid-1990s was a period in which health care issues rose to the top of federal and state agendas, and we appear to be entering another such period of acute interest in expanding health insurance coverage. While few have forgotten the failed Task Force on National Health Care Reform under the Clinton Administration, more easily forgotten are the concurrent efforts by states to provide universal health insurance coverage. There are important lessons to be learned from generations of state initiatives, lest states be condemned to relive the failed policies of the past.

Illinois is among the states that have recently become interested in expanding health insurance; though much of this interest is simmering below the surface of the present budgetary wreckage. As recently as 2007, for example, the widely-ignored Illinois Adequate Health Care Task Force recommended implementing "guaranteed issue" and "community rating" regulations in the individual insurance market. Community rating is a regulation that forbids an insurance company from adjusting premiums for age, gender, or health status and at least in theory formulates a premium that represents average

health care expenditures for the community rather than the individual. Guaranteed issue is a regulation that, as the name implies, requires an insurance company to offer a policy to all prospective customers. If the guaranteed issue requirement is not combined with community rating, the effect of the policy in isolation is unclear because carriers could simply offer policies with very high experience-rated premiums. Likewise, community rating without guaranteed issue is also unlikely to have a broad impact as carriers could simply not offer policies to potentially risky individuals. As this recent example demonstrates, new state proposals can frequently repeat the mistakes of old proposals.

A Brief Examination of Insurance Theory

Noted economist Mark Pauly in 1970 demonstrated quite convincingly that community rating is an inefficient strategy to either match appropriate health insurance policies to individuals or to increase coverage. The opposite of community rating is individual experience rating, in which the individual is charged a premium equal to his or her expected (or average) health care utilization. Essentially, community rating represents an effort to subsidize the premiums of the sick by taxing the premiums of the healthy. Ignoring the predictable changes in enrollment



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(lower enrollment among the healthy due to higher premiums and higher enrollment among the unhealthy due to lower premiums), such a tax/subsidy mechanism would cause the healthy to buy less insurance coverage than they otherwise would prefer in the absence of the tax and the unhealthy to buy more insurance coverage than they otherwise would prefer in the absence of the subsidy. Put differently, because of the price distortions the insurance purchased does not provide the ideal, most desired coverage for either the sick or the healthy. Moreover, Pauly also observes that community rating represents a redistribution of income from the healthy to the sick. While all redistributions involve value judgments, it is clearly not the case that all healthy people have high incomes and all unhealthy people have low income. Hence, redistributive aims could certainly be accomplished in a more efficient manner than through community rating.

Beyond the fact that community rating will induce individuals to buy the “wrong” policy given their preferences, it will also induce some individuals, specifically healthier individuals, not to buy health insurance at all. Others with a working spouse may opt for group insurance coverage. It is also likely that unhealthy individuals with pre-existing conditions will find a community-rated individual policy more appealing given the subsidy; combining a guaranteed-issue requirement may make hitherto unavailable coverage possible. Insurers will anticipate the insurance demand as well as the influx of unhealthier enrollees, but they are essentially forced to guess about the likely responses when deriving the community-rated premiums. If the higher community-rated premium is too high, the insurer will be left with only the sickest individuals most desperate for coverage; if the community-rated premium is too low, the insurer may not be able to cover health care claims with premium revenues, which could lead to another round of premium increases. This second round of premium increases will cause the remaining relatively healthy to drop coverage and the pool of remaining covered individuals shrinking to include a still sicker pool of enrollees. The process could continue until only the sickest of sick remain in the market paying very high de facto experience-

rated premiums.

Far from an academic fancy, these “adverse selection death spirals” have been documented in health insurance markets (see, for example, Cutler and Reber, 1998). In practice, such spirals would be unlikely to occur indefinitely as employers or insurance companies would eliminate plans that are obviously experiencing significant adverse selection. Moreover, adverse selection spirals are most likely to be caused by (or at least aggravated by) regulation. Indeed, a death spiral appears to have taken place in the New Jersey individual health insurance market: Monheit and colleagues (2004) document declining enrollment and continually increasing premiums, the very definition of an adverse selection death spiral. An individual mandate could, in principle, alleviate the selection issue, though the effect of a health insurance mandate is questionable particularly given the limited success of other insurance mandates.¹

It is worthwhile at this point to comment on the aforementioned practice of experience rating in health insurance. Some may find it objectionable, prima facie, to charge sick individuals more for health insurance. Again, it is important to go back to first principles of insurance. Insurance only works for indemnification against risks that have yet to reveal themselves – risks that are known only probabilistically. Just as one cannot buy homeowner’s insurance after one’s house has burned down and expect to be financially indemnified, expecting an insurer to pay for claims for adverse health outcomes that have already revealed themselves is similar folly. Forcing an insurer to sell an insurance product at a premium that is below the expected health care expenditures is analogous to selling a \$10 bill for \$5: it is a great deal for the purchaser, but not a sustainable business practice for the seller. For the practice to be sustainable, the seller must necessarily offset those money-losing sales with an equal number of sales of \$5 bills for \$10. Thus,

¹ The efficacy of individual mandates to purchase health insurance is certainly subject to debate. Virtually all states have implemented compulsory automotive insurance, yet data suggest that the mandates have mixed success: roughly 15 percent of motorists are uninsured, which bears a striking similarity to the percentage lacking health insurance (Insurance Research Council 2006). This point regarding the questionable enforceability of an individual health insurance mandate has been made elsewhere (see Tanner 2006).

as long as people keep buying the over-priced \$5 bills, the system can work. But herein lies the difficulty with community rating: the people buying the over-priced \$5 bills might get wise to the fact that it is not a good deal, and, presuming there is nothing to prevent them from no longer making the purchase, they will drop out of the market.

Past and Present State Regulatory Initiatives and Research Findings

Currently Maine, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington states have community rating in their individual health insurance market. Insurers in these states are not allowed to charge differential premiums based on the health of applicants. Community-rating regulations are subdivided between so-called pure community rating, requiring insurance carriers to charge the same premiums for all plan participants regardless of age, gender, health status, or other factors, and adjusted or modified community rating, which allows for some premium differentials typically by age or gender. Of the states mentioned here, only New Jersey, New York, and Vermont are pure community-rated states. The other four states, however, implemented adjusted community-rating regulations, which still allow limited premium variation by specified amounts. In addition to the seven currently community-rated states, New Hampshire and Kentucky previously implemented community rating along with guaranteed issue, but later eliminated both requirements. Both Kentucky and New Hampshire maintain restrictions on rating, but allow premium variation for health status and other characteristics. An additional nine states also have limits on premium rating by health status and other characteristics in the form of rating bands, but do not have a guaranteed-issue requirement.

One recently published national study examined the consequences of the individual health insurance regulations enacted in the 1990s. Lo Sasso and Lurie (2009) examined how state community-rating regulations combined with guaranteed issue laws affected the purchase of individual insurance by different risk groups and how the composition of the risk pool changed as a result

of the regulations. The authors also examined the extent to which insurance products changed as a result of community rating. Their results suggest that community rating of the individual health insurance market was associated with a significant change in the risk composition of the individual market. Using data from large, national surveys the authors found strong evidence that community rating made healthy people less likely to be insured by individual health insurance. They also found less consistent evidence that healthy people were more likely to be uninsured as a result of community rating, though this was certainly the case for some young and healthy individuals. Unhealthy individuals were more likely to be insured through individual policies yet the authors only found limited evidence suggesting that uninsurance decreased among the unhealthy. On balance, the effects on either tail of the distribution canceled each other out so that no overall effect on coverage was evident. The results regarding individual insurance market compositional changes were further supported by examining the impact of community rating on the health status and health care utilization of persons with individual insurance before and after community rating in a subset of states, which suggests that enrollees as a group were sicker as a result of the community rating laws.

Conclusion

The information presented here provides a compelling portrait of the predictable distortions that can result from regulations aimed at improving perceived deficiencies in the individual and small group health insurance markets. The predictions from economic theory are unambiguous and the bulk of the scholarly literature consistently points to decreases in coverage for young and healthy individuals and a disturbing and potentially unsustainable trend toward a sicker pool of enrollees in the market.

There are at least two wildcards to consider for state policy makers envisioning reform efforts. The first is the potential efficacy of individual insurance-purchase mandates to increase, through admittedly heavy-handed methods, the take-up of health insurance. We will probably get our first

inkling on how successful such an approach is as the Massachusetts experiment rolls forward. The second wildcard is the potential role of high-deductible health savings accounts in making insurance more attractive or at least more affordable to an expanded spectrum of the country. Although the downstream effects of greater consumerism in health care are difficult to predict, it could potentially augur greater transparency in prices for medical care and even some modest competition among providers as more health-care dollars transition from third-party insurer payers to first-party consumer payers armed with a tax-preferred vehicle to save for future individual and family health-care needs.

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