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Community rating and the market for private non-group health insurance

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ABSTRACT

Prior research on adverse selection in health insurance markets has found only mixed evidence for adverse selection in group settings. We examine the impact of state community rating regulations enacted in the 1990s, which greatly limited insurers' ability to risk rate premiums, to determine if adverse selection is more evident in non-group insurance markets. Using data from large, national surveys we find evidence of a shift to a less healthy pool of non-group enrollees as a consequence of community rating. Community rating made healthy people 20 to 60% less likely to be insured by non-group health insurance; in addition, we found evidence that young and healthy people were 20 to 30% more likely to be uninsured as a result of community rating. We also find evidence that individuals in poor health were 35 to 50% more likely to be insured in the non-group market, but only limited evidence suggesting that persons in poor health were less likely to be uninsured. Our results are further supported by findings suggesting that non-group enrollees were sicker as a result of the community rating laws. Lastly, we find evidence suggesting that HMO penetration in the non-group market increased disproportionately in states that implemented community rating relative to states that did not.

1. Introduction

The phenomenon of adverse selection in health insurance markets has been noted since at least Arrow (1963), yet only recently have economists made some headway in empirically demonstrating adverse selection. Insurance provided within large groups is unlikely to be affected by significant adverse selection, but as the group size shrinks there is more potential for individual enrollees to influence overall health care expenditures. Hence adverse selection becomes incrementally more likely, though still not assured, in small groups. It is therefore not surprising that work on the subject has been mixed: some studies have found little evidence of adverse selection in small group markets (see for example Buchmueller and DiNardo, 2002), while others have found some evidence of adverse selection (see Simon, 2005; Monheit and Schone, 2003). As the group size diminishes to one the presence of adverse selection becomes less ambiguous. However, another vein of research has highlighted the importance of multiple forms of heterogeneity that cloud the ability to identify adverse selection in insurance markets more generally (see Chiappori et al., 2006). Finkelstein and McGarry (2006) examine long-term care insurance markets and determine that purchasers are heterogeneous in the type of private information they have: some are high risk and thus purchase more insurance and use more services while others have a strong taste for insurance and thus purchase more insurance but use less services. Fang et al. (2008) study the Medigap insurance market and find that cognitive ability dominates risk preference and other characteristics as a factor explaining the decision to purchase coverage. Our goal is to identify and understand the nature of adverse selection in non-group health insurance markets. Specifically, we examine how state community rating regulations combined with guaranteed issue laws, which eliminate insurers' ability to experience rate premiums based on characteristics associated with health care expenditure risk such

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as age, gender, or health status, affected the purchase of non-group insurance by different risk groups and how the composition of the risk pool changed as a result of the regulations.

Our research differs from most prior work because we estimate the impact of community rating on both ends of the risk distribution: the healthy and the sick. We examine whether the regulations served to induce some people to purchase non-group coverage and other people to drop non-group coverage, and whether we observe reciprocal effects on uninsurance. We find that community rating was associated with a 20–60% reduction in the likelihood of being covered by non-group health insurance though no significant increase in the probability of being uninsured among healthier individuals overall. However, we do find that among young healthy unmarried men community rating laws are associated with both a decrease in non-group coverage and a 20–30% increase in uninsurance. In contrast, non-group coverage increased 35–50% among unhealthier individuals, though we did not find consistent evidence that uninsurance decreased among those in poor health. The combined impact of these results are further supported by examining the impact of community rating on health status characteristics and health utilization of persons with non-group insurance before and after community rating for a subset of states, which suggests that the enrollees as a group were sicker after community rating laws were enacted. This evidence is consistent with the hypothesis that community rating worsened the extent of adverse selection in the non-group market. However, perhaps tempering the adverse selection effect, we also find evidence that HMO penetration in the non-group market increased disproportionately in states that implemented community rating relative to states that did not.

2. Community rating in the non-group health insurance market

During the early- and mid-1990s states were active with regulatory efforts aimed at improving the perceived inequities and inefficiencies in the small and non-group health insurance markets. While small group regulatory efforts were more common, in many cases the small group regulations were done in tandem with similar regulations implemented in the non-group health insurance market. Of the numerous regulations enacted by states in the non-group market during the 1990s[2] the regulatory regime that is most likely to have an unambiguous effect on health insurance markets is community rating combined with a guaranteed issue requirement. Community rating requires insurance carriers to charge the same premiums for all plan participants regardless of age, gender, health status, or other factors.[3] By restricting the ability of insurers to charge differential premiums by risk, states intended to create a market in which those in poor health would not be "discriminated" against in the form of higher premiums.

Table 1 lists the eight states that enacted non-group community rating laws and guaranteed issue for all non-group health insurance products during the 1990s.[4] Note that of the states that enacted community rating, most enacted modified community rating laws, which allows limited premium variation by specified demographic characteristics (typically age) or region. Although modified community rating is likely to diminish somewhat the potential for adverse selection, the absence of underwriting for health status represents a qualitatively different regulatory regime in relation to non-community rated states. Similarly, the bite of the policy is greatly augmented by the guaranteed issue requirement because it further restricts the insurer's ability to limit coverage to those deemed a profitable risk. The table also indicates availability of data for residents of the states in our two data sources, the Survey of Income and Program Participation (SIPP) and the National Health Interview Survey (NHIS).

A final important point is that all states that enacted non-group community rating laws also enacted similar policies in their small group health insurance markets generally at the same time.[5] As there were a number of other states that only implemented small group community rating, we have the ability to examine to a limited extent the degree to which there were spillover effects from the small group market that affected non-group coverage. To identify the impact of non-group community rating, our regression models will include an indicator for the presence of small group community rating laws in the state. The indicator is identified because more states implemented community rating in the small group market than in the non-group market.[6]

3. Previous research

Several studies have examined aspects of non-group market regulations in the 1990s (see Zuckerman and Rajan, 1999; Percy, 2000; Sloan and Conover, 1998), but they suffer from a number of shortcomings. Notably, the prior research does not identify whether there was a compositional change within the pool of those covered by non-group policies after implementation of the regulations based on health status. The second general concern regarding prior work is that the data used—typically the CPS—do not contain sufficient detail regarding the respondent's health status and the timing of their insurance coverage. Our research uses the SIPP and the NHIS, both of which include measures of insurance coverage and health status thereby extending the previous literature by examining the composition of the non-group market pre- and post community rating.

[2] Such regulations included rating restrictions, guaranteed issue requirements, limits on exclusions for pre-existing conditions, reinsurance requirements, minimum loss ratio requirements, and premium rate restrictions. Fully 33 states implemented some type of regulation in the 1990s (Blue Cross and Blue Shield Association, 2000).

[3] We will generally apply the term community rating to rating restrictions that fall short of pure community rating, but nonetheless involve strong restrictions on insurers' ability to experience rate non-group insurance policies.

[4] Because we are concerned about the potential for policy endogeneity, in an earlier version of this work we studied the factors affecting state decisions to implement non-group community rating using a discrete time hazard model. In general we did not find that past levels of either uninsurance or non-group health insurance coverage were predictive of the enactment of community rating regulations, though we did observe a positive relationship between lagged changes in managed care penetration and the enactment of community rating. An appendix detailing this analysis is available upon request of the authors.

[5] Only Massachusetts had a significant lag between implementing community rating in its small group market (1992) and its non-group market (1996).

[6] We thank Kosali Simon for providing us with information on small group market regulations.