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State health insurance market reforms and access to insurance for high-risk employees

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Abstract

A specific focus for state regulations of the small group insurance market was to increase offers and stabilize premiums for firms with high-risk workers. We examine the effect of reforms implemented from 1993 through 1996 on the likelihood of employer sponsored insurance coverage. We find that packages of reforms that included both guaranteed issue of some products and some form of rate variance restriction had significant positive effects (4.5 percentage points) on ESI coverage for high-risk compared with low-risk workers within small firms and a small negative effect (–1.7 percentage points) on low-risk workers in small compared with large firms. The mechanism for these effects was an increase in take-up, rather than offer. Reform packages that included both guaranteed issue of all products and rate variance restrictions had similar effects overall, although they did not meet criteria for significance. These effects seemed to act through increased offer rather than take-up.

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1. Introduction

Employment based health insurance is the largest source of insurance coverage for Americans. In 2002, 64.2% of non-elderly Americans had insurance through their own employer, or received coverage as a dependent through the employer of their spouse or parent (Fronstin, 2003). However, many Americans who are workers or linked to workers lack insurance coverage, suggesting that the system of employer sponsored insurance (ESI) has important gaps. Overall, 43.3 million Americans lacked health insurance coverage in 2002, and 83% of the uninsured were in a family with a worker (Fronstin, 2003).

Workers in small firms are particularly disadvantaged in their ability to obtain ESI. For example, only 54% of workers in the smallest firms (fewer than 10 employees) work for employers that sponsor ESI coverage, compared with 95% for workers in firms with 100 or more employees. Although only 34% of workers are employed at firms with fewer than 100 workers, 62% of uninsured workers are at these smaller firms (Garrett, 2004).

In the late 1980s and early 1990s, concerns were raised about insurer practices with respect to small firms that were thought to affect access to coverage. Small firms faced higher premium rates because fixed administrative costs were spread over a small number of persons. However, in the absence of regulation, small firms were also subject to other differences. Many insurers refused to offer insurance to small firms due to the size of the potential risk group and the inherent instability within the risk group over time. When insurance was offered, detailed medical underwriting for small firms was often used to identify workers and dependents with high expected costs. The presence of such workers increased premiums for the firm relative to the average. These elevated premiums discouraged employers from offering coverage and could reduce take-up by employees in small firms that did offer. In addition to relatively high premium rates, small firms were subject to very steep increases in premiums after one or two years, once pre-existing condition restrictions expired. Thus, even when small firms offered coverage, it was common for them to change insurers frequently, and employees may have dropped coverage as premiums increased.

In an effort to improve the climate of access to insurance for small firms and their workers, states implemented a variety of regulatory reforms starting in the early 1990s. In most states, firms with fewer than 50 employees were the target for these reforms. A specific focus of the reforms was to improve the ability of firms with high-risk workers to get offers of coverage with relatively stable premiums by broadening the risk pool. By high-risk workers, we mean workers in a family where some member has a chronic health condition likely to result in high health care expenditures. These reforms preceded the small group market reforms that were mandated by the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996, and in many states they continue to be more restrictive than the reforms mandated by HIPAA, and hence are still relevant to current policy.

The reforms generally fall into one of two main categories: issue reforms, which affect which firms must be offered insurance and what packages must be offered by insurers, and premium variance restrictions, which affect the prices insurers may charge. Issue reforms are designed to make insurance coverage easier to obtain for small groups. Four major types of issue reforms were implemented during the early 1990s:

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