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Adverse selection in health insurance markets? Evidence from state small-group health insurance reforms

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Abstract

The past decade witnessed major changes in state laws governing the sale of health insurance to small employers. States took measures to restrict insurers' ability to distinguish between high and low-risk customers because of concern about the low rate of coverage among workers in small firms, the high prices in the small-group market and the absence of federal health reform. Using both individual-level and employer-level data, I test predictions about the effect of reforms on the employer-provided health insurance market. I estimate these effects for small firms and their workers using large firms and their workers in the same states, as well as large and small firms and their workers in non-reform states, as comparison groups. I find the reforms decreased the rate of employer coverage on average for workers in small firms by less than two percentage points. Within small firms, low-expenditure individuals experienced a larger decline in the rate of coverage through their employer, while the coverage rate of high-expenditure individuals rose slightly in some specifications. There is also evidence that comprehensive reforms increased premiums slightly for small employers, and that most of this increase was passed on to workers through higher employee contributions.

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Fearing that low health insurance coverage in small firms could be partly due to experience rating and redlining,[1] many states introduced laws that restricted these practices in the small-group market. Inability to price and issue policies in accordance with risk could worsen informational asymmetry and resulting adverse selection relative to the unregulated market. Adverse selection is thought to generally reduce the insurance consumption of the low-risk groups, to transfer resources from the low-risk group to the high-risk group in cases where subsidized equilibria are sustained, or to result in a market failing to exist altogether. A simple model of insurance where employers buy policies on behalf of their heterogeneous workforce suggests that small group reforms may decrease coverage for the low-risk and increase coverage for the high-risk (see Simon, 2004), while the predicted changes are ambiguous for the market on average. This comprehensive empirical analysis of state attempts to standardize the terms of insurance across different risk types suggests that reforms have not succeeded in increasing coverage in small firms as a whole. Instead, they may have inadvertently led to a small overall decrease in coverage through an increase in premiums and employee contributions. This analysis also suggests that certain low-cost populations have suffered larger declines in coverage than others.

1. Government involvement in small-group health insurance

Starting in the early 1990s, state legislators took steps to "promote the availability of health insurance coverage to small employers regardless of their health status. . .and to improve the overall. . . efficiency of the small-group health insurance market".[2] From 1991 to 1996, 47 states implemented some combination of the small-group reforms described below. Rating restrictions limited the insurers' ability to use certain predictors of health care use in setting premiums, while guaranteed issue laws banned denial of policies. Some states allowed insurers to market a guaranteed 'bare bones' plan to first-time insurance buyers. Pre-existing conditions exclusion laws and portability laws improved continuity of access to health insurance while working for small firms.[3]

Most states followed the language of model laws published by the National Association of Insurance Commissioners (NAIC) (1998). The area in which most variation exists is rating reforms. Most states allowed premiums to vary by certain demographic factors called 'case characteristics' and permitted variation around average prices through 'rate bands' within which group-specific information could be used. The language of most rating statutes is not straightforward, and many allow insurance commissioners to decide

[1] Redlining is the practice of systematically refusing to insure groups in certain high-risk industries or occupations.

[2] This quote is taken from Section 2 of the 1992 National Association of Insurance Commissioners (NAIC) Small Employer Health Insurance Availability Model Act.

[3] The regulatory information used in this analysis was gathered through a careful primary investigation of state statutes and bills checked against all available secondary data sources, and from personal communication with almost all state insurance departments (Simon, 2000). See Hall (1999) for detailed discussions of these reforms.