

HIPAA'S SMALL-GROUP ACCESS LAWS: WIN, LOSS, OR DRAW?

Mark A. Hall

Perhaps the least controversial aspect of the Health Insurance Portability and Accountability Act (HIPAA) is the set of provisions regulating access to health insurance by small employers (those with 2–50 workers). HIPAA builds on an extensive set of regulations that states began enacting in the early 1990s to make health insurance easier to purchase and to keep. Its requirements include not only the guaranteed renewability and portability provisions, but also an all-products guaranteed issue mandate, which prevents insurers from refusing coverage under any of their small-group products.

Although the vast majority of states (over 40) already had versions of these laws in place prior to HIPAA, a few did not, and there was some variation among those that did. Most important, roughly half the states with guaranteed issue laws applied them only to certain designated products with standardized benefits that were designed for higher risk subscribers. HIPAA requires that higher risk purchasers be able to choose any of an insurer's offerings in the small-group market. HIPAA took what existed in most states and made it universal and uniform.

Assessments of HIPAA's guaranteed issue and related access and portability provisions generally conclude that they have achieved their limited aims and have done no immediate economic harm (Sloan et al. 1999; Hall 1999). Although coverage has not measurably increased as a result, small employers can purchase comprehensive coverage regardless of their workers' (or their workers' families') health problems, as long as they are willing to pay the cost. Because few previously uninsurable employers have elected to add coverage, in most markets there has not been any substantial, measurable increase in small-group premiums that is directly attributable to this added protection.

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Mark A. Hall is Professor of Law and Public Health at Wake Forest University.

There certainly continue to be a large number of small employers who don't purchase health insurance. But it appears that the reason for not purchasing is the affordability of insurance, not its accessibility. Prior to guaranteed issue requirements, some insurers certainly turned down high risks, but they were not turning down very many people who actually wanted to purchase insurance for the price at which it could be offered.

In sum, HIPAA's small-group provisions might be scored a draw. By increasing accessibility but not helping affordability problems, HIPAA at best creates a modest gain at no great cost, but also with no great improvement. Appearances, however, can be deceiving. In addition to the added regulatory and administrative costs entailed in HIPAA's portability provisions, there are two sets of hidden costs: the foreclosure of market innovations, and the creation of new administrative burdens at the state level.

Foreclosing Market Innovations

HIPAA is constructed to fit the market structure as it existed in 1990, one that consisted of three distinct segments: individual (or non-group) purchasers, small groups, and large groups.

There are two kinds of dangers entailed in locking into place such a market structure. First, it could prevent the market from evolving into a more seamless or efficient structure. Second, solidifying market gradients creates unnatural opportunities for gaming, which then entail further regulatory costs to prevent regulatory circumvention.

The health insurance market's three segments (large, small, and individual) are not simply parts of a continuum (Hall 2000). They constitute entirely different product lines, often sold by different sales forces, and serviced by different insurers or corporate divisions—as distinct in their economic and legal characteristics as are mobile homes, apartments, and single-family houses. The characteristics of each market segment, and the way in which the boundaries are defined, have pervasive strategic and regulatory importance.

The market structure for health insurance first distinguishes between the individual, or non-group market, in which people buy insurance on their own, outside the workplace, and with after-tax dollars, versus the group market of employer-sponsored insurance, which is divided into the small-group segment and the large-group segment.

The large-group market, which accounts for roughly two-thirds of private health insurance, consists in great measure of self-insured employer groups. Self insurance is a strategy designed to take advan-

tage of the Employee Retirement Income Security Act's (ERISA's) preemption of state regulations such as solvency oversight and mandated benefits. The small-group portion of the employer-sponsored insurance market consists of groups so small that they find it very difficult, if not impossible, to self-insure. Because adding extra regulations to the employer group market would encourage more opting out of state regulatory systems through self-insurance, HIPAA's insurance reform provisions apply only to groups of 50 or fewer workers, the level at which self funding is thought to be infeasible.

At the other extreme, the individual market, which accounts for less than 10 percent of private health insurance, consists of insurance purchased outside the workplace. Such insurance generates fewer or no tax breaks, and its regulation is almost entirely the province of the states. Most states do not impose the set of access and rating rules that apply to small groups because this market segment is too fragile and the tendency would be too great to price lower risks out of the market.

Small-group laws must be spliced in between these two extremes. Doing so requires not only defining precisely who counts as an employee, but also providing a special set of rules for the self-employed, who, after all, are small "groups" of one. Aside from these boundary-defining and border-policing problems, crafting different rules for different market segments creates a regulatory gradient, which presents opportunities for gaming the regulatory structure. Because different portions of the health insurance market have different economic characteristics and they are subject to different regulatory approaches, insurance purchasers will consider strategic opportunities to pose themselves as being on one side or the other side of a somewhat artificial regulatory divide.

Moreover, HIPAA's regulatory structure assumes that these market divisions are, and will continue to be, the natural and optimal shape of the market. Market innovations and evolutionary trends that might be contrary to this assumption are inherently disfavored. Examples of each type of problem follow.

Fictitious Employees and Groups

High-risk individuals may wish to present themselves as a group in order to claim the benefit of guaranteed issue. This can be done by employers falsely claiming sick friends or family members as employees in order to get them onto the group policy, or when people have "day jobs" with firms that do not offer insurance and use another part-time activity to claim the status of business proprietor for themselves or family members.

To guard against these abuses, most insurers require payroll and tax form documentation of business and employee status. Despite this, some employer fraud continues to occur. Because insurers in the small-group market lack most of their other underwriting tools, some insurers have become very aggressive in demanding and reviewing this documentation, even from clearly legitimate enterprises, to the extent that screening for these and other group eligibility criteria (such as minimum participation and employer contribution requirements) now receives as much or more attention by some insurers as did medical underwriting prior to reform. These developments also make it more difficult for legitimate sole proprietors to purchase insurance. A number of group insurers refuse to sell to “groups of one,” and others charge a substantially higher per capita rate than for groups of 2 to 50, in order to avoid attracting higher risks from the individual market.

Small-Group Self-Insurance

Small groups can also cross their market boundaries; by seeking the advantages of ERISA preemption that come with self-insuring. Healthier small groups may wish to do so in order to avoid mandated benefits or to escape rate regulations that inevitably accompany access protections (see below). To accommodate this desire, some insurers and agents have developed a modified form of “stop loss” or reinsurance that is feasible for employer groups as small as about 20 employees. Even the largest self-funded employers purchase some catastrophic reinsurance coverage at annual expense levels above a particular “attachment point.” Small employers also can self fund simply by lowering the attachment point to a level that is relevant to their financial exposure and their resources—levels as low as \$10,000, for instance. But this low level of “stop loss” reinsurance is barely distinguishable from a high-deductible insurance policy that offers *primary* coverage.

The difficulty created by this arrangement is that various consumer protections often do not cover such reinsurance policies. An unsophisticated self-insured employer may not realize it is not protected from cancellation or steep premium hikes. Because these policies are written to cover only claims submitted during the policy period (coverage is extended on a claims-made basis rather than an event-occurrence basis), employers can be stuck with large unreimbursable expenses if the reinsurer cancels coverage after someone receives expensive treatment but before the claims for it are submitted. Smaller employers who do not have sophisticated experience in pur-

chasing insurance and do not necessarily have the resources to hire high-cost advisors may be vulnerable to abuse or mismanagement by thinly capitalized offshore reinsurance carriers that are not regulated by individual states. To prevent these problems, many states ban the sale of reinsurance policies that kick in at the lower levels required by smaller groups.

Purchasing Associations

Small employers can also band together to form a larger group that self insures through more conventional reinsurance. This is done through various group purchasing vehicles known as Multiple Employer Welfare Associations (MEWAs), or simply private associations (Hall, Wicks, and Lawlor 2001). Many of these vehicles have been developed and marketed by entrepreneurs that lack adequate capital, or who have fraudulent motives, resulting in waves of bankruptcies that have left millions of dollars of unpaid medical bills.

Purchasing associations attempt to price their policies apart from the regular small-group market in a state. They prefer an experience-rated approach, in which the association's rates reflect the claims experience for those who participate in the pool, which is how insurance is priced for large employer groups. Because the association's rates are separate from the regular small-group market, purchasing associations provide a way to bleed off the "better" risks from community-rated small-group pools.

A purchasing association also limits HIPAA's guaranteed issue and renewability provisions to those employers eligible to participate in the association pool or to those insurance carriers with contracts to service that association. Once an employer leaves the association, or a carrier and the association sever their contract, the HIPAA protections don't attach to the departed employer or the former carrier.

HIPAA seeks to prevent "fictitious groups" by requiring that private associations have a *bona fide* professional or trade purpose. Nevertheless, associations abound that exist primarily for purchasing insurance and that have no meaningful membership restrictions. They operate under names such as "Associated Industries," "Business Council," and "Association of Self-Employed," which some observers derisively refer to as "air breather" associations, meaning anyone who breathes air is eligible to join. In substance and form, these insurance associations do not differ from broadly inclusive associations formed by Chambers of Commerce and other legitimate business groups, so the regulatory attempt to differentiate the two has been ineffective and confusing. Complex regulatory approaches to deal with this issue

also foreclose opportunities to set up bona fide purchasing associations in somewhat different, but more optimal, ways.

Pending legislative proposals that would create entities called HealthMarts or Association Health Plans are designed to reduce this confusion and increase the opportunities for collective purchase of small employer plans (Hall, Wicks, and Lawlor 2001). Yet the more one liberalizes the ground rules, the more one begins to erode the very foundations of HIPAA: guaranteed issue and renewability.

List Billing

Self-insurance and private associations involve small groups crossing the market border into the large-group terrain. Other techniques move small groups in the opposite direction, toward the individual market. These techniques go under various terms, the most common of which is “list billing.” The meaning of this technical term varies somewhat within the industry, but the gist is to describe arrangements where employers facilitate their employees’ purchase of individual insurance rather than purchasing a group policy. In short, the insurer, rather than billing for a group rate, bills for a list of designated employees who have opted for individual coverage. This can be done in two different ways. One is to bill the employer, who pays some or all of the cost of the insurance. The other is for workers to bear the entire premium, but to allow them to pay through payroll deduction; the insurer only notifies the employer of the amounts to deduct from employees’ paychecks. In the latter case, the employees purchase their own insurance with after-tax dollars (Hall 2000).

The first form of list billing, where employers pay a portion of the cost of individual insurance, is banned by small-group reforms. The concern is that employers will drop coverage for sick workers or family members and cover only their healthy workers. However, this ban also prevents or discourages the second form of list billing, in which employers merely facilitate workers’ own purchase of individual insurance through payroll deduction. Prior to small-group reforms, this facilitation was popular with both insurance brokers and employees. For brokers, it created easier access to new clients. For employers, it allowed those who do not otherwise offer insurance to do something constructive for employees.

As employers begin to contemplate a move toward defined contributions rather than defined benefits for health coverage, the ban on list billing creates considerable uncertainty about whether employers can legally subsidize workers who purchase their own coverage. HIPAA’s insistence that employer-supported health insurance be

regulated as group insurance is a major legal deterrent to market innovations that blur the distinctions between the individual and group markets. A defined contribution health benefit in which an employer contributes to the cost of insurance coverage could allow employees to select whatever plan they want from all the offerings in the marketplace. But HIPAA was written with a dichotomized or balkanized world view in which either individuals purchase their insurance entirely on their own, with no employer assistance, or their employer pays all, or virtually all, the costs for one or more group plans that the employer chooses to sponsor.

Attempts to devise hybrid approaches, such as where there is a partial subsidy from the employer or employees select from a much wider array of plans, run up against a regulatory model that assumes clear-cut categories. HIPAA is concerned that employers financing group coverage might try to circumvent, for example, the requirement that if employers offer health insurance, the same options must be provided to every full-time employee regardless of their health conditions. Therefore, HIPAA requires that insurance arrangements be regulated as "group" coverage if there is any employer support. Also, HIPAA requires insurers to charge composite group rates rather than to rate each employee separately. This makes it much more difficult for small employers to offer products from more than one carrier, since insurers are concerned that they will not be able to charge more if they do not receive a fair mix of both good and bad health risks.

In summary, HIPAA's need to define and police the borders between small groups and individuals, and between small and large groups, not only creates significant costs of regulatory oversight but results in foreclosing or deterring a number of potential market innovations. Those include bringing to the self-employed the advantages of group coverage, allowing small groups to achieve the efficiencies of large-group purchasing, and giving workers greater choice among health insurance offerings.

The Complexities of Rate Regulation

While HIPAA has sweeping protections against being denied insurance coverage, it says nothing about what prices insurers may charge when coverage is mandated. HIPAA leaves rate regulation entirely to the states, and so the degree of effective protection varies widely across the country. The General Accounting Office reports that some states allow insurers to charge as much as six times their standard rates for "federally eligible" subscribers who move from

group to individual coverage (U.S. General Accounting Office 1998: 8). This vividly documents that guarantees of insurance coverage depend heavily on how much insurers may increase rates for higher risks. Accordingly, in the small-group market, most states have implemented some form of rating restriction that prevents insurers from varying their prices among lower- and higher-risk purchasers more than a defined amount (Hall 2001).

State small-group rating rules vary considerably, but there are three basic approaches: rating bands, adjusted community rating, and pure community rating (Hall 1994). Those approaches require successively greater degrees of rate compression. The key distinguishing factor is the extent to which insurers may reflect various risk factors in their rates. *Rating bands* allow health status to affect rates, but only within a defined range. States originally allowed ranges of +/- 25–35 percent, but many have since tightened the range to +/- 10–20 percent. Allowing no rate variation based on individual health status is called *modified community rating*, which contrasts with *pure community rating* by still allowing adjustment for age and sometimes gender. Pure community rating allows rate adjustment only for location, benefits, and family size.

Rules that allow separate rates for different blocks of business add another layer of complexity. Many states apply rating limits separately to a limited number of blocks, defined according to how insurance policies are sold or managed, or whether they have a fundamentally different design. In order to prevent circumvention of the rating limits by block gerrymandering (segregating high and low risks into different blocks), a number of states also limit the pricing variation *among* blocks. For this purpose, a 20 percent limit is typical.

Another dimension in which rating reforms restrict price variation is the amount that insurers may increase a purchaser's rates over time. Most states limit year-to-year premium increases for any given subscriber to 10–15 percent above the insurer's "trend." Trend is defined as the increase in the insurer's rates for new business. The concept is to allow marketwide cost increases that are driven by technology advances, inflation in the medical sector, and the like, but to limit those increases that reflect group-specific health risk.

Flexibility in Rating Bands

Each one of these separate rating approaches entails considerable complexities based on its own internal logic. For example, reform laws that create rating bands typically restrict rating flexibility to a prescribed range above or below an "index rate," which is the mid-

point between the highest and lowest rates. This appears to tightly compress rate variation, so that the highest risks pay only moderately more than average risks.

This appearance is deceiving. To start, realize that insurers are not required to set their standard rates in the middle or to have their mid-point rates match any particular spot in the distribution of health risks. Instead, this range is defined solely by a comparison of the top and the bottom rates. In order to make maximum use of the allowable range, many actuaries rate standard groups near the bottom end of the premium range, not the middle, in order to give them essentially double the leeway to increase rates for higher risks.

To avoid a high risk, all an insurer needs to do is to offer a slightly higher price than someone else by making greater use of the allowable rating range. Insurers who make aggressive use of this rating flexibility have almost as much underwriting impact as they did when they could decline applicants outright. A number of Blue Cross plans and HMOs that traditionally had used modified or pure community rating as a matter of social policy were forced by HIPAA's guaranteed issue requirement to adopt underwriting practices that use the allowable rating flexibility much more aggressively. For some insurers, this required a major investment at great cost and disruption in order to gain the rating sophistication required to compete effectively with insurers with established underwriting prowess.

Durational Effects

Rating rules that limit increases over time are intended to prevent a practice known as churning. Churning resulted from insurers giving deep discounts initially but then increasing rates steeply at renewal, forcing subscribers to look for new coverage, even if claims did not exceed first-year estimates. Insurers have justified these increases by observing that claims costs tend to increase rapidly after the first year or two of coverage. This phenomenon, known as the "durational effect," occurs because the advantage from careful underwriting wears off after a year or two as initially healthy groups or individuals regress to the mean. Limits on rate increases over time require insurers to anticipate these effects in their initial pricing so that purchasers do not receive rate shocks one or two years after initial coverage.

Insurers expected that guaranteed issue would greatly reduce the durational effect since it was thought to arise mainly from careful medical underwriting. To their surprise, however, the durational effect appears to remain strong (Hall 2001). Actuaries report that loss

ratios for small groups that renew are substantially higher than for new purchasers or for groups whose policies lapse—an indication that the durational effect continues despite guaranteed issue. This natural selection effect stems from the fact that people with health problems are averse to making any changes in their health insurance. Most people who buy insurance already have coverage elsewhere, but people shopping for new coverage are healthier than those who are not.

The continuing strength of the durational effect is significant for insurers' pricing strategies because it means insurers improve their risk pools by attracting newer subscribers. This can intensify price competition, but it can also lead to market volatility through strategic "low balling" or "buying market share." The durational effect allows new market entrants to offer lower premiums initially, but this advantage wears off rather rapidly. New insurers often find that they have to raise their rates steeply after just a year or two, especially if they underpriced initially relative to the risks they received. If so, their enrollment will deteriorate rapidly because existing healthy subscribers will leave, and the insurer will not attract new enrollees if its new business rates must, by law, keep within, say, 15 percent of the pace set by its renewal rate increases.

Market reforms may be partially to blame for this low-balling and market volatility. Portability provisions that allow groups to easily leave insurers when they receive steep rate hikes increase volatility. Following HIPAA, a number of insurers reported very high "lapse rates" of 30–40 percent of their groups dropping coverage each year.

Adjustment for Benefit Differences

Rating reforms allow insurers to vary their rates by however much is actuarially justified by differences in benefits among their various plans. Valuing benefit differences is a matter that entails actuarial judgment, however, and for which there are different techniques. One technique is to declare that benefits are worth the claims cost they generate, so that different benefit packages are rated according to the claims experience for the entire pool of subscribers to each package. The difficulty with this approach is that it confounds benefit differences with health status factors. If some plans are more attractive to healthier or sicker populations, then the claims experience will reflect underlying health risk of those covered as well as benefit differences.

Using only claims experience can result in anomalies such as plac-

ing a higher actuarial value on a benefit package that objectively is less rich. For instance, if two plans are identical except that Plan B offers free membership in a health club, Plan B should be more expensive but, measured by claims experience, just the opposite is likely since health-conscious subscribers will be attracted to the free membership. In states that, prior to HIPAA, required only certain standardized benefit plans to be guaranteed issue, this actuarial technique was employed in a way that resulted in much higher prices for these guaranteed-issue plans than for similar medically underwritten plans. Even though the guaranteed-issue plans had somewhat leaner benefits, those types of plans had risk pools that generated considerably more claims than the medically underwritten plans with richer benefits. The rate differences were sometimes dramatic. One audit in North Carolina, for instance, found that several insurers were charging two or three times more for the leaner statutory plan than for their richer plans that had more favorable risks.

A different sorting of risks occurs even when all plans are guaranteed issue, because then the higher risks tend to seek out richer benefits. For instance, plans with lower deductibles or better drug benefits are likely to attract sicker patients who expect to use these benefits. If a risk-neutral actuarial valuation is used, this selection effect is ignored in adjusting rates for differences in benefits. But if actual or projected claims experience is used to value these increased benefits, then insurers could use the benefits adjustment to reflect the full impact of the increased health risk of those who purchase these richer policies.

Some actuaries do not attempt to use this leeway in the rating rules but instead set benefit factors according to national actuarial standards and data, which they apply equally to low- and high-risk pools. Actuaries at other insurers, however, set benefit factors according to the actual medical expenses they produce, which results in adjusting rates, in part, based on differences in health status. Some state regulators consider these rating tactics to be legitimate because claims experience is a relevant measure of the value of benefits. Other regulators attempt to avoid the influence of health risk on benefit factors to any extent, by focusing on this aspect of rating in the actuarial certifications they require insurers to file. However, there is no settled way to disentangle these combined factors, so actuaries are still able to use benefit adjustments as an indirect surrogate for health risk. Avoiding this altogether could only be done by scrutinizing the data and detailed assumptions that actuaries use to develop their rating structures, but regulators rarely have the resources or expertise to do this.

Implications for Insurance Reforms

In summary, while few analysts believe that HIPAA's small group reforms have achieved the "win-win" success that was intended for them, most people see HIPAA as, at worst, a no-gain and no-loss draw. Instead, I score HIPAA as a small gain, but one with hidden costs. Those costs arise from the necessarily complex regulatory scheme needed to make HIPAA's insurance reforms functional. The seemingly simple proposition of guaranteed issue requires that market boundaries be drawn to avoid imposing the requirement in the non-group segment where it does not work and to avoid encouraging more employers to opt out of regulation through self funding their health plans. Having drawn those boundaries, they must then be policed, for any such regulatory gradient naturally creates opportunities for gaming. Such policing entails greater direct regulatory costs, but, more importantly, there are hidden, indirect costs created by HIPAA's forestalling of innovative arrangements that do not fit this mold.

The other major regulatory impact of guaranteed issue is the accompanying need, which falls on the states, to regulate rating practices. Rating restrictions also give rise to a plethora of complications and countermoves that consume considerable regulatory resources. This may cause one to question the entire enterprise. However, the complexity of rating reforms cannot be avoided, once the process of rate regulation has begun. Some demarcation of market borders is necessary, and some type of rating reform is essential for any guaranteed issue requirement to be meaningful. Regulatory complexity is unavoidable because effective reforms require careful specification and diligent monitoring (Hall 1998).

Drawing the proper balance between regulatory precision and complexity on the one hand, and market flexibility on the other hand, is one of the many dilemmas one must confront when crafting a workable set of reforms for the complex machinery of the private health insurance market. Where best to settle along the range from unrestrained market forces to broad rating bands to guaranteed issue and pure community rating of all insurance is a question that involves both issues of social justice and practicalities of market mechanics and regulatory oversight.

Regardless of how much flexibility insurers are allowed to retain, careful attention must be paid to how various features of the regulated market might be used strategically to achieve risk selection objectives not intended by reforms. Regulators can attempt to minimize these side effects, but doing so requires vigilance and expertise.

So far, HIPAA's implementation, both at the federal and state levels, has not lived up to this ideal.

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