

Reducing Premium Variation in the Small-Group Market in Delaware: Possible Revisions to Chapter 72 of the Insurance Code

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Small Business Committee
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by

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This document is a report of the work that the Economic and Social Research Institute conducted as a follow-up to an earlier project done for the Small Business Committee of the Delaware Health Care Commission. That project examined the workings of the small-group market with respect to the wide disparities in premiums facing small employers. In that earlier study, we interviewed stakeholders to understand their perception of the problem and possible solutions and then prepared a report outlining the nature and extent of the problem and analyzing a range of possible solutions.¹ The Committee decided that further work was necessary to provide more information about one specific solution—namely, altering Delaware’s small-group insurance rating law to reduce the range of premium variation that insurers could charge. The Committee engaged us to determine how the law could be changed to accomplish the objective of narrowing rate variation in a way that is practical, easy to understand and enforce, and not onerous for insurers.

Before explaining how we approached this assignment and laying out our conclusions, it is useful to quote from our earlier report regarding the problem.

With the exception of the insurance company executives, most [of the people we interviewed] think that the small-group market is not performing particularly well. They generally agreed that the wide variation in rates paid by small groups is a deficiency. Insurers charge different premiums to different groups depending on the insurer’s assessment of the risk that the people covered under each employer’s plan will incur significant medical expenses. State law and current insurer practices allow theoretical premium variations of more than 9 to 1. Actual variations in premium rates of 4 or 5 to 1 occur with some frequency; that is, an employer with a substantially older, less healthy work force may pay five times the premium that would be offered to an employer with the youngest, healthiest work force. And a single employer can experience a very large increase from one year to the next, as might happen if one or two employees pass an age demarcation that puts the firm into the

¹ Elliot K. Wicks, *Premium Variation in the Small-Group Market in Delaware: Analysis of the Problem and Possible Solutions*, prepared for Small Business Committee, Delaware Health Care Commission, September 2005.

next higher risk category or because someone in the group develops a chronic disease or other serious illness. The largest premium renewal increases—sometimes 40 percent to 60 percent—occur when changes in the characteristics of people in an individual firm’s workforce cause rate hikes that are added on top of the general increase in premiums (“trend”) that is passed on to all insured small firms.

The size of such increases is obviously a problem, but so is the year-to-year instability and unpredictability for individual firms. Small employers often have very limited discretionary resources and little financial flexibility. So they have difficulty absorbing large, unexpected cost increases. They would find it easier to cope with the increases if the year-to-year changes were more similar in size and predictable, because it would then be possible to budget for them, even if the aggregate increase over a period of years was the same.

Delaware’s small-group rating laws (Chapter 72 of the Insurance Code) gives insurers great latitude, allowing a wide range of variation. Among the states that have adopted rating restrictions, Delaware’s rules are among the more permissive, although similar to many. The Delaware law is based on model legislation drafted by the National Association of Insurance Commissioners (NAIC), although Delaware’s law allows insurers somewhat greater latitude to vary premiums rates.

The provisions of the Delaware law are complicated and difficult to understand and interpret. Some of the allowable rating factors can be used to vary rates from group to group, others from year to year. The factors include gender, geography, age, claims experience, health status, duration of coverage, industry, group size, unhealthy lifestyle choices, and up to nine different classes of business. These factors have different individual limits and apply in different circumstances, and they interact in complex ways. Current regulators suggest that the complexity makes interpretation and effective enforcement difficult if not impossible. . . . The conclusion is that the rating laws allow wide premium variation and that this creates problems of affordability for high-risk groups.

The people we interviewed frequently expressed the opinion that at the time when Delaware’s small-group insurance reform law was initially passed in 1992, the expectation was that it would be more effective in limiting rate variation than has proved to be the case. For example, a paper prepared by the Health Care Commission urging small business support for the pending legislation observed that the proposed bill “would prohibit insurance companies from dramatically varying small employer health insurance premium rates from the rates of other groups based on certain demographic factors.”² The paper goes on to say, “The reforms instituted by [the proposed legislation] will allow more small business people to provide health insurance for their employees in a stable and more predictable environment” That kind of language, while technically accurate, may have helped to create the impression that the law would bring greater changes than it has.

Methodology

We approached this second project by interviewing people knowledgeable about the small-group insurance market. In talking with them, we focused especially on how they thought a new rating law could be structured to ensure that it would achieve the desired result of narrowing the range of possible rate variation and not create unanticipated consequences or pose undue administrative problems for insurers and regulators. We interviewed insurance regulators in Delaware, Maryland, Virginia, and Colorado. We talked to high-level insurance executives at Coventry and Blue Cross and Blue Shield, including actuaries. And we spoke to a health insurance analyst at the National Association of Insurance Commissioners. While we sought their opin-

² Delaware Health Care Commission, “Insurance Reform Agenda,” Sept. 21, 1992.

ions about the way to structure the law technically, we also sought their judgment about whether implementation of rate compression of the sort contemplated was likely to produce good results.

In talking with interviewees, we asked their judgment about a specific approach, one that we recommended in our earlier report. Before outlining that approach, it is important to recall how Delaware's present rating law is structured.

Chapter 72 of the Insurance Code allows insurers to vary premiums based on a large number of specified rating factors. In some instances, the law sets numerical limits on the amount of variation that can be applied when using a particular factor. For example, rates can be varied for different "classes of business" by 20 percent and within each class by ± 35 percent; another 15 percent can be added for the health risk of the group and yet another 15 percent for the employer's industry classification; etc. But for other rating factors, no numerical limits are specified. For example, age can be used as a rating factor, but the only limit on the amount of variation permitted is that it has to be "actuarially justified," a standard that leaves much latitude. One consequence of this complicated and hard-to-decipher approach to limiting rates is that it is very difficult to predict by just how much rates will vary from the lowest-risk group to the highest-risk group. In practice, the total rate variation can probably be as much as 9:1 or 10:1 and still comply with the law, though, in practice, rates typically fall within a smaller range.

In our earlier report, we had suggested a different approach. The objective of rating laws is to limit the difference between what high-risk and low-risk group pay for coverage to ensure that coverage is reasonably affordable for higher-risk groups. If that is the objective, it makes sense to *start* there: we suggested previously that the first decision the legislature should make is how much *total* rate variation is acceptable, regardless of what rating factors are used. For example, the law could start by saying that the rate variation cannot exceed a range of 2.5:1. So the highest-risk group, *considering all rating factors in combination*, could not be charged more than 2.5 times the rate for the lowest-risk group (for the same benefit package). This approach is similar to that in force in Maryland, which, in effect, specifies that the total variation cannot exceed a ratio of 2.3:1.³

Once the decision is made regarding the appropriate overall allowable rate variation limit—whether 2.3:1, 2.5:1, 3:1, 4:1, 5:1 or whatever—then the legislature would decide what rating factors to allow insurers to use in varying rates within that limit. The choice might be to allow the rating factors that are in the law now—which include class of business, age, gender, geography, claim experience, health status, duration of coverage, group size, and industry. Or the choice might be limited to a few, such as age and group size. (Maryland allows only age and geography.) Of course, use of family composition and the nature of the benefit package ("plan design") as rating

³ The actual language of the Maryland law is ". . . a carrier may charge a rate that is 40% above or below the community rate."

factors is totally non-controversial; insurers would always be able to vary rates for family composition and plan design. They are not really risk-related factors.

While the choice of rating factors is important, and will be addressed later, the most important decision is what the overall rate variation limit will be. There is no “right” answer to that question. It is a matter of balancing the desire to make sure that higher-risk groups are not priced out of the market with the need to avoid having large numbers of lower-risk groups leave the market because their rates go up when more higher-risk groups are brought under the insurance umbrella. We will examine this issue in more detail later.

The Response on Technical Grounds

It was this general approach of placing an overall limit on rate variation in the small-group that we asked our interviewees to comment on. The virtually uniform response from both the regulators (in Delaware and other states) and the insurers in Delaware was that this is a technically workable and sensible approach. They concurred in saying that it was easier to understand and enforce than the present law and would not create undue administrative problems or hassles for insurers or regulators. The public would be able to understand what the outcome of implementation would be. The insurers reported that they are used to the present law and have processes in place to comply with it without undue problems, but they also indicated that this alternative approach would not pose particular technical or administrative problems for them, other than those created by having to make any change. So from a technical standpoint, this approach seems sensible and workable.

The Policy Issues

If we conclude that this approach is technically sound, three important policy questions remain:

1. By *how much* should rates be compressed—that is, what overall ratio should be specified in the legislation?
2. What rating factors should be permitted?
3. What other legislative changes need to be made to ensure that the intended result is not thwarted by actions taken by employers or insurers to avoid having to comply with the intent of the law?

We will address these issues in turn.

How much rate compression?

The purpose of imposing an overall limit on rate variation is to make coverage relatively more affordable for high-risk groups and to make rates more stable as the risk characteristics of a group change. This is accomplished by moving in the direction of community rating. The extreme application of the insurance principle of pooling risks is pure community rating: every group pays the same premium (for a particular benefit package) regardless of risk differences from group to group. The opposite ex-

treme is self-insurance: each group fully assumes all the risk for the expenses of the members of its group; there is no pooling of risk with other groups at all.⁴

In deciding where between these two extremes to set public policy, it is important to keep in mind that the insurance principle is based on spreading risk: the people who are healthy and incur few medical expenses subsidize the cost of medical care for people who happen to incur high medical costs during the period. Community rating represents the broadest sharing of risk. It reflects the view that most differences in risk are beyond the immediate control of the individuals being insured. Because people have little control over the probability of incurring expenses, community-wide sharing of risk seems the fairest approach. Departures from community rating are thus justified primarily to ensure that lower-risk people do not leave the risk pool because they make the judgment that the coverage is too expensive given their low probability of incurring high costs.

It follows that rating regulations need to avoid rate variation that makes coverage unaffordable for high-risk groups. (In this context, coverage is unaffordable if higher-risk groups that could afford to buy coverage if they could get it at a community rate cannot do so at the current rates). At the same time, rating regulations need to avoid creating a situation such that large numbers of low-risk groups drop coverage because it is so costly that they decide it is not worth the price.

In deciding how much to compress rates, the most difficult problems result from the fact that while rate compression lowers rates for higher-risk groups, it necessarily raises rates for lower-risk groups. Even if the average risk profile of the total insured group remains the same because the same groups stay in the pool—so that the average premium remains the same—if higher-risk people pay less, lower-risk people must pay more. If reducing rate variation draws in more higher-risk groups—which is one of the objectives of the reform—the average rate will rise, and lower-risk groups will pay even more. The concern is that the lower-risk groups will respond to rising premiums by simply dropping coverage, which would raise the average rate of the entire group. The result could be a spiraling erosion of the risk pool, as rates continue to rise and more and more low-risk groups leave.

The insurance company officials we interviewed expressed concern about this potential problem. They worried that moving too far toward community rating could cause lower-risk groups to drop coverage. Previous research on this issue, most of it qualitative in nature and all of it done some years ago after a number of states changed their small-group insurance laws, found no evidence that the risk profile of the insured population was related to the strictness of a state's rating laws. Low-risk groups did not appear to drop coverage in greater numbers in states with laws that com-

⁴ Self-insurance is actuarially and financially sound only if the self-insuring group is so large that the members of that group make up a representative sample of risk, so that the total cost of providing protection for the members of the group is predictable.

pressed rates to a greater degree. Likewise, states that prohibit risk rating on the basis of health status did not appear to enroll a higher proportion of higher-risk people.⁵

In some ways, this result is not very surprising. The research evidence shows that, in general, small employers are not very sensitive to price changes. One study, for example, concluded that a 30 percent decrease in rates would cause only 15 percent of small employers to newly offer coverage.⁶ It follows that a 30 percent increase in premiums would cause only 15 percent of employers to drop coverage. Some other studies find even less price sensitivity.⁷

In recent years, there has been a fall-off in the number of small groups buying coverage. But this seems to be a national phenomenon, not one that is confined to states with strict rating laws. The smallest firms are especially less like to offer coverage than in the past. (See Exhibit 1.) State officials we spoke to in Maryland and Colorado, both of which have fairly tight rating constraints, said that coverage in the small-group market has declined somewhat. (See Exhibit 2.) But they said they saw no evidence that this decline is due to the rating laws. They attributed it to the rapid increase in premiums experienced by all the insured population, increases which reflect the rising costs of providing medical care.

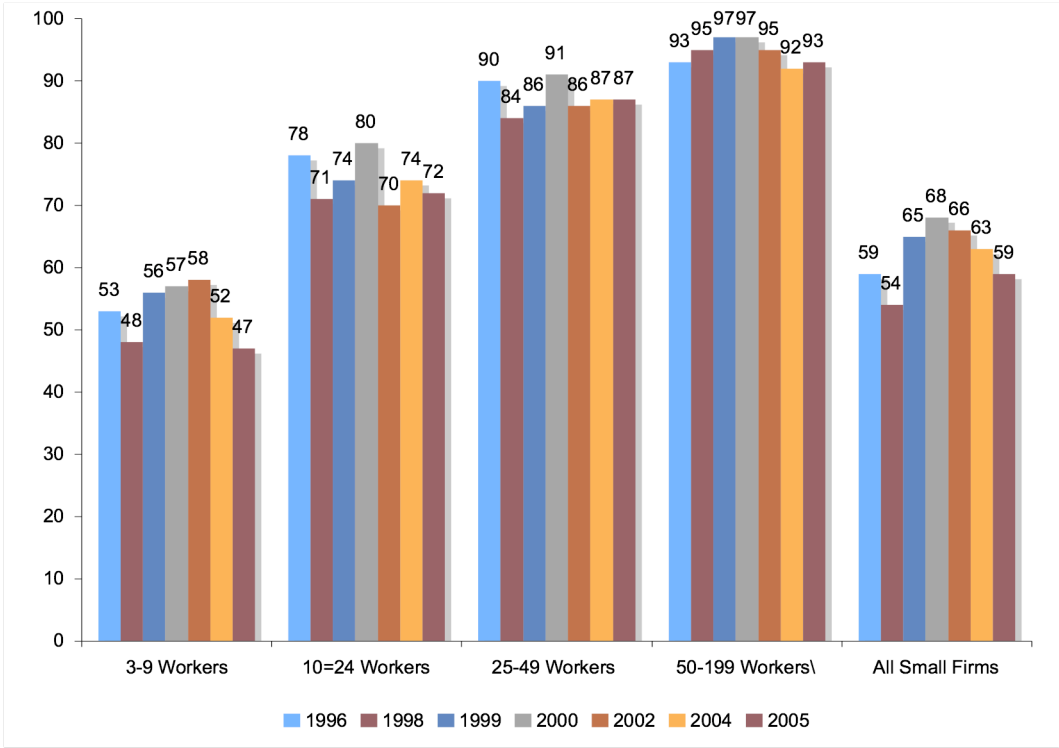
If rate compression were to cause some appreciable drop in coverage among low-risk small groups, the question is whether this is a worthwhile tradeoff for making coverage more affordable for higher-risk groups. Is the prime objective to cover as many small groups as possible, or is *who* is covered as important as *how many* are covered? Clearly, if many low-risk employers dropped coverage, the consequences would be much higher rates for everybody else, which is not a good outcome. But if relatively few low-risk groups dropped coverage, while more higher-risk groups are getting coverage, an argument could be made that this is a good outcome: if the choice has to be made between coverage for high-risk groups or low-risk groups, it may be better that high-risk groups have coverage because they are the ones that are most likely to need expensive medical care and are thus most at risk of suffering a financial disaster if they are left without coverage.

⁵ A 2001 GAO study reached this conclusion: “[W]e compared average medical expenditures and use, demographic characteristics, and self-reported health characteristics for individuals insured through a small employer in states that (1) prohibited premiums from varying for health characteristics and (2) allowed at least some variation for health or had no restrictions. We found individuals in both groups of states to have generally similar expenditures, use, demographic characteristics, and health characteristics.” The same study found that insurance premiums were about 6 percent to 7 percent higher in the states that allowed no rate variation for health status. The two findings seem to conflict, however: if the risk profiles of the insured small groups are not different between the two groups of states, it is hard to understand how the tighter rating restrictions could be the cause of the higher rates in the states that have more restrictive rating rules, since rate restrictions would be expected to cause rates to rise only if they cause an influx of higher-risk enrollees. U.S. Senate, GAO-02-8, October 2001.

⁶ James D. Reschovsky and Jack Hadley, “Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly,” Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

⁷ M. Susan Marquis and Stephen H. Long, “To Offer or Not to Offer: The Role of Price in Employers’ Health Insurance Decisions,” *HSR: Health Services Research*, Vol. 36, No. 5, October 2001, p. 946.

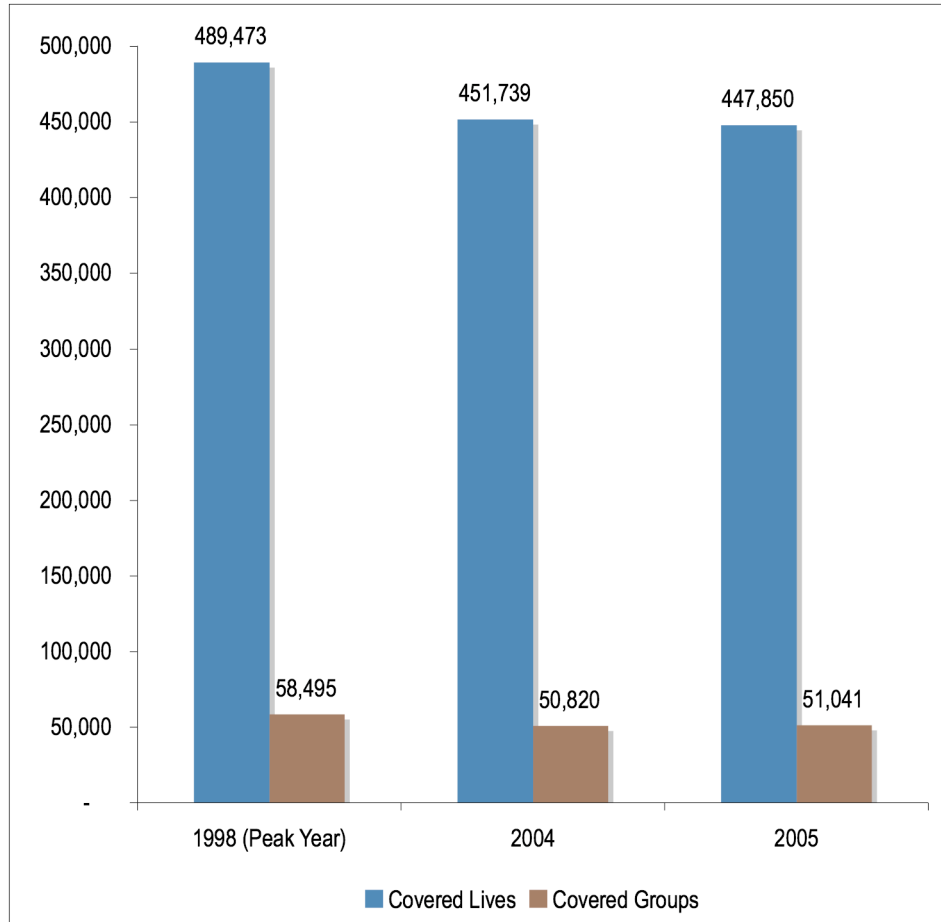
Exhibit 1: Percentage of Firm Offering Health Benefits, by Firm Size, 1996-2005, United States



Note: Some estimates are statistically different from the previous year. For details, see the original source. Data prior to 1999 do not reflect several methodological changes that were made to the survey, including standardizing survey weights to U.S. Census data.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1996, 1998.

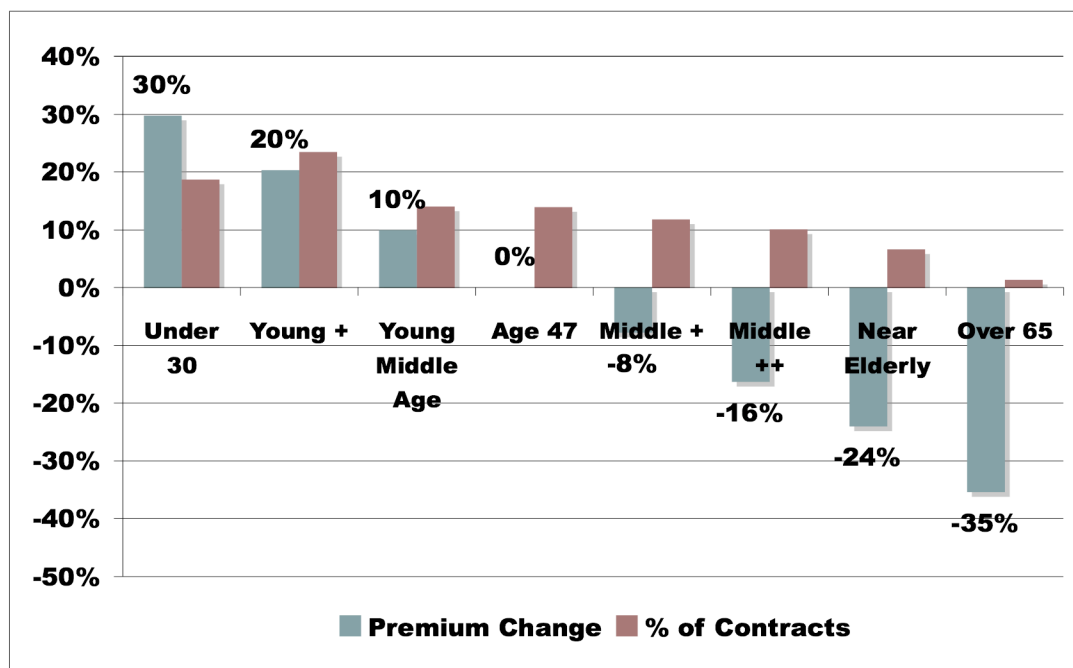
Exhibit 2: Number of Covered Lives and Covered Groups in Maryland Small-Group Market, 1998 (Peak Year), 2004 and 2005.



Source: Maryland Health Care Commission, "Maryland's Small Group Market Summary of Carrier Experience for the Year Ending December 31, 2005," May 18, 2006

To get some sense of the likely impact of rate reform, in our discussion with insurers we asked them to outline how they might alter rate rates for people at various risk levels if Delaware were to restrict rate variation as discussed here. Specifically we asked them to consider a change in which the only rating factors would be age and perhaps SIC and/or group size, with an overall rate limit of 3:1. Based on those conversations, we think it is reasonable to suggest that premiums might change roughly corresponding to the pattern shown in Exhibit 3. The graph also shows the approximate proportion of total insurance contracts that are in each age grouping so that the reader can have a sense of how many groups would experience substantial changes.

Exhibit 3: Approximate Percent Change in Premium by Age Group, with Age and SIC as Only Rating Factors and Maximum Range of Rate Variation Equal to 3:1; and Percent of Contracts by Age Groups



If the changes shown are reasonably indicative of how insurers would react, it is clear that substantial numbers of lower risk groups would experience significant rate increases. In assessing this outcome, however, it is important to compare these new rates against the “standard” of community rating. Compared to community rating, these lower-risk groups would still be paying considerably less than the average rate. For example, the data shown in the graph above were based on an average premium (the “community rate”) of about \$520 per contract per month. The lowest risk group would pay a premium of about \$333, while the highest-risk group would pay \$1,000.

One way to avoid a major one-time jump in rates for low-risk groups while still moving toward substantial rate compression would be to phase-in the compression. For

example, if the present law commonly produces rate variation of 5:1, the law could be amended to move gradually to, say 2.5:1, starting with a limit of 5:1 in the first year, 4:1 in the second year, 3:1 in the third year, and 2.5:1 in the fourth year.

What rating factors?

As noted, the choice of which rating factors to use is less important if the insurance laws set an overall limit on the amount by which rates can vary, and the narrower the rate limit, the less important the rating factors are. Nevertheless, a discussion of which factors to include is relevant. Delaware's present insurance law includes many factors. The inclusion of so many makes enforcement complex and probably opens up the possibility for insurers to "game" the system by manipulating their use of the rating factors to allow them to pick off the lower-risk groups by doing very effective medical underwriting. In various states in the past, some small insurers that account for only a small market share have used such practices to attract only the low-risk groups. Tightening the rate limits makes this less likely, but "cherry picking" is still a potential problem. If some insurers are able to cherry pick, it dilutes the remaining risk pool and causes rates to be higher for everybody else. It is a way of thwarting the intent of the law. Limiting the number of rating factors makes this less likely.

The objective here is to include in the law *rating factors that will allow insurers to fairly and accurately distinguish among groups according to the risk they pose*. In choosing rating factors, it seems sensible to try to apply two principles: (1) It would be desirable to use rating factors that do not cause a group to suddenly face a much higher rate because of a group change. (2) It would also be desirable, in the interest of fairness, to avoid rating factors that cause groups to experience increases because of factors over which the individuals in the group have no control. Unfortunately, it is not always possible to apply both of these values. In fact, most of the commonly used rating factors conflict with the second principle to some degree.

Using age as a rating factor is consistent with the first value but not the second: the age of people in small groups is likely to change gradually (unless the group newly hires people of markedly different age than those in the group already), so rates would change gradually; but people do not have control over their age. However, older people are more likely to have higher incomes than younger people and thus are, on average, more likely to be able to afford higher premiums. Most people who are students of adjusted community rating agree that age should be used as a rating factor. It is generally agreed to be the best single predictor of the need for medical services. And all of the insurers we spoke to agree that it should be used.

A second group of rating factors are those that relate to the health status of people in the insured group. Insurers can measure or approximate health status in various ways, but one measure that is specifically included in the current law is previous medical claims experience. People who have incurred major medical expenses in the past are more likely than others to do so in the future. Most state rating laws have put strict limits on the use of health status as a rating factor, probably because it seems to violate a sense of fairness. (The current Delaware law allows an adjustment of 15 percent.) Using health status seems like punishing people for getting sick. Just

because they really need insurance, they have to pay more, even if they have had coverage for a long time. There is another reason to reject health status as a rating factor: it makes “cherry picking” easier. It provides a reward for seeking out healthy groups through selective marketing, marketing only to groups that are likely to be healthy—younger people, members of health clubs, better educated groups, etc. It also violates the first principle articulated above: a group’s rate could increase dramatically because someone in the group contracted an illness that is likely to require expensive treatment. These are strong arguments to not include health status as a rating factor.

States (for example, Maryland) often allow geography or firm location as a rating factor, since health care costs tend to vary within states, and it does not seem appropriate to make people in low-cost regions subsidize those in high-cost regions. In a state as small as Delaware, however, location may not be a relevant factor. One of the major insurers reports that they have not found enough difference in claims cost by region to warrant the use of geography as a rating factor. It appears to not meet the test of being an accurate way to distinguish among groups on the basis of risk.

Some states allow gender as a rating factor, though its use has become less common, probably because the public perception is that it represents an objectionable form of discrimination: people obviously have no control over their gender.

Delaware currently allows insurers to use group size to determine rates (within the small-group market, which is composed of groups with 50 or fewer employees). It is more costly to market to small groups, since the marketing costs are more-or-less fixed, and there are fewer insured lives to spread those costs over. Perhaps more importantly, the per capita medical expenses of very small groups (reflected in insurers’ loss ratios) tend to be higher, probably because such small employers, which often struggle financially, are more likely than large groups to buy coverage when someone in the group needs expensive medical care and to drop it at other times because of the expense. These are possible arguments for allowing group size as a rating factor.

Another rating factor used in Delaware and elsewhere is industry; firms are classified by SIC code (standard industry classification) of the U. S. Department of Labor. The fact that insurers choose to use SIC as a rating factor shows that employees in some industries are at greater risk of needing expensive medical care that is covered by health insurance. The ethical rationale for using industry may be questionable. Working in some industries clearly puts people at greater risk of illness and injury. But work-related injuries and illness are typically covered by Workers’ Compensation insurance; health insurance does not cover these costs, and so work-related medical expenses do not justify the use of industry as a rating factor for standard medical insurance. If work-related illness and industry are not the cause of medical insurers’ cost differences for different industries, the cost variation must be due to the personal characteristics of people who work in one industry relative to another. Because people have only limited choices regarding where they work, it does not seem reasonable to expect them to make a job change based on the cost of health insurance.

Current Delaware law allows “class of business” as a rating factor. Insurers can divide their business into different classes if they employ different marketing and sales approaches to some groups compared to others, if they have acquired the business of another insurance company, or for coverage sold to certain associations. The insurers we spoke to about this issue seemed to believe that it was not essential to use class of business as a rating factor.

To summarize, it seems important to use age as a rating factor. Another factor that might be worth including is group size. The case for including other factors is weaker. Excluding health status or indirect measures of health status, such as claims experience, seems particularly appropriate.

It is important to recognize that it might be good policy to reduce the number of rating factors that are allowed in Delaware even if the state did not adopt the overall rating limit approach suggested here. It is worth considering whether the rating factors currently in the law have a strong rationale. For example, a number of states prohibit the use of health-related factors as a basis for varying rates. Reducing the number of rating factors makes the system simpler and easier to understand and would probably reduce the potential for cherry picking.⁸

Other needed legislative changes

The intent of narrowing rating limits is to spread risk more evenly among the insured population. Any action which results in low-risk groups leaving the insurance pool thwarts this intent and needs to be prevented.

One potential problem is that lower-risk small groups may seek to lower their insurance costs by “self insuring” and then buying stop-loss coverage, or reinsurance, that kicks in at a relatively low level of health expenditures, such as \$10,000. In this instance, the employer and employees would cover the first \$10,000 per year of medical expenses out of pocket, with the stop-loss insurer paying thereafter. Of course, such an employer is not really self-insuring because their exposure is limited to such a low level. They are just buying a high-deductible plan that is not subject to the rating laws. Allowing this kind of behavior permits employers to buy coverage outside the small-group pool, thereby thwarting the intent of the law, which is to pool low-risk and high-risk groups. Several of the people we interviewed indicated that they believe this problem is emerging in Maryland.

The most obvious solution to this problem is to impose a legislative ban on the sale of stop-loss coverage (reinsurance) in the small-group market. Such an approach is simple and straightforward, and it would be effective. It is entirely appropriate to ban such sales, since small employers are in no position to truly self-insure because their employment base is not large enough to be able to spread the risk. If just one or two

⁸ The issue is complicated, however. Assume that the only allowable rating factor is age, and that any differences in rates have to be actuarially justifiable. At first glance, that might seem to limit the range of rate variation. But unless there is also a limit on the number age rating groups the insurers can use, groups composed of older workers might pay many times more than groups of younger workers. An insurer might create a separate age category for just people age 64 to 65, charging them a very high rate reflective of their much higher risk.

people in a small group have a catastrophic medical event, the amount the employer set aside per insured person would not be nearly enough to cover the cost. A less straightforward approach than a total ban would be to require that stop-loss coverage have a much higher “attachment point,” for example, \$200,000. The effect would be to make it impractical for a small employer to buy such coverage, since they could not safely bear the risk of paying the first \$200,000 of medical expenses from their own resources.

A more complex problem results from the fact that Delaware’s definition of small groups includes so-called “groups of one,” that is, self-employed people. The problem is created by the fact that these self-employed people have the option of buying coverage in the individual market or the small-group market. They will naturally choose whichever option is cheaper. If they are low-risk, it will often be cheaper to buy in the individual market, where their rate reflects their low risk. If they are high-risk, group coverage will usually be cheaper, since their rate does not reflect the full expected cost of their higher risk.⁹ For very high-risk people, small-group coverage may be the only option, since only in the small-group market is coverage provided on a guaranteed-issue basis. The problem is exacerbated by the fact that groups of one can switch back and forth between individual and group coverage as their risk level changes. But the effect of giving self-employed people this option is to dilute the small-group risk pool: because the low-risk people will go outside the pool, the risk is not spread among all the groups as intended, and everyone left in the group will pay a higher premium. Reducing the range of allowable rate variation in the small-group market would exacerbate this problem, since low-risk groups of one would face higher rates than they do now, so the incentive for them to switch to individual coverage when it is cheaper would be stronger.

One way to address this problem would be to exclude groups of one from the small group market, as Maryland recently did and many other states do. They would then buy coverage in the individual market, as other individuals do. If this is determined not to be doable or desirable, another approach would be to alter the rating limits somewhat for groups of one, giving insurers somewhat greater latitude in varying rates. Perhaps the best way to do this would be to allow an additional adjustment for groups of one above and beyond the normal limit. For example, if the overall limit for the small-group market was a ratio of 3:1 (using all rating factors in combination), groups of one could be rated up by as much as an additional, say, 20 percent. In that instance, a high-risk group of one might pay as much as 3.6 times the amount charged to the lowest-risk group of two or more ($3 + [20\% \times 3] = 3.6$) rather than the 3:1 limit that applies to the groups with two to fifty employees.

⁹ Insurers contend that some “groups of one” are created solely for the purpose of getting less expensive group coverage. A person needing coverage who would be denied individual coverage or charged a very high rate because of a serious medical condition may start a “business” just to get coverage. Insurers can ask for documentation to prove that the business is legitimate, but they still suspect that they are experiencing some adverse selection because of this practice.

Rate limits for renewal coverage

One provision of Delaware's current rating law not yet addressed in this analysis should probably be retained—namely, the law's limitation on rates of increase when a group renews coverage. In essence, the law says that when a small employer renews coverage from one year to the next, the insurer cannot charge the employer a rate that is greater than 15 percent above what insurers refer to as “trend,” which is the rate of increase in an insurer's average cost of coverage across all of its small-group business, without reference to risk factors. If an insurer's average cost of coverage has risen by 10 percent, taking into account increased costs of paying medical providers and administrative costs, the insurer will normally pass on that 10 percent in higher premiums to all groups. In addition, a group that includes a person who is very sick during the year and several other enrollees who move into an older age bracket might be assigned an additional 25 percent because of the group's greater risk, if the extremes allowed by the rating factors were applied. The total increase would be 35 percent in this example. However, the law limits the increase that is attributable to increased risk to 15 percent, so that the maximum rate increase for the firm in this instance would be 25 percent—10 percent for trend plus 15 percent for increased risk.

Under stricter rating limits of the sort discussed in this paper fewer groups would need to take advantage of this provision that limits increase due to increased risk; because the overall range of rate variation is more severely limited, fewer groups would experience high rate increases. But it still seems appropriate to retain that protection against extreme year-to-year rate hikes. This would be accomplished by specifying (as now) that year-to-year increases attributable to a change in a group's risk factors must be limited to 15 percent. Of course, the consequence of including this provision would be that other groups would pay somewhat more, as with all forms of rate compression.

One insurance company official who had strong reservations about the more general approach to compressing rates outlined earlier suggested it would be worth considering as an alternative another possible approach to limiting renewal increases—namely, placing an *absolute* cap of perhaps 20 percent on rate increases upon renewal. In other words, in calculating the rate increase due to trend plus any change in a group's risk factor, the maximum increase for the two elements in combination could not exceed 20 percent. Such an approach would provide even greater protection for high-risk groups that happened to move into a higher-risk category in the same year that the trend factor was high and would help in achieving the objective of greater year-to-year rate stability.

The effect on competition

Several of the insurers interviewed expressed the opinion that passage of legislation to compress rates in the small-group market could cause some carriers to leave the Delaware small-group market. They did not explain why this is a likely result, but presumably the logic is that insurers that “compete” successfully by being able to identify and attract low-risk groups and avoid higher-risk groups—thereby being able to offer lower rates than their competitors—would find that strategy more difficult

to follow. With less variation in rates and fewer rating factors, it is harder to enroll just low-risk groups: they are now mixed in with higher-risk groups, and lower-risk groups would not enjoy the same price advantage.

There is some reason to believe that this result could occur. In some other states that have adopted tight rating laws, many of the niche carriers have withdrawn. (A decrease in the number of competitors has occurred in other states as well, an indication that tighter rating factors may not be the only cause of the decline in those states that have more restrictive laws.) But the important question is whether these companies that survive by being effective at risk selection really represent worthwhile competition. If the purpose of competition is to keep average premium costs down across the market, they do not contribute to that result. They compete not by being more efficient, but by being better at risk selection. The resources they use to be good risk selectors serve no social purpose. If they were really more efficient, their premiums would be lower than those of the Blue Cross and Blue Shield or Coventry across the whole range of risk, and they would account for a larger market share. Niche players' participation in the market place does not put pressure on the dominant carriers to be more efficient and thus bring down premiums. In fact, the more effective these small insurers are at drawing off low-risk groups, the higher will be the rates of the two major insurers. The small insurers that now participate in the market but do not depend upon being good risk selectors would have no reason to leave the market under tighter rating rules.

Further, in a market that is so dominated by two insurers, as is Delaware's, it is doubtful that any competition other than that between those two—or with some other major insurers that might aggressively enter the market—is likely to be very effective. The bulk of the cost of health insurance is what the insurers pay to the medical providers who care for their enrollees. Only large carriers have the market share to have an influence on these costs, through bargaining with providers regarding payment rates, selecting efficient providers for their networks, monitoring to detect and correct high-cost practice patterns, etc. Major carriers are not attracted to a market because its rating rules allow insurers to risk select, so changing the state's rating rules should not deter major carriers from participating in the Delaware market. Their decisions are likely to be based on other factors.

Relevant Federal Legislation

Federal legislators have introduced a bill that, if passed, would render any attempts Delaware might take to tighten small-group rating rules null and void. Senate Bill 1955, the Health Insurance Marketplace Modernization Act (HIMMA), was introduced by Sen. Michael Enzi and debated by the Senate in May 2006. The bill failed to come to a vote because cloture was not reached.

If the bill were to be passed, it would pre-empt state rating rules if they are more stringent than the new federal rules, as those being considered in this paper would be. The federal rules would provide very wide flexibility for insurers to vary rates, and states could not adopt stricter rules.

There is a possibility that the bill may be taken up again this fall, but it seems doubtful that it will pass. Similar legislation has been on the docket for many years, so it seems appropriate to move forward in Delaware on the assumption that the state would be permitted to enforce any rating rules it passes.

Conclusion

Changing Chapter 72 of the insurance code to limit the extent to which insurers can vary rates between high-risk and low-risk groups is one sensible way to make coverage more affordable for high-risk groups. While such a change would be expected to keep high-risk groups from dropping coverage and induce some others to newly acquire coverage, it should not be seen as a tool for increasing the overall rate of insurance coverage. Some low-risk groups may drop coverage as a result of the change. However, past experience in other states that have implemented such changes suggests that no appreciable change in the overall rate of coverage is likely to occur.

Another significant benefit of reducing allowable rate variation is that small employers would be less subject to large year-to-year variations in premiums. Rates would be more stable and more predictable.

If rate compression is seen as a desirable goal, the conclusion of this research is that using the approach that starts by setting a limit on the overall range of variation to be permitted and then subsequently deciding which rating factors to allow within that overall limit is sensible and would not create significant administrative or compliance problems. The present rating laws permit rate variation that results in some groups paying at least eight times more than others, though most groups probably fall within a range of 5:1. Reducing the range of variation to something like 2.5:1 or 3:1 seems reasonable. To prevent major one-year increases in rates for the lowest-risk groups, it might be desirable to phase the change in, starting with a 5:1 ratio and then gradually moving year by year to the lowest ratio.

It is possible that a change in the rating laws of this sort could cause some small insurers to leave the small-group market in Delaware. But the small insurers that would leave because of this change do not really provide any form of effective competition at the present time, and their departure would almost certainly not cause the insurance market to be less efficient than it is now.