



Community Rating and Guaranteed Issue in the Individual Health Insurance Market

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During the long debate over health reform, much attention was given to the challenges faced by individuals with pre-existing conditions when seeking health insurance in the non-group, or individual, market. The Patient Protection and Affordable Care Act (ACA) seeks to facilitate access to coverage for this population through a variety of means. Most notably, the new health insurance exchanges where individual policies will be sold will prohibit insurers from charging differential premiums based on health status (known as community rating) and require them to offer coverage to all people wishing to purchase it (known as guaranteed issue).

The primary concern with community rating and guaranteed issue is that these regulations can lead to adverse selection, destabilizing the insurance market and potentially causing total market collapse (see Figure 1). This scenario is commonly termed an adverse selection death spiral.

Aware of these concerns, policymakers included a provision in the ACA mandating all individuals to have health insurance. This mandate has been controversial on several fronts. Numerous legal challenges have been mounted regarding its constitutionality while others fear that it is too weak to keep all people in the insurance risk pool and thus will do little to protect against market instability.

States' Use of Community Rating

While new at the national level, community rating is not a new regulatory approach having been adopted by a number of states in the 1990s. Seven states – Maine, Massachusetts, New York, New Jersey, Oregon, Vermont, and Washington – currently use some form of community rating and guaranteed issue in their individual markets.¹ Kentucky and New Hampshire also tried these regulations in the 1990s but backed away from the approach

Figure 1. The Destabilizing Impact of Adverse Selection

- Community rating lowers premiums for individuals in poorer health and increases them for healthier individuals.
- Guaranteed issue allows people to purchase coverage when they get sick, decreasing the need to maintain insurance coverage.
- Healthy individuals respond by dropping coverage and entering the market only when they need coverage, thus the pool of enrollees becomes increasingly older and sicker.
- This adverse selection pushes premiums for all remaining enrollees higher, provoking further departures by those at the healthier end of the spectrum.
- Premiums increase again to reflect the higher costs of the ever-worsening risk represented by remaining enrollees.
- The cycles continue, further destabilizing the market and potentially leading to complete market collapse.

after experiencing significant instability in their insurance markets. Washington state responded to similar market turmoil by easing its guaranteed issue requirement significantly instead of abandoning the regulations altogether.^{2,3}

New Research on the Impact of Community Rating

In this essay I describe new work that I conducted with my colleague Ithai Lurie to investigate how the community rating and guaranteed issue regulations adopted by these states affected insurance coverage in the individual market for different health risk groups.⁴ This work extends prior research by using better data on individuals' health status and timing of insurance coverage, enabling us to take a closer look at changes in the composition of the individual market risk pool and type of coverage after community rating was implemented.

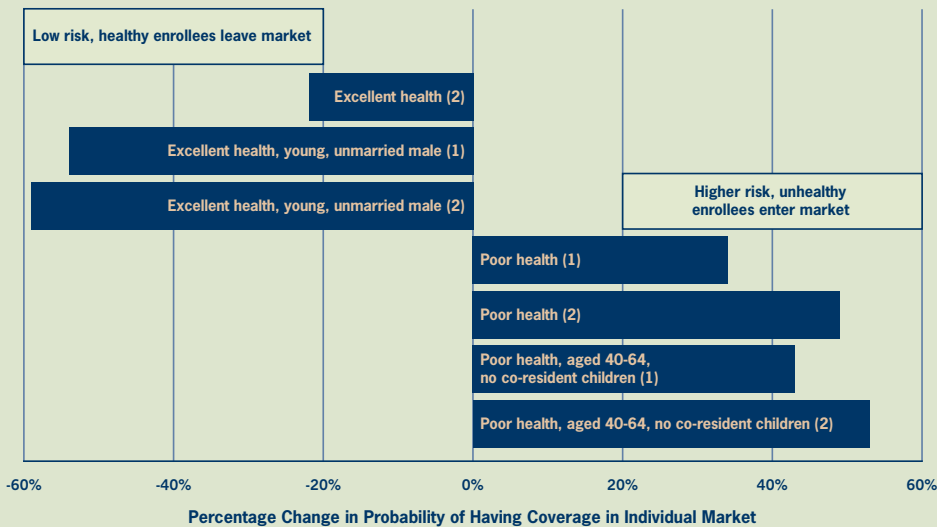
Impact on Coverage Varies by Health Status.

As shown in Figure 2, adoption of community rating in the non-group market had different impacts depending on the individual's health

status. For those reporting excellent health, community rating was associated with a 22 percent reduction in the probability of having non-group coverage. When focusing on a subgroup of the healthy population that closely resembles the so-called "invincibles" in health insurance policy discussions – young, unmarried men reporting excellent health – we found a 54 to 59 percent decrease in the likelihood of having non-group coverage following implementation of community rating (depending on the model specification).

At the other end of the health risk spectrum, individuals who reported poor health were 34 to 49 percent more likely to have non-group coverage after community rating was implemented. Older individuals in poor health without co-resident children experienced an even larger relative increase in non-group coverage. These findings indicate that community rating did help those in poor health – the intended beneficiaries of the policy – to obtain coverage in the individual market. However, we found no significant change in overall coverage rates among the higher risk individuals, suggesting they may have been moving from other forms of coverage into the non-group market.

Figure 2. Impact of Community Rating and Guaranteed Issue Regulations on Composition of Risk Pool



Model (1) includes individual demographic characteristics, time-varying state-level variables that could affect insurance coverage, and state and time fixed effects. Model (2) adds a variable indicating whether the state also had community rating in the small group market. Graph reflects the statistically significant estimates from these models.

Sensitivity analyses using alternative specifications to identify good and poor health status yielded results comparable to those described above. In addition, we found only small and insignificant effects on coverage when estimating our models using the full sample without distinction by risk group. On balance the effects on either tail of the risk distribution effectively offset one another, leaving no evidence of an impact for the overall non-group market. This result is broadly consistent with prior research showing that community rating has had only small or no effects on coverage in the aggregate.

Worsening Risk Pool. The above results show that community rating was associated with a worsening of the non-group risk pool as younger and healthier individuals left the individual market while older and sicker individuals joined or remained in the market. To test the robustness of this conclusion, we used data from the National Health Interview Survey (NHIS) to compare changes in detailed measures of health status and utilization for people with non-group coverage in several community rating and non-community rating states. We found that those maintaining non-group coverage after the adoption of community rating were significantly more likely to have days when they were restricted to bed or when their activities were otherwise restricted because of health problems as well as more doctor visits and hospital stays. In other words, community rating in the non-group insurance market led to a pool of enrollees in poorer health.

Greater Use of Managed Care. With their narrower provider networks and more tightly managed care, HMO insurance products typically offer lower premiums and, thus, may be appealing to lower risk individuals seeking a way to retain affordable coverage rather than leave the non-group market. Our analysis of the NHIS data bore out this hypothesis. We found that the probability of having HMO coverage in the non-group market increased disproportionately in states that implemented community rating relative to states that did not implement community rating, particularly among the younger cohort.

Policy Implications

Our results provide a compelling portrait of the distortions that can result from community rating and guaranteed issue regulations in the non-group market when there are no provisions in place to keep people enrolled in coverage. The deterioration of the risk pool is consistent with predictions from economic theory and potentially lays the foundation for an adverse selection death spiral. Indeed, a new report examining the Massachusetts reforms, which are widely regarded as a bellwether for national reforms, has found evidence of increased adverse selection for non-group policies. Despite the state's mandate to carry health insurance, some individuals have been acquiring coverage only when they need it, then dropping it after incurring high costs. This behavior has left remaining enrollees to subsi-

dize their high costs, and some relatively healthy enrollees are now dropping their coverage, too, after short enrollment periods.⁵

As national reforms continue to be implemented, a key wildcard will be the individual mandate. Even apart from current challenges to its constitutionality and a new legislative proposal from Senators Wyden and Brown that would permit states to seek an exemption to the mandate as early as 2014, another unknown is whether the penalties for violating the mandate will be strong enough to minimize adverse selection. Other mechanisms, such as limited open enrollment periods, reasonable exclusion periods for coverage of pre-existing conditions, and late enrollment penalties for those who enroll after initially declining coverage (as used in Medicare Part D), can also help to curb gaming behavior. Another way to keep lower risk individuals in the risk pool (subject to minimum benefit provisions) is to make lower cost policies available to them, such as managed care products and consumer directed high deductible plans. The experiences in Massachusetts and Medicare on all of these fronts certainly merit continued attention as we move forward.

- 1 Georgetown University Health Policy Institute. "Consumer Guides For Getting and Keeping Health Insurance." <http://www.healthinsuranceinfo.net/>. Accessed November 4, 2010.
- 2 Wachenheim L and Leida H. "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets." Milliman Report to America's Health Insurance Plans. August 2007.
- 3 Kirk AM. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." *Journal of Health Politics, Policy and Law*, 25(1):133-73, 2000.
- 4 Lo Sasso AT, Lurie IZ. "Community Rating and the Market for Private Non-Group Health Insurance." *Journal of Public Economics*, 93(1-2): 264-79, 2009.
- 5 Welch DK, Giesa K. "Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets." Oliver Wyman Report to the Health Care Access Bureau of the Massachusetts Division of Insurance. June 2010.

Data and Methods. We used 1990 to 2000 data from the Survey of Income and Program Participation to compare changes in coverage in states adopting community rating and guaranteed issue provisions during this period with coverage changes observed over the same period for people living in states without these regulations. We also used 1992 and 1994 data from the National Health Interview Survey for the four states adopting community rating and guaranteed issue rules in 1993 and four control states from the same region of the country to estimate how the new regulations affected the composition of the individual market risk pool and the type of insurance products people were buying.