

Issue Brief

Rising Costs in the Small-Group Market: Issues and Options

Introduction

After a brief respite in the mid-1990s, health care costs again are on the upswing. According to the U.S. Department of Health and Human Services, health care spending increased by 8.7 percent in 2001, the largest increase since the recession of 1990-1991. The Centers for Medicare and Medicaid Services (CMS) projects that health care spending will represent 17 percent of the nation's Gross Domestic Product (GDP) by 2011, up from approximately 13 to 14 percent of GDP in 2002.¹ Rising health care costs have recently led to double-digit increases in the cost of health insurance premiums after several years of relatively flat or small increases, threatening access to affordable coverage for millions of individuals and families.

A recent study conducted by PricewaterhouseCoopers for the American Association of Health Plans (AAHP) found that health insurance premiums increased, on average, 13.7 percent between 2001 and 2002.² Major factors causing the rise in health care costs and health insurance premiums include: spending on prescription drugs and new medical technologies; rising provider expenses (including hospital consolidations); government mandates and increased regulation; increased consumer demand; and the costs of litigation and risk-management.³

In the small-group health insurance market, these rising health care costs make it increasingly difficult for some small employers to continue offering coverage. A Henry J. Kaiser Family Foundation survey found that small employers on average experienced a 13.2 percent increase in the cost of their premiums, compared to an average 12.7 percent increase for large employers, from 2001 to 2002.⁴ Very small employers – defined by the Henry J. Kaiser Family Foundation as firms with 3 to 9 employees – had some of the highest increases, with premiums rising on average 14.5 percent from 2001 to 2002.

This paper explores and discusses issues unique to the small-group market that cause small-group premiums to be consistently higher than those in the large-group market. The paper intentionally does not include extensive discussion of the cost drivers discussed in the PricewaterhouseCoopers study described above. The first section of this paper describes factors contributing to problems of access and affordability in the small-group market. The second section describes state and federal regulation of the small-group market. The third section describes incremental and comprehensive strategies that have been or could be implemented to expand access to affordable coverage for small employers and small business employees. Key terms are written in bold font and are defined in the shaded box on page ten.

I. Access and Affordability of Coverage in the Small-Group Market

Relatively Low Offer Rates Among Small Employers

Small businesses with fewer than 50 employees -- which represent more than three-fourths of all U.S. private establishments and employ nearly one-third of the private sector workforce⁵ -- are much less likely than large firms to provide health coverage for their employees. While 96 percent of firms with more than 50 employees provide health coverage to their employees, 71 percent of employers with 10 to 49 employees sponsor coverage, and only about 36 percent of employers with fewer than 10 employees sponsor coverage.⁶

Small employers not offering coverage indicate that the primary barriers preventing them from doing so are rising health care costs and the administrative burden of making coverage available.⁷ According to a recent survey, almost three-quarters of small business executives whose firms do not provide health insurance coverage cited the cost of coverage as “a very important reason”⁸ for their decision not to do so.

Low Rates of Participation Among Small Business Employees

Just as small firms are less likely than large firms to offer employer-sponsored coverage, small business employees are less likely to enroll in coverage offered by their employers.⁹ In 1997, 14.9 percent of workers employed by small firms (with fewer than 10 employees) declined offers of employer-sponsored coverage and were uninsured, whereas 8.7 percent of workers employed by larger firms (with 100 to 249 employees) declined offers of employer-sponsored coverage and were uninsured.¹⁰ It is notable that participation in the health insurance market is decreasing among both large and small

groups. From 1987 to 1996, employee acceptance of employer-sponsored coverage decreased from 88.3 percent to 80.1 percent.¹¹ While individuals who decline offers of employer-sponsored insurance may receive coverage through other options, such as spousal coverage, research indicates that acceptance rates for employer-sponsored coverage fell from 1987 to 1996, even after accounting for this possibility.¹²

Due to the size of the small-group market and the disproportionately low rates of participation, it is not possible to spread risk across a large population to keep costs down. Therefore, extensive use of services by a few individuals in this market can drive up the cost of coverage substantially for the entire group.

Adverse Selection

Related to the problems of low employer offer rates and low employee acceptance of small business coverage is the phenomenon of adverse selection: The relatively small number of employees who do accept small employer offers of coverage are those most likely to use a high volume of health services. Younger and healthier workers may be more likely to forego small-group coverage, and those who do choose it may drop it if premiums rise. Because individuals remaining in the market as costs increase will tend to be older and in comparatively poor health, the cost of premiums will be driven even higher. The cycle of rising costs and potential deterioration of the health insurance risk pool caused by adverse selection is commonly known as a “death spiral.”

Critical to the health and viability of the small-group market is adequate participation, especially among young people who, on average, are in relatively good health and require less medical care than those who are older. Broad participation among relatively young and healthy individuals in the small-group market would provide for a broad sharing of risk to offset the claims costs of less healthy individuals and thus would help keep

premiums affordable for the entire group. Any policy designed to improve the access and affordability of coverage in the small-group market needs not only to encourage small firms to offer coverage, but also to encourage young employees of small firms to purchase coverage.

II. Efforts to Regulate the Small-Group Market

During the 1990s, in an effort to address the varied cost and access issues associated with the small-group market, many states enacted rating rules governing the small-group market. Many of these laws were based on one of the three NAIC small-group model acts.¹³ They included guaranteed issue and guaranteed renewability requirements, limits on pre-existing condition exclusions, portability requirements, and rating restrictions through **community rating** or **rate bands**.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was enacted. HIPAA established federal minimum standards for access to coverage in the individual and group markets. In general, HIPAA established portability, pre-existing condition, nondiscrimination, and guaranteed renewal rules for both the small- and large-group markets. It also established guaranteed-issue rules for the small-group market (defined as employers with two to 50 eligible employees). Finally, it established guaranteed issue, portability, and renewability rules for the individual market. HIPAA's requirements represent a federal "floor," which states are allowed to exceed with more stringent requirements. Some states have exceeded these federal requirements, and others have addressed areas not covered by the federal law, such as rate restrictions. HIPAA does not address the price of coverage in the individual or small-group markets.

Rating Restrictions

States have taken a variety of approaches to rate regulation. Most states have enacted laws that restrict the extent to which premiums in the small-group market can be increased. Thirty-five states have implemented rate bands in an attempt to limit the variation in rates in this market, while 12 states use community or **modified community rating**.

A "pure" community rating system in the small-group market requires health insurers to charge the same rate to all small employers within the community, with no variations. By contrast, an "adjusted" or "modified" community rating system will specify certain variables that may be used to justify rate variations between small employers in a community. Typical examples of permissible adjustments, within a modified community rating system, are geography, family composition, age, and gender. However, in order for particular adjustments to be permitted, they must be expressly delineated in the state's statutes or rating regulations.

Only two states – New York and Vermont – require insurers to charge a pure community rate.¹⁴ By requiring insurers to charge all small businesses the same rate for coverage, small firms employing individuals with high health care costs theoretically will have access to more affordable coverage options. At the same time, however, these rating restrictions will, in all likelihood, increase costs for younger and healthier individuals in groups.

A recent study found that as a result of New York's small-group and individual market reform laws, which require guaranteed issue of all products and community rating, the typical 25 year-old male pays 60 percent more for coverage than he did before the laws were enacted, while a 55 year-old male pays 30 percent less for coverage than he had previously.¹⁵ According to the U.S. General Accounting Office (GAO), small-group premiums in states that prohibit insurers from using health status to rate premiums were six percent higher than were small-group premiums

in states that allowed limited variation based on health status or had no restrictions on premium rates.¹⁶ The GAO analysis controlled for geographic differences in the cost of physician services.

Ten states have instituted adjusted community rating laws that allow for limited variation of premiums, based on non-health characteristics, such as age.¹⁷ While age is correlated with health, age rating does not eliminate the inherent cross-subsidization that occurs between low- and high-risk individuals of the same age.¹⁸ Allowing insurers to adjust premiums on the basis of age allows substantial reductions in the price of premiums charged to younger groups.

To the extent that increasing participation in the health insurance market is desirable, allowing insurers to consider age when pricing small-group products tends to provide incentives for younger and healthier individuals – who also tend to be relatively low wage earners -- to opt for coverage, thereby increasing the ability to spread risk (and keep prices lower) across the entire market. However, in response to the spiraling costs that occurred throughout the small-group market after the enactment of modified community rating laws, two states -- Kentucky and Florida – repealed these laws and restored limited **experience rating**.

Rate bands, which restrict the range of premiums that can be charged to different groups for the same plan, can be used either alone or in conjunction with other rating restrictions, such as modified community rating. Many states follow the framework developed by the NAIC in the 1992 Small Employer Health Insurance Availability Model Act which permits premium variation on the basis of certain “case characteristics” – such as age, gender, geographic area, and group size – as well as limited premium variation based on claims experience, health status, or duration of coverage. Most states that use rate bands use a band that is plus or minus 25 percent, or 1.66 to 1. The District of Colum-

bia, Hawaii, Michigan, and Pennsylvania have no statewide restrictions on premiums.¹⁹

Groups of One

In an attempt to provide more affordable coverage to the self-employed and sole proprietors, 13 states have enacted laws defining small groups to include “groups of one.”²⁰ The theory behind these laws is that small-group premiums will be lower, and therefore more attractive, to individuals than are premiums in the underwritten individual market, thereby making coverage more attainable for these “groups of one.” Experience has shown, however, that including groups of one in the small-group market, which is subject to guaranteed issue requirements, tends to drive up the cost of coverage for all small groups. The resulting cost increase is due largely to adverse selection among the groups of one who choose to purchase this coverage. Indeed, some carriers report that the cost of claims for self-employed individuals can be as much as 59 percent higher than the cost of claims in the 2-50 market.

Mandates

The proliferation of mandated benefit laws has helped fuel the rise in health insurance costs across all markets. Approximately 1,500 mandates have been enacted in the states and at the federal level. When combined with the costs of increased government regulation, mandates accounted for, on average, 15 percent of the increase in health insurance premium costs in 2002.²¹ By significantly increasing the cost of coverage, mandates lead to an increased number of uninsured individuals and families.

Duke University researchers found that 20 to 25 percent of uninsured individuals and families lack coverage because of state mandated benefits.²² State and federal mandates are particularly problematic in the small-group market. Small groups – because of their inability to spread risk and therefore spread cost across a large pool of covered individu-

als – often are less able than large firms to absorb the additional costs associated with mandated benefits. Large groups have the option to self-fund and, consequently, are exempted from coverage mandates and from state insurance regulation. However, generally it is not appropriate or feasible for small firms to self-fund.

III. Additional Strategies to Address Problems in the Small-Group Market

State and federal efforts to address access to and affordability of coverage in the small-group market have had mixed results. To provide for adequate risk-spreading and therefore lower coverage costs for small businesses, reforms should focus on increasing the number of small businesses sponsoring health coverage and on the number of employees opting for coverage.

This section examines incremental as well as broader strategies that have been discussed and in some cases implemented to address small-group market issues. These strategies include: limited enrollment periods; rating flexibility; use of high-risk pools; pooled purchasing arrangements; association health plans; medical savings accounts (MSAs); premium subsidies for small businesses and their employees; mandate review commissions; and laws allowing the development and sale of basic coverage policies.

Limited Enrollment Periods

As discussed above, in the 13 states allowing groups of one to buy into the guaranteed-issue small-group market, adverse selection has proven to be a major concern. To mitigate adverse selection and the cost increases associated with it, one policy option that has been discussed is to establish limited enrollment periods (e.g., one month out of a calendar year) within which groups of one may purchase coverage. Such a system could limit the potential for individual “groups of

one” to purchase coverage only when they get sick and to drop coverage after their health improves.

Rating Flexibility

Rating restrictions in the small-group market are intended to prevent wide variations in premiums among small groups and to protect small groups from disproportionately steep premium increases from year to year. Rating restrictions also are intended to provide high-risk groups with access to more affordable coverage options. However, in the past several years, some states have narrowed or tightened their rate band requirements significantly. This narrowing of established rate bands has undermined health insurers’ flexibility to provide affordable coverage options that meet the varied and diverse needs of the small-group population. Allowing health plans increased flexibility in rate-setting by refraining from rate band compression can help keep coverage affordable and thus maintain or even increase participation in the small-group market.

High-Risk Pools

One option under consideration to expand coverage in the small-group market is to make high-risk pools available to small groups. Twenty-nine states offer some form of high-risk pool for consumers who are unable to obtain coverage.²³ Generally, high-risk pools cap the cost of premiums and subsidize coverage, either through general state revenues, an assessment on insurance carriers, provider taxes, or other sources. A study by the Urban Institute concluded that “adequately funded high-risk pools, without enrollment caps and without statutory definitions of high-risk, can be useful components of a coverage-enhancing policy mix.”²⁴ Another recent study by the Center for Studying Health System Change suggested that high-risk pools could make insurance coverage more affordable in the individual market. The study found that a high-risk pool which removed the highest one percent of the riski-

est individuals from the individual market reduced premiums for the remainder by 14 percent.²⁵

Despite the potential of state high-risk pools, their ability to reduce the number of uninsured has been limited. Participation in high-risk pools is relatively low. Of the 11 to 16 million people estimated to purchase coverage in the individual market, just 101,000 participated in high-risk pools in 1999.²⁶ The cost of premiums in high-risk pools remains high, due to the inherent costs of insuring a population with significant health problems. State funding has not been sufficient to cover costs in many instances, and enrollment has been capped to limit losses. Some states have abandoned their high-risk pools entirely, and Florida's high-risk pool has been closed to new enrollment since 1991.²⁷

Some states, such as Texas, have considered allowing small employer groups access to coverage through these state-administered high-risk pools. The rationale behind this proposal is that removing the subset of small groups likely to have the highest claims from the risk pool should lower premiums for the remainder of the small-group market. This change may have the effect of reducing premiums for the small-group market while attempting to ensure access to comprehensive coverage for very small groups at a capped, albeit higher, rate.

Similarly, states that define small groups to include groups of one could require that these individuals be moved to a high-risk pool. Such an effort, which has been proposed but not formally considered by state legislatures, could help ameliorate adverse selection in the small-group market, while at the same time allowing access to coverage for the self-employed.

Ensuring adequate funding for high-risk pools is critical if these mechanisms are to be viable. Federal grants to states may help stabilize and strengthen high-risk pools so that they can provide coverage for the uninsurable. Legislation recently passed by Con-

gress – the Trade Act of 2002, which includes reauthorization of the Trade Adjustment Assistance Act – will provide grants to states through fiscal year 2004 to help them establish high-risk pools and will provide federal funding during that time period to support the operation of high-risk pools in states that already have them.

Another potential approach that has been discussed as an option to stabilize the costs of high-risk pools is to modify the benefit structure and delivery system used in policies offered in conjunction with high-risk pools so that these policies more closely resemble those available in the commercial insurance market. The majority of private health insurance plans today contract with a network of providers; in contrast, many high-risk pools continue to operate like indemnity plans and do not. It has been suggested that by contracting with networks of providers, high-risk pools could leverage significant discounts and price reductions, and thus could provide more affordable coverage. Additionally, some have suggested that introducing some cost-sharing strategies and managed care techniques comparable to those used by private and many other public health insurance plans also could promote the financial stability of high-risk pools.

Pooled Purchasing Arrangements

Pooled purchasing arrangements, in which businesses band together to offer more affordable coverage to employees, also have been discussed as an option for expanding coverage. The rationale is that the consolidation of administrative functions and risk-sharing will provide the economy-of-scale advantages often associated with large-group coverage.

State-sponsored pooling arrangements, however, have had a mixed record. While pooled purchasing arrangements have provided additional health plan options, they have not succeeded in reducing costs or increasing access to coverage.²⁸ Enrollment in pooled purchas-

ing arrangements remains very low. It has been estimated that there are fewer than 20 state and local purchasing cooperatives providing coverage to no more than a total of one million employees and dependents,²⁹ and a 2001 study found that they represented less than five percent of the small-group market.³⁰ Because of their low enrollment, these arrangements have been unable to leverage premium reductions. Many pooled purchasing arrangements, such as those in Kentucky, Florida, and Texas, failed because their rates were not competitive with the non-pooled market and they experienced the same adverse selection pressures which generally occur in small-group market.

Association Health Plans

Proposals to facilitate group-purchasing arrangements for health coverage also have been considered at the federal level. In 2001, the U.S. House of Representatives passed legislation, as part of H.R. 2563, the Bipartisan Patient Protection Act, to allow for the formation of association health plans (AHPs).

Similar to pooled purchasing arrangements at the state and local levels, AHPs would seek to reduce the cost of health insurance by consolidating administrative functions and by pooling the risks of small firms. But, in contrast to state and locally sponsored pooled purchasing arrangements, AHPs, as currently designed, would be exempt from most state regulation, including rate regulation and solvency standards, and from all state mandates. Exempting AHPs from state regulation and mandates would have the potential to segment and destabilize the small-group market. Relatively young and healthy individuals would be most likely to purchase such coverage, leaving a relatively older, less healthy population in the fully regulated market and thus leading to a cycle of spiraling premiums that could threaten the viability of the regulated market.

While AHPs have been promoted as an effort to significantly reduce the number of unin-

sured Americans, recent studies suggest that they may not achieve that goal and in fact could have the opposite effect. The Congressional Budget Office estimated that AHP proposals could provide coverage only to an additional 330,000 individuals nationwide.³¹ A study by the Urban Institute suggests that AHP proposals could cause small employer coverage to decline by approximately one percent, causing 250,000 workers to lose health coverage.³²

Concerns also have been raised about current proposals to exempt AHPs from state solvency standards. Exempting AHPs from state solvency standards could bring back the multiple employer welfare arrangement (MEWA) bankruptcy problems that left hundreds of thousands of individuals and families with unpaid medical bills. Many organizations, most notably the NAIC, have testified that the solvency standards of current AHP proposals are inadequate to protect consumers and have the potential to leave consumers exposed to unpaid medical bills if an AHP becomes insolvent.³³

Medical Savings Accounts

HIPAA authorized establishment of medical savings accounts to provide an additional coverage option for small business employees. MSAs are tax-advantaged savings accounts that small business employees and self-employed individuals can use to pay for current or future medical expenses. HIPAA requires MSAs to be accompanied by a high-deductible insurance policy (defined as between \$1,500 and \$2,250 for individuals and \$3,000 and \$4,500 for families). Pursuant to HIPAA, MSA enrollment is capped at 750,000 lives. As of 2000, only 62,000 individuals had chosen this option. According to the Internal Revenue Service, 42 percent of individuals participating in MSAs were uninsured in the previous year.³⁴ Despite the relatively low enrollment in MSAs, many bills have been introduced in Congress to expand eligibility for MSAs and remove some of the statutory restrictions on their use.

MSAs have relatively low premiums, and proponents have described them as a low-cost alternative to more comprehensive health coverage. However, because MSAs require enrollees to pay out-of-pocket expenses up to a high deductible, some have expressed concern about the potential for MSAs to attract primarily young and healthy individuals. Because participation in MSAs has remained low, it is difficult to determine what, if any, effects they have had on the small-group market. Some have expressed concern that if MSA enrollment increased substantially to account for a larger share of the insurance market, they could cause a major disruption in the risk-spreading that is essential to keep coverage affordable.

Premium Assistance Programs

Providing premium subsidies to small businesses and their employees is another option for promoting increased participation in the small-group market. The Commonwealth Fund identified 15 state-sponsored premium assistance programs and eight locally sponsored programs designed to assist low- and moderate-income uninsured individuals and families in purchasing health insurance coverage.³⁵ Some state programs subsidize the premiums of small businesses, while others subsidize the premiums of small business employees. Some of the programs target the low-income uninsured, while others have broader eligibility requirements. Funding for premium assistance programs also comes from a variety of sources, including general revenues, taxes on alcohol and tobacco, and assessments on hospital services.³⁶ States also have the flexibility of using Medicaid and S-CHIP funds to subsidize employer-sponsored coverage for individuals and families. Subsidies for premium assistance programs vary, with at least one state offering assistance through tax credits and others utilizing various public and private funding sources to subsidize and promote employer-sponsored coverage for small firms and their employees.³⁷ Some programs offer subsidies

to encourage firms not sponsoring coverage to employees to begin providing it, while others subsidize coverage for all small firms and their workers, as well as individuals who are self-employed.³⁸

Overall, premium assistance programs have been only modestly successful, with 15 state-initiated efforts subsidizing coverage for approximately 380,000 small business employees who were previously uninsured.³⁹ According to a study by the Center for Studying Health System Change, a broad-based 30 percent subsidy for employer-premium assistance programs (which represents the average subsidy for these programs) would result in only 500,000 people nationally gaining access to coverage.⁴⁰ To facilitate increased coverage for small businesses and their employees, premium subsidies would need to be quite generous.

One innovative approach implemented recently is a two-year pilot program to provide health insurance coverage for uninsured individuals who work for small firms in Sacramento County, California. This program provides subsidies to both employers and employees, ranging from 40 to 65 percent of the cost of the premium. Small businesses, defined as those with two to 50 employees, that have not offered coverage to their employees in the previous year are eligible for the subsidy. To be eligible for this program, individuals must be full-time employees with family incomes less than 300 percent of the federal poverty level. Small business employees also must have been uninsured for the previous six months and must not be eligible for public programs or employer-sponsored spousal coverage. The Sacramento program is funded through tobacco litigation settlement funds. While data on enrollment in the program are not yet available, the county projects that it will provide coverage to approximately 500 uninsured individuals and their dependents.

Start-up firms represent a substantial portion of businesses that do not sponsor health insurance coverage. Targeting subsidies at the

employer level to start-up firms and phasing those subsidies out over time could help close the coverage gap while limiting the fiscal impact of such assistance programs on state budgets.

Mandate Review Commissions

Another strategy that some states have used to address the affordability of health coverage in both the large and small-group markets is to establish mandate review commissions. Overall, a dozen states have enacted laws that require the review of proposed health benefit mandates, with some states requiring fiscal impact statements and others requiring formal review panels or commissions to examine the medical efficacy and costs of the mandates under consideration.⁴¹ Nine states, including most recently California, Massachusetts and South Carolina, have enacted laws that require formal panels or independent commissions to review proposed benefit mandates.

Mandate review commissions in Pennsylvania and Washington have been particularly effective in providing a systematic and independent review of the benefits and costs of proposed benefit mandates.⁴² In Pennsylvania, for example, the review commission requests data from both proponents and opponents of a proposed benefit mandate when examining the financial, social, and medical impact of the proposed mandate.⁴³

While mandate review commissions' recommendations typically are not binding on state legislatures, there is some evidence to suggest that mandate review commissions can lead to a more thoughtful process of evaluating the impact of proposed mandates. The majority of proposed mandates reviewed by Pennsylvania's review commission have not been adopted and, in Washington, of the four mandates that the commission did not recommend to enact, none has been enacted.⁴⁴

Basic Coverage Policies

During the late 1980s and early 1990s, in response to small firms' concerns that state benefit mandates were driving up the cost of health coverage, 42 states enacted laws allowing the sale of basic coverage policies. Basic coverage policies are free from many state-mandated benefits and/or permit increased enrollee cost-sharing. Their premiums also are significantly lower than those associated with other health insurance policies.⁴⁵ Despite their relatively low cost, enrollment in basic coverage policies remains low, typically ranging from a few hundred to a few thousand individuals in each state where they are offered.⁴⁶ Due to the low enrollment, some states have repealed the laws authorizing the development and sale of these policies. As health care costs continue to rise, basic coverage policies are again being discussed among the range of options available to cover the uninsured.

Conclusion

The problems facing the small-group market for health insurance coverage are complex, and no one initiative can solve all of the access and affordability problems facing small businesses and their employees. The single largest threat to access in the small-group market is not unique to this market: rapidly rising health care costs. In addressing access and affordability specifically in the small-group market, the key challenge is to ensure adequate participation, particularly among the young and the healthy. Efforts to encourage more small businesses and their employees to purchase coverage will strengthen the risk pool in the small-group market, which has been beset by adverse selection, access problems, and spiraling increases in the cost of coverage. Small businesses and their employees are diverse and have a wide range of health care needs and preferences. Requiring all health insurers to adopt a one-size-fits-all approach to coverage undermines flexibility and precludes health plans from developing

innovative products that meet the specific health care needs of small employers. Enactment of additional mandates increases the cost of health insurance, which can lead some small businesses to stop providing coverage to their employees. To move closer to the goal of providing all Americans with access

to quality, affordable coverage, public policy should seek to create a flexible health insurance environment in which employers and consumers can choose from a variety of health insurance options that meet their specific health care needs.

Small-Group Reform Paper Glossary

Community rating: A rating method under which the same premium is charged to everyone in the same plan. In a community rating system, insurers and health plans are prohibited from varying premium rates based on the health status or claims experience of the group, and from establishing or adjusting premium rates based on the demographic characteristics of the group. Premiums may, however, differ by geographic area and family size.

Experience rating: A rating method under which premiums may reflect health status and claims experience.

Modified community rating: A rating method that prohibits insurers and health plans from considering health status or experience in developing or adjusting premium rates, but allows for limited premium rate variation on the basis of certain demographic characteristics of the group, such as age, gender, industry type, geography, and group size. Also known as *adjusted community rating*.

Rate bands: A rating methodology that limits the range of premiums that can be charged to different groups for the same plan.

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For more information about studies and findings in this publication, contact Greg Gierer, Policy Analyst, AAHP, at 202-778-8480 or ggierer@aahp.org

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