

The Geography Of Health Insurance Regulation

A guide to identifying, exploiting, and policing market boundaries.

BY MARK A. HALL

ABSTRACT: The health insurance market consists of three distinct segments—individual, small group, and large group—each governed by different economic and regulatory structures. A number of border-crossing techniques have arisen for avoiding the burdens of one segment and capitalizing on the benefits of others. Draw-

ing from extensive qualitative research into the functioning of existing market structures, this paper describes these techniques and their purposes and effects. This road map helps to identify which reform proposals seek to produce true economic efficiencies and which have the potential to undermine previous reform objectives.

POLICYMAKERS FREQUENTLY express dismay at the crazy-quilt complexity of the health insurance market. Pending legislation and reform proposals promise to add still more layers of regulation and new institutions by creating “association health plans” and “health marts,” or by allowing employees to purchase individual coverage.¹ This paper draws from an extensive qualitative research study in seven states (Colorado, Florida, Iowa, New York, North Carolina, Ohio, and Vermont) and among national insurers to explain the complex functioning of existing health insurance market and regulatory structures.² The purpose is not to analyze specific proposals for reform; however, better understanding of the current geography of health insurance regulation is critical to anticipating the likely effects of new proposals.

Conventional Market Boundaries

The health insurance market consists of three distinct segments, each of which is governed by fundamentally different economics and regulations: large group, small group, and in-

dividual (Exhibit 1). These are not simply points on a continuum; they constitute entirely different product lines, often sold by different sales forces and serviced by different insurers or corporate divisions—as distinct in their economic and legal characteristics as are mobile homes, condominiums, and single-family homes. The characteristics of each market segment and the way in which the boundaries are defined have pervasive strategic and public policy importance. Some business and political strategies seek to minimize these market differences, to spread the advantages of one segment to the others. Other strategies depend on maintaining these divisions and so are threatened by market activity that seeks to circumvent or exploit these boundaries.

■ **Large-group market.** The large-group market, which consists of employer-based insurance for groups of more than fifty workers, accounts for roughly two-thirds of private health insurance. Regulation of these groups is determined by whether they are self-insured—that is, whether the employer bears the financial risk for most claims. A quarter to

Mark Hall is professor of law and public health, in the Schools of Law, Medicine, and Management, at Wake Forest University, in Winston-Salem, North Carolina.

EXHIBIT 1
Characteristics Of Insurance Market Segments

Market segment	Definition	Approximate portion of private market	Economic attributes	Regulatory attributes
Large group	Groups of more than fifty persons	65 percent	Cohesive Economies of scale Subsidized No adverse selection No individual underwriting Experience-rated among groups, community-rated within group 85–95% medical loss ratio Some plan choice	ERISA preemption for self-insured group
Small group	Groups of fifty or fewer persons	25 percent	Lesser version of large groups 75–85% medical loss ratio Limited plan choice	Small-group reform laws Mandated benefits Managed care protections
Individual	Nongroup	10 percent	No cohesion No economies of scale Unsubsidized Strong adverse selection Intense medical underwriting Risk-rated 60–75% medical loss ratio Full choice	Limited reform laws Mandated benefits Managed care protections Rate regulation

SOURCE: Author's compilation.

NOTE: ERISA is Employee Retirement Income Security Act.

a third of groups of 100–500 workers are at least partially self-insured, as are more than half of groups of more than 500 workers.³ For these groups, the Employee Retirement Income Security Act (ERISA) preempts the core of state-law insurance regulation, with virtually no supplanting federal regulation. Preemption includes regulation of solvency and other financial matters, consumer protection regulation, and regulation of the content of health insurance. Self-insurance also preempts premium taxes and other assessments used to support regulatory activities and access initiatives such as high-risk and reinsurance pools. For large groups that are not self-insured, these matters are subject to state regulation. State law has some degree of uniformity but also varies a great deal. The type, extent, and source of state regulation also vary according to indemnity insurance versus managed care and the many permutations of each.

Large-group insurance is experience-rated

among groups but community-rated within groups. Larger groups enjoy economies of scale and purchasing power, which result in medical loss ratios that typically run in the high 80s or low 90s.⁴ Also, because the employer selects and pays for employees' insurance, there is much less of a tendency for insurance to be selected with the health condition of particular subscribers in mind (adverse selection). This allows the market to function well with little or no medical underwriting (that is, screening and evaluation of individual health risks), since underwriting is focused on group averages. Another advantage to employer-based insurance is the subsidy it confers to subscribers, because the employer pays a large portion of the premium and because this premium contribution is not taxed as income to the employee. Finally, larger groups typically offer employees a choice of plans.

■ **Individual market.** At the other ex-

treme, the individual or nongroup market consists of insurance purchased outside the workplace, such as by self-employed or unemployed people, or people with jobs that do not provide health insurance. This market segment accounts for less than 10 percent of private health insurance. Its regulation is almost entirely the province of the states.⁵ States typically regulate solvency and other financial matters, the content and wording of policies, and managed care activities. Regulation in the individual market is much more diverse and varied among states than is the case for large or small groups. For instance, only seven states have adopted comprehensive reforms in the individual market similar to those in the small-group market, and even these do not follow the National Association of Insurance Commissioners (NAIC) models.⁶ In other respects, regulation can be stricter in the individual market. States that require prior rate approval or that set limits on medical loss ratios are usually more demanding in these requirements for individual insurance than for other portions of the market.

The economic characteristics of the individual market also differ fundamentally from those of large groups. High marketing costs, diminished economies of scale, and less competitive conditions result in medical loss ratios in the 60s to mid-70s. Individuals do not receive the same tax break as employees do. Also, because the purchase of individual insurance is determined entirely by purchasers' health needs, adverse-selection concerns are much greater. Thus, medical underwriting is very prominent, in the form of premium variations, coverage limitations or exclusions, and outright denials of coverage. On the positive side, purchasers in the individual market can choose from the full array of product types and variations in coverage. Also, because purchasers bear almost the entire cost from after-tax income, they are much more cost-sensitive, which lessens the "moral hazard" problem that arises from excess insurance.

■ **Small-group market.** In between these two extremes lies the small-group market, which consists of employer groups of fifty and

fewer, accounting for about a quarter of private insurance. Very few of these groups are self-insured, so this market segment is governed mainly by state law, augmented by the federal Health Insurance Portability and Accountability Act (HIPAA). Because of states' widespread adoption of small-group market reforms in the early 1990s, followed by HIPAA in 1997, there is a fair degree of uniformity in these regulations. Also, it is in this arena that states exercise the most oversight of plan content and managed care activities.

Small groups exhibit a mix of economic characteristics from large groups and individuals. Medical loss ratios typically run in the high 70s to mid-80s. Regulation has diminished medical underwriting, but it is still present. Insurers are not allowed to refuse coverage or exclude conditions altogether, but because of the potential for some adverse selection, they are allowed to (and typically do) limit coverage for preexisting conditions, and prices may vary somewhat based on factors that predict health status and claims costs.⁷

'Border-Crossing' Structures And Techniques

A number of alternative structures have arisen for crossing or altering these market divisions by aggregating or disaggregating in ways that alter ordinary market locations (Exhibit 2). Individuals might try to present themselves as groups, or small groups as individuals or as large groups. These alternative market structures are intended in large measure to seize on the favorable characteristics noted earlier and avoid the unfavorable ones, either by exploiting differences in the regulatory treatment of these different market segments or by capitalizing on their economic characteristics.

■ **Group trusts for individuals.** Insurers selling coverage to individuals have sought to avoid regulation as individual insurance by the use of "group-trust" arrangements. Because these mimic the sale of large-group insurance, they also bypass small-group regulation, as follows. The insurer creates a legal entity known as a trust, to which it issues a

EXHIBIT 2

Characteristics Of Border-Crossing Techniques

Technique	Target market	Market replicated	Economic advantages	Regulatory advantages
Group trusts	Low-risk individuals	Large group	Economies of scale	Neither individual nor small group Out of state
Fictitious groups	High-risk individuals	Small group	None	Guaranteed issue Community rating
Self-insured small groups	Low-risk small groups	Large group	Lower costs	ERISA preemption
List billing	Small groups	Individual	Payroll deduction Tax deduction	Avoid small-group laws
Associations	Low-risk small groups	Large group	Economies of scale	Avoid community rating ERISA preemption

SOURCE: Author's compilation.

NOTE: ERISA is Employee Retirement Income Security Act.

“master” group policy. The insurer then sells to individuals “certificates” under the master policy, in the same way that employees are signed up under an employer plan. In the world of insurance regulation, certificates under a group policy are fundamentally different legal constructs from individual policies. In the group arrangement, there is a single contract with the employer or the trust, which covers many individuals, similar to the way that a family that buys insurance is a single subscriber unit with several members.

The impact that group-trust arrangements have on the regulation of insurance depends on fine points of wording in each state's insurance law. If these laws apply to individual policies sold rather than to certificates issued, then group trusts avoid regulation as individual insurance because the policy is issued to the trust on a group basis, and coverage is sold to individuals as certificates for members joining the group rather than as individual policies. Moreover, group trusts are often set up in one state to do business in several or many others. Again, depending on each state's treatment of jurisdictional issues, the large-group policy issued to the trust may also effectively avoid regulation as group insurance, except in the state where the trust is formed, even though certificates are sold in many other

states. This allows insurers to shop among the states for the most favorable regulatory environment. This also allows insurers to create a regulatory vacuum that avoids both individual and small-group laws, since the trust is considered a large group.⁸

There is no careful documentation of how much individual coverage is sold through group trusts in different states, but knowledgeable industry sources interviewed for this study verify that this is a common practice, especially in midwestern states. Interview subjects explained that some insurers prefer this marketing vehicle, not so much for the inherent efficiencies of group arrangements, but primarily because of the following regulatory advantages: not having to file and seek approval of policy forms in every state where an insurer does business; avoiding prior rate approval by issuing the group policy in a state where this is not required; avoiding certain coverage mandates; and paying lower premium taxes.

The regulatory advantages are especially strong in states with individual-market reforms, which sometimes permit group trusts to avoid guaranteed issue and community rating laws. For instance, in Ohio group trusts account for at least half of all individual coverage. These arrangements took shape before

the market-reform laws, but avoiding open enrollment is another inducement to retain the practice. As a consequence, several of the largest indemnity insurers in Ohio do not have a single open-enrollment subscriber. The reform law's impact on group trust and other association arrangements is also pronounced in Kentucky. There, associations were exempted from guaranteed issue and community rating requirements in both the individual and small-group markets, making them the only source available for medically underwritten coverage. Following rapid shifts in enrollment, in 1997 forty-five associations accounted for 35 percent of the combined individual and small-group market in Kentucky. Several Kentucky insurers sold only through exempt associations, and most of those who did not left the market altogether.⁹

Other states, however, do not allow group-trust and other association arrangements to entirely avoid the basic requirements of insurance market reforms. As discussed more below, these states may alter the rating and insurance rules somewhat to recognize the unique characteristics of group-purchasing arrangements, but they include these arrangements within the basic scope of the reform law. These increased regulatory burdens cause some insurers to leave these markets, however, especially insurers with very small enrollments, on whom the individual market is more dependent. Also, the need to seek regulatory approval in each state whenever even small changes are made in insurance products may discourage frequent product innovations.

■ **Fictitious employees and one-person groups.** A more straightforward way for individuals to present themselves as groups is to claim to be a small business. One motive for doing so is to obtain the more favorable pricing and broader range of product offerings found in the group market. Another motive is to seek the advantage that guaranteed issue and community rating create for older people or those with health problems, in states where these reforms exist only in the small-group market. Group products also tend to have more mandated benefits for services

such as mental health or maternity care, which is attractive for those who anticipate needing these services.

The ability to opt into a group status depends on what size of group is covered by a state's small-group reforms and how actively the state polices the legitimacy of employer groups. All states reach down to employers with two full-time workers, even if they are related, thus covering "mom-and-pop shops." Thirteen states also cover the self-employed, or so-called one-person groups.¹⁰ Calling these lone subscribers "groups" appears anomalous, but the key distinction is whether or not insurance is purchased through a business, not how many people are covered.

While this is valid for owners of legitimate businesses, there are opportunities for cheating when employers falsely claim sick friends or family members as employees to get them onto the group policy, or when people have "day jobs" with firms that do not offer insurance and use a part-time activity to claim the status of business proprietor for themselves or family members. To guard against these abuses, most insurers require payroll and tax form documentation of business and employee status.

Most subjects interviewed in this study believed that this eliminates the major opportunities for claiming illegitimate group or employee status. However, most subjects thought that employer fraud occurs to some extent and some, to a great extent. Others thought that some insurers are too aggressive or somewhat selective in demanding documentation, to weed out legitimate groups with health problems or to allow in individuals with favorable risk profiles. A number of insurers said that screening for these and other group-eligibility criteria (such as participation and minimum contribution requirements) now received as much or more attention as did medical underwriting before reform.

Without this level of scrutiny, employer abuse would likely be much higher. One insurer with a large block of small employers in Ohio discovered through selected audits that

40 percent of its groups had eligibility problems, which it estimated added 7 percent to its small-group rates. A large insurer in New York likewise found eligibility problems in 50 percent of cases it audited, before instituting more systematic eligibility screens.

■ **Small-group self-insurance.** We now look at techniques that small groups use to cross their market boundaries, either at the low or the high end. At the high end, small groups can seek the advantages of ERISA preemption by self-insuring. Self-insurance is generally thought to be infeasible for small groups because the risk would be too great. This is the main reason that small-group laws usually operate only below a group size of fifty, because increasing the group size to a point at which self-insurance is feasible would only prompt more medium-size employers to opt out of state-regulated insurance.

However, some insurers and agents have developed a modified form of self-insurance that is feasible for employer groups as small as about twenty. They write stop-loss or reinsurance coverage that has a very low attachment point of \$10,000–\$15,000 per employee. Although this effectively functions like ordinary indemnity coverage with a very high “catastrophic” deductible, in some states this coverage is not regulated as part of the small-group market because it technically covers only the employer and not the employees. The employer remains primarily obligated for all medical expenses; the low-attachment, high-deductible stop-loss functions only as secondary insurance to the employer.

Because small-group laws and other consumer protections often do not cover reinsurance policies, a self-insured employer may not realize that it is not protected from cancellation or steep premium hikes. Since these policies are written to cover only claims submitted during the policy period, employers can be stuck with large unreimbursable expenses if the reinsurer cancels coverage after someone has received expensive treatment but before the claims are submitted.

Some states block this attempt to escape small-group regulation, either by banning the

sale of stop-loss with very low attachment points, or by regulating stop-loss insurance as part of the small-group market once the stop-loss attachment point falls to a certain level (\$15,000–\$25,000). However, in *American Medical Security Inc. v. Bartlett*, the federal Fourth Circuit Court of Appeals (covering Maryland, North Carolina, South Carolina, Virginia, and West Virginia) ruled that this move is barred by ERISA, casting into doubt states’ ability to police this regulatory border.¹¹ State regulators hotly contest the validity of this ruling, and so until the Supreme Court or other circuits rule on the issue, some states will continue to assert jurisdiction over self-insured arrangements by small employers.

Accordingly, in interviews conducted in 1997 and 1998, we found little evidence that small-group reforms were prompting a move to self-insurance.¹² However, in states that do not regulate small-group self-insurance, there is evidence that this escape route is being used more aggressively, with stop-loss policies as low as \$5,000–\$10,000 being sold to employer groups as small as ten workers.

■ **List billing.** Self-insurance and other techniques discussed below involve small groups’ crossing the market border into the large-group terrain. Other techniques move in the opposite direction, toward the individual market. These techniques go under various terms, the most common of which is “list billing.” The meaning of this technical term varies somewhat within the industry, but the gist refers to arrangements whereby employers facilitate their employees’ purchase of individual insurance. In short, the insurer, rather than billing for a group rate, bills for a list of designated employees who have opted for individual coverage.¹³ This can be done in two ways. One is to bill the employer, which pays some or all of the cost of the insurance. The other is for employees to bear the entire premium but to allow them to pay through payroll deduction; the insurer only notifies the employer of the amounts to deduct.

The first form of list billing, in which employers pay a portion of the cost of individual insurance, is generally banned by small-group

reforms, since it is seen as an attempt to circumvent the requirements of whole-group coverage and community rating. The concern is that employers with workers who have health problems will seek to cover only their healthy workers, a practice sometimes called "lasering out" the sick workers. Also, employers with younger, healthy workers might erode community-rated risk pools by purchasing individual coverage for all workers at rates lower than community-rated group rates. In interviews with agents, insurers, and regulators, in most states we found little evidence of these blatant forms of list billing.

In the second form of list billing, employers merely facilitate employees' own purchase of individual insurance through payroll deduction. This is sometimes permitted by small-group regulations and is popular with both agents and employees. For agents, it creates easier access to new clients. For employers, it allows those that do not otherwise offer insurance to do something constructive for employees. Using "Section 125" cafeteria plans, employees may purchase individual coverage with before-tax income, receiving the same tax break that exists for employer-paid premiums.

Whether the payroll deduction form of list billing is allowed depends in great part on how regulators in a particular state interpret their laws' definition of *group insurance*. Some regulators take a lenient view, according to which group insurance exists only if the employer directly pays for a significant portion of the premium (usually, 25–50 percent). One insurer we interviewed combines list-billing arrangements with a group-trust arrangement to create a perfect regulatory vacuum in which the coverage that is sold is considered (in some states) to be neither individual nor group insurance.

Other states take a stricter view, under which group insurance is involved under either type of list-billing arrangement, as long as the premium is paid with a company check rather than a personal check. They are concerned that it is too easy otherwise for employers to drop group coverage and switch to list billing for individual insurance, since they

can simply increase employees' wages to compensate for the loss of fringe benefits. Regulators in more lenient states take the position that they have no authority or ability to monitor employers' behavior, even if it involves differential and strategic wage increases.

Interview subjects said that the payroll deduction form of list billing, in which employers do not pay any portion of the premium, is present but not widespread in states that take a more lenient view. No subjects complained that list billing was eroding small-group reforms. However, in the stricter states a number of agents complained, some vociferously, that the regulators' interpretation of the reform law was prohibiting a practice that previously had great value to employees and that could be used to expand coverage.

■ **Private associations.** The techniques surveyed so far can be combined in various ingenious ways to multiply their effects or to extend them into different market arenas. This is done primarily through various kinds of private purchasing associations. Precise definitions and uniform terminology do not exist in this evolving netherworld of market structures. Necessarily, then, this discussion is somewhat generic and focuses only on prototypical arrangements.

Classic purchasing associations are those created by business and professional groups such as chambers of commerce or industry-specific trade groups. No fully accurate accounting exists of these structures, but there are certainly hundreds of them throughout the country, covering millions of people.¹⁴ In our market testing study, 45 percent of 143 agents (in eight states), contacted by an employer of three, mentioned the possibility of purchasing health insurance through a private association. Most associations are local to states or metropolitan areas, but some are multistate. Typically, a trade or professional group contracts with a licensed insurer to offer its products at a discount, as a benefit of membership, just as it might sponsor or endorse credit cards, vacation packages, or telephone plans.

Group-trust arrangements. Association mem-

bers might be either individuals, small groups, or occasionally groups of more than fifty.¹⁵ In their simplest form, associations are not intended to alter the regulatory treatment of the insurance they offer; instead, associations are treated as a mere conduit or sales vehicle, and the products they sell are regulated according to the identity of the purchasers. However, association arrangements have been used in a variety of ways to alter regulatory boundaries. One way, already noted, is a group-trust arrangement that seeks to sell individual insurance as certificates under a group product.

Self-insured associations. A second regulatory effect occurs if associations self-insure to capitalize on ERISA preemption. Self-insured associations first became known as “multiple-employer trusts” (METs) but are now called “multiple-employer welfare arrangements” (MEWAs), according to a provision added to ERISA in 1983. The regulatory status of METs/MEWAs has evolved over time, largely in response to their sordid history.¹⁶ While many of them are legitimate and well run, some have engaged in outright fraud or have been poorly operated, resulting in bankruptcies that have left thousands of people with unpaid medical bills.¹⁷ Increased oversight by the U.S. Department of Labor has helped to stem this rampage of abuses, but problems persist because of uncertainties and gaps in regulatory authority that are too complex to explain in the available space.

‘Bona fide’ associations. For associations that are not self-insured, there is a third regulatory effect, one that merits more detailed explanation. To the extent that associations sell to small groups, they might also seek to avoid guaranteed-issue and community-rating reforms. Most states, and HIPAA, apply small-group laws to policies sold through associations, but with certain exceptions. These laws make special accommodations for certain “bona fide” associations that were formed for

“noninsurance purposes” and that existed for several years prior to the law or prior to offering insurance. These bona fide associations must meet guaranteed issue and renewability requirements inside the association (that is, all members must be eligible) and membership requirements cannot be used as a proxy for excluding unhealthy groups. However, insurers need not sell the same policies outside the association and may choose to sell only through one or more associations.

“Many interview subjects viewed small-group associations as ‘scams’ that undermine the purpose of the small-group law.”

More importantly, bona fide associations are often exempted from rating restrictions or given special leeway in rating. Exempt associations are sometimes allowed to set their rates according to the claims experience for the association as a whole, as if it were a large group, rather than rating each group using the insurer’s rate tables for the rest of the small-group market. In states with community rating,

this occurs only through special statutory or regulatory permission. Some regulators allow associations to use full experience rating, whereas others allow deviation from community rates only to the extent that associations can document administrative cost savings from group purchasing. In other states with more relaxed rating bands, leeway exists automatically without special permission or justification, because each association is treated as a separate bloc of business.

Impact of association exemptions. These rating allowances are intended to recognize the important role that associations have played in bringing affordable coverage to small businesses, and to allow them to benefit from their bargaining power and economies of scale without engaging in risk selection or excessive risk segmentation. For the most part, the association exemption has been successful in this regard. Most associations observed in this study are open to all forms of small businesses—what one subject called “air-breather” associations (anyone who breathes

air may join). Associations that are more restrictive appear to legitimately confine membership to existing professional and trade categories and do not engage in covert or strategic risk avoidance. Although associations have some ability to engage in risk selection by marketing more strongly to favored risk groups, so can insurers that sell in the regular market. Several insurers said that they are making less use of associations because of regulatory changes that limit the price advantage they are allowed to give to more select risks, which diminishes the incentive to use associations to engage in risk selection or segmentation.

However, in other respects, the association exemption has created difficulties for small-group reforms. In community-rating states where associations are allowed to experience-rate, they offer an attractive, cheaper option for younger, healthier small groups. For instance, in Vermont, which has nearly pure community rating for both individuals and small groups, experience-rated associations are a notable feature of the small-group market. There are fifteen to twenty large, prominent ones, some of which are restricted to particular trade or professional groups, but others of which are open to any employer. These associations account for more than 60 percent of small-group enrollment market-wide and more than 95 percent of Blue Cross's small-group enrollment, which is by far the largest small-group carrier. The portion of small-group business sold as community-rated plans is shrinking at such a rate that one subject described the small-group market as "disappearing" into associations. Two others said that the only people who continue to buy outside of associations are those who are "too befuddled" to have "figured it out yet."

Allowing associations to base their rates on the claims experience of enrolled members can result in large differentials between community rates and association rates. In New York association rates for individual (self-employed) coverage are 30 percent less than in the individual community-rated market. In Vermont community rates for some insurers are 30–50 percent higher than what they offer

through associations for the same products. However, some of the nonassociation insurers in Vermont offer community rates that are much lower than are association rates from other insurers. Also, in New York the association rates are equivalent to the small-group community rates. Therefore, it cannot be said that the association exception has completely undermined the community-rating laws in these states. In New York associations have allowed self-employed workers an entry into the group market they otherwise would not have. Also, in Vermont the association exception has allowed insurers such as Blue Cross, which otherwise are subject to stricter rating rules, to offer discounts commensurate with those permitted for commercial insurers in the open market. Still, published community rates in Vermont are essentially irrelevant for many small-group insurers since, for most of the significant insurers, the more competitive rates can be found only in associations.

Insurers' views. Views differ over whether this is a good market structure. One way to describe the result is that the small-group market in Vermont has been converted from one of community rating to one composed of large, experience-rated associations, which functions essentially like the large-group market. That is not what was intended by the law, but it does have the potential to aggregate purchasing power and therefore lower prices through economies of scale and increased bargaining power. Agents in New York said that associations offer the only affordable option for the self-employed, who are not covered by guaranteed issue in the small-group market and must purchase in the individual market at community rates that are much steeper because of adverse selection. Another advantage of associations is that they make it easier for new insurers to quickly gain a foothold in the market by bidding for an entire bloc of association business, which helps to justify the investment required to develop a managed care network.

Many interview subjects, however, viewed small-group associations in negative terms. Several described them as "scams" that under-

mine the purpose of the small-group law, fragment and destabilize the market, and allow insurers to compete by “cherry picking.” Because many small employers join associations primarily only to buy insurance, they are willing to switch associations frequently to achieve slightly lower rates. This can result in wild swings in both association membership and the rates for their health insurance plans. For instance, in Vermont the following cycle has occurred for several of the business associations: An association that begins with a small and more select membership finds that its lower insurance rates are a strong draw for new members (who pay association dues), and so the association uses its low insurance rates to advertise aggressively for even more members. As small employers flock to the association, its membership multiplies (as much as twenty-fold), but its risk pool becomes less select, and so the insurer imposes a steep (20–35 percent) premium increase. This causes a “melt-down” in which employers switch to smaller associations with better risk pools, and the tumultuous process repeats.

This is obviously not the market environment envisioned by reformers. Using experience-rated association pools to promote price competition makes for an unstable market because, unlike larger employer groups, there is nothing that binds individual members to the group. Moreover, price differences among associations are driven more by risk selection than by bargaining power or administrative savings. For the most part, small employers are careening from one association to another simply to find the best risk pool for the same type of coverage.

Reform laws attempt to keep this behavior in check by requiring associations to establish “bona fide” status before receiving favorable regulatory treatment. This requires showing prior existence and a noninsurance purpose. Prior existence can be satisfied easily by the vast number of trade and professional associa-

tions that do exist. Most of these existed originally for noninsurance purposes, but once insurers adopt them as a vehicle for selling insurance, the tail begins to wag the dog. We observed several instances in which associations’ membership grew exponentially once they began to offer discounted insurance in regulated markets. We were told repeatedly and with great assurance that for many of these so-called air-breather associations, the vast majority of members join only to obtain insurance. Nevertheless, regulators have approved these as bona fide associations because they offer some noninsurance benefits and have a stated purpose to pursue general trade or professional objectives.

Policy Implications

This paper aims to be descriptive, not prescriptive, but it

clearly has public policy significance. Understanding existing features of the private insurance market helps to predict the likely effects of proposed reforms and innovations. Although the complex tapestry of market boundaries and border-crossing techniques does not lend itself to quick understanding or easy resolution, some general, overarching observations are possible.

First, it is readily apparent that substantial regulatory and economic gradients exist among market segments and that many techniques have arisen to exploit these gradients. Second, existing structures and patterns should not be assumed to be fixed or immutable. The market is capable of rapid and large-scale movements, into and out of these arrangements. Whether this results in constructive or destructive market forces depends in large part on whether these techniques are focused on the economic rather than the regulatory features of market divisions and whether the latter are thought to be important, artificial, or ill-advised. Views on these issues will obviously differ, but it is possible to identify a few points for which there should be general consensus.

“It is naïve to think that market boundaries, like the Berlin Wall, can be torn down overnight.”

The economic features of these market segments spring from who makes the purchasing decision and who pays the premium. To a considerable extent, it is not possible to alter or replicate these economic realities. Large employer groups are stable and have low overhead costs, not simply because they are large but also because the employer selects and pays for the insurance. The assumption that large groups of individual purchasers can achieve the same economic advantages ignores how large employer groups differ in fundamental ways. Because individuals make separate purchasing decisions, the administrative costs of selling and servicing insurance will remain high, even in large associations. And because individuals select benefits according to their anticipated medical needs, adverse selection will always be a much greater problem in other market segments than it is for large employer groups. For these and other reasons, some differences in regulatory policy are essential, to reflect these economic realities. And, once regulatory policy has been established, care should be taken to avoid undermining it by accident.

On the other hand, much of the regulatory landscape is accidental, a result of history rather than logic. ERISA preemption is a primary case in point. So is the ad hoc and shifting mix of state versus federal oversight of small-group and individual markets. Regulators' attempts to achieve airtight divisions among market segments might likewise be criticized as artificial and excessively rigid, but to a considerable extent this is necessary, to make sense of the larger-scale regulatory framework. For instance, ERISA preemption of solvency regulation works well enough for large employers with assets to back up their pledge of employee benefits and expertise to choose adequate and reliable stop-loss reinsurance. But the same is not true for small employers or individuals, and so proposals to extend regulatory preemption to these market segments must include alternative solvency protections. For different reasons, it is difficult to extend guaranteed issue and community rating to the individual market. And,

similar points can be made about other types of regulations.

THESE REALITIES necessarily create regulatory gradients that cannot be eliminated without eliminating or reducing the very reforms that have improved different market segments. It is thus naïve to think that market boundaries, like the Berlin Wall, can be torn down overnight, or that, like the U.S./Canadian border, they can still function with multiple points for easy crossing. Because of the complex interconnections between regulatory and market institutions, altering or undoing any significant piece could cause major disruption. This makes it difficult to know in advance what effects will be produced by any one or combination of appealing reform ideas. However, this should not deter us from trying, for the insurance market is an organic and evolving system, not a finished work.

This research was funded by a grant from the Robert Wood Johnson Foundation, under its Changes in Health Care Financing and Organization Program. Elliot Wicks and Janice Lawlor participated in this research. Although the analysis and conclusions are solely my own and do not necessarily reflect the views of the foundation or these colleagues, I am deeply indebted to them for their support and assistance, which made this work possible.

NOTES

1. For description and analysis, see E. Wicks and J. Meyer, *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?* (Washington: National Coalition on Health Care, May 1999), available online at www.nchc.org/releases/stevesedit.html.
2. This research, its methods, and its other findings are described in more detail on the Web at www.phs.wfubmc.edu/insure. Briefly explained, seven states were selected for in-depth interviews with insurance industry sources about the impact of small-group and individual-market reforms enacted in the early 1990s. Selected states represent a broad range of regulatory and market environments. Interviews were conducted in two rounds, 1997 and 1998, and extensive quantitative data were collected about products, prices, and sales activity. Also, a market-testing study was conducted in which a small employer

- with three workers contacted eighteen agents in each state to inquire about the purchase of insurance for the group, as well as individual coverage for one worker with serious health problems.
3. M.S. Marquis and S.H. Long, "Recent Trends in Self-Insured Employer Health Plans," *Health Affairs* (May/June 1999): 161-166.
 4. The medical loss ratio is the percentage of premium paid out in claims. Because it can vary quite a lot among groups, insurers, or years, these figures, and those below, reflect rough industry averages over a course of years.
 5. The notable exception is the Health Insurance Portability and Accountability Act, but in the individual market it primarily requires insurers only to offer coverage to those leaving group coverage. Even then, it allows diversity among states about how to implement this protection, and it does not regulate rates.
 6. The NAIC—a private, nonprofit professional association of state insurance regulators—has proposed a large number of model laws that, while advisory, are often followed and so help to bring some consistency to state regulation.
 7. Of the forty-six states with small-group reforms, only seven require pure or nearly pure community rating. Six allow adjustment for age or sex, and thirty-three allow additional adjustments for individual health status or related factors.
 8. Note, however, that according to this description, the trust does not self-insure and so does not claim ERISA preemption. This additional technique is available, however, and is used by trusts with sponsors who are not insurers. In such cases, they constitute multiple-employer trusts (METs) or multiple-employer welfare agreements (MEWAs), discussed later.
 9. Kentucky Department of Insurance, *Market Report on Health Insurance* (Frankfort: Kentucky Department of Insurance, April 1997).
 10. R. Curtis et al., "Health Insurance Reform in the Small-Group Market," *Health Affairs* (May/June 1999): 151-160.
 11. 111 F.3d 358 (4th Cir. 1997).
 12. This is also confirmed by a quantitative study, Marquis and Long, "Recent Trends."
 13. There is some confusion in the use of this term between these billing arrangements for individual insurance versus for true group insurance. Under ordinary group insurance, employers sometimes are billed in a way that identifies the unique cost for each employee, based on demographic or health status factors, rather than being billed on a composite basis. The discussion here is not concerned with alternatives to composite billing under group insurance, however. Instead, it addresses the use of list billing as a means to sell individual, rather than group, insurance in the workplace.
 14. In 1997 approximately 500 associations accounted for \$6 billion in health insurance premiums and covered four million people. J. Connelly, "A Report on Association Member Health Plans," *Association Management* (March 1998): 73-90. In 1992 a General Accounting Office survey of state insurance regulators reported 1,034 group-purchasing arrangements classified as MEWAs, serving 2.6 million people. U.S. General Accounting Office, *Employee Benefits: MEWA Regulation*, Pub. no. GAO/HRD 92-40 (Washington: GAO, March 1992). Long and Marquis found in a 1997 nationwide employer survey that 26 percent of all employers, and 33 percent of employers with ten or fewer workers, use some type of pooled purchasing arrangement. S.H. Long and M.S. Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs* (July/Aug 1999): 105-111.
 15. Also significant are large employer purchasing groups that negotiate discounts and monitor plan performance. See H.H. Schaffler and T. Rodriguez, "Exercising Purchasing Power for Preventive Care," *Health Affairs* (Spring 1996): 73-85. However, these structures do not alter regulatory boundaries and so are not included in this discussion.
 16. See K. Polzer and J. Jones, "Multiple Employer Purchasing Groups (METs, MEWAs, HINs, HIPCes): The Challenge of Meshing ERISA Standards with Health Insurance Reform," Issue Brief no. 604 (Washington: National Health Policy Forum, September 1992); K. Polzer, "Preempting State Authority to Regulate Association Plans: Where Might It Take Us?" Issue Brief no. 707 (Washington: National Health Policy Forum, October 1997); A. Martin et al., "MEWAs: An Exception to ERISA Preemption: Why, What, and When" (Washington: American Law Institute—American Bar Association, February 1992); and C. Forrelli, R. Jones, and C. McHugh, "Regulation of Multiple Employer Welfare Arrangements: The Dilemma of Dual Federal/State Regulation," *FICC Quarterly* (Fall 1995): 45-63.
 17. See R. Tillman, *Broken Promises: Fraud by Small Business Health Insurers* (Boston: Northeastern University Press, 1998); F. Damon, "Multiple Employer Trusts: A Historical Perspective from ERISA to the California Approach," *Journal of Insurance Regulation* 2 (1983): 20-29; and GAO, *Employee Benefits: MEWA Regulation*.