



# Comments on Consumer Response to a National Marketplace For Individual Insurance

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# Are State Regulations Driving Uninsurance Rates?

- **McCarran Ferguson Act (1945)**

- Congress concluded that insurance would be regulated by states. Insurance companies have to adhere to state regulations such as mandated benefits, providers and coverage, guaranteed issue and community rating regulations, any willing provider laws

- **Regulations→high premiums→low demand for insurance**

- Problem is magnified because consumers are unable to buy insurance from outside their state

- **What would happen to insurance coverage if health insurance could be sold across state lines?**

- Political motivation:

- Health Care Choice Act would amend current law to allow interstate commerce in health insurance plans; Proposed Association Health Plans would allow small businesses to purchase group health insurance that is free of some forms of state health insurance regulation

- Economic Motivation:

- Opening up state markets would force prices of health insurance plans to be competitive and affordable, leading to more demand for health insurance

- **Estimate that uninsurance rates could drop by a lot**

- Alternative scenarios: Competition among regions, among all 50 states, among 5 largest states:69,445-16.9 million newly insured

## Snapshot of the Individual Market

- The paper clearly addresses an important issue:
  - There are nearly 47 million uninsured in the US
  - The uninsured are typically those who are unable to access the employer or group market, or are priced out of it
  - Focus on individual market which functions like a residual market
  - About 18 million people buy insurance in the individual market
  - High cost of health insurance major reason for uninsurance
  - Regulations mainly affect non-group or individual market since employer provided insurance is exempt from McCarran Ferguson under ERISA
  
- State Regulations have trade-offs
  - High prices
  - Adverse Selection
  
- Variation in premiums across states
  - Regulations
  - More specific to each individual



## Individual Market Premiums and Regulations by State, 2006-2007

<b>Single Coverage (Source: AHIP)</b>			
<b>Massachusetts (CR,GI,33 mandates)</b>	<b>\$8537</b>	<b>New Jersey (CR,GI,30)</b>	<b>\$5326</b>
<b>National Average</b>	<b>\$2613</b>	<b>New York (CR,GI,34)</b>	<b>\$4734</b>
<b>Michigan (GI,19)</b>	<b>\$1878</b>	<b>Wisconsin (21)</b>	<b>\$1254</b>

## Study Outline

- Literature Survey of the Individual Market
  - Obtain empirical estimates of the impact of regulations on premiums
- Obtain premium data adjusted by age, and sex
  - From Congdon et al.(2005)
  - Adjusted data for regulations
    - A person in State A pays \$10 for insurance. If he is able to buy in State B, then he has to pay \$10-effect of lower regulations in State B.
- Assign individuals in MEPS to certain states
- Allow for competition between states and regions
- Obtain estimates of take-up rates under different scenarios

## Studies Not Comparable....

<b>Paper</b>	<b>Premium Data</b>	<b>Time Period</b>	<b>Controls</b>
<b>Congdon et al. (2006)</b>	<b>State-level, 43 states, Ehealthinsurance, only high-deductible policies</b>	<b>Cross-section, 2003</b>	<b>Policy and purchaser characteristics</b>
<b>Henderson (2007)</b>	<b>City-level</b>	<b>Panel, 1994-2002</b>	<b>High risk pools, no policy characteristics</b>
<b>New (2005)</b>	<b>State-level, 37 states, different plans offered by 4 insurance companies</b>	<b>Cross-section, 2005</b>	<b>No controls for CR, GI. Direct access to specialist, liability laws</b>
<b>Hadley and Reschovsky (2003)</b>	<b>State-level, 35 states, CTS</b>	<b>Panel, 1999-2001</b>	<b>High Risk pool, limits on premium increases</b>



## Summary of Impact

	<b>Minimum</b>	<b>Maximum</b>
<b>GI</b>	<b>0</b>	<b>114%</b>
<b>CR</b>	<b>0</b>	<b>34.6%</b>
<b>Mandates (same paper)</b>	<b>(0.4%)</b>	<b>(0.9%)</b>
<b>AWP</b>	<b>1.5%</b>	<b>12%</b>

## ....Multiple Empirical Estimates: Pick One

- **Estimates vary a lot from specification to specification even within the same paper, depending upon which controls are included or excluded**
  - Congdon (2006): GI: 109.5%-118.6% (94-114%), CR:10.2%-17.1% (20%-27%),total mandates:0.26-0.74(0.4-0.9)
- **A change in estimates could have a big impact on the results**
  - 1.9 million-11.9 million
- **A better approach might be to pick one study that is comprehensive, includes the full-range of controls. Or choose estimates from studies that are comparable in terms of data, controls, methodology**
  - Panel regression or fixed effect estimates are always more reliable since they control for state unobservables. Not really a range of estimates when one study uses cross-section data and another panel data
  - Cross-section data: regulation variables might be correlated with other state-level variables
- **Incorrect to interpret results for mandates as “each additional mandate increases premiums 0.4-0.9%”**
  - Fixed Effects versus OLS: when using OLS one can determine how the existence of a mandate affects premiums. When using fixed effects one can examine how *adding* a mandate to the regulatory mix affects premiums

## Premium Data Not Standardized

- Premium data is not comparable across states
  - “These premiums were first adjusted by age and sex to reflect standard actuarial differences in health care costs, and then they were adjusted by the effects of regulations”
    - Other characteristics also need to be controlled for. For instance, premiums could vary because of race, health status, smoker, occupation, characteristics of the policy (high deductible), cost of health care provision. Only after controlling for these, can we say that the rest is the effect of regulations
- Is coverage standardized as well?

## State Imputations

- **Since MEPS does not provide state identifiers, the sample selected for analysis had to be assigned to specific states through an imputation process.**
  - Four demographic characteristics of the state samples from ACS were used to do this imputation: age, income, sex and race. While this does match up the socio-economic characteristics of the state, there are several important variables relevant for insurance take-up rates that could have been used to do the imputation as well.
  - Reported health status or smoking habits, insurance coverage, small firm employment, union membership, education etc. These data are available from MEPS and use of these would create a better match between the state population and the MEPS sample. The paper should report how the matched sample does with respect to these criteria.
  
- **What are the insurance rates derived for each state once the state simulations are done. How different are they from those derived from other estimates?**

## Take-up rates: Supply...

- **Assumes that as regulations are lessened, premium prices fall, quantity demanded goes up, and coverage rates go up**
- **Regulations have benefits as well: mandates increase treatment options, provide flexibility in choosing a provider, guaranteed issue and renewal and community rating ensure that insurance coverage is made available even to the high-risk patients**
- **A loosening of these restrictions could have different effects depending on the impact of the change on availability of coverage**
  - If the cheapest policies were available in states with no CR or GI, would high-risk people be able to purchase these policies?
  - If there were no mandates, what sort of coverage would be provided?
  - Very likely that a few less regulated states would cover the healthiest people, while the other states would be left to cover the sick. What would be the impact on state insurance companies under this scenario? What would be the effect on coverage?

## ....and Demand

- Even if prices fall, demand may not increase
  - Individual buyers more price sensitive since they have to pay the full cost of their coverage as opposed to employees, where more than 70 percent of the premium is paid by the employer
  - Some uninsured individuals do not consider health insurance a good buy. This is evidenced by the fact that families who can apparently afford health coverage choose to forgo coverage. Of the estimated 47 million uninsured, about 16 million live in households with annual income greater than \$50,000 (half earn more than \$75,000 yearly).
  - Take-up rates in the small group market are often low since there is a tradeoff between wages and health benefits

## Other Issues

- The premiums are adjusted for state regulations by subtracting the effect of having the state regulation on premiums. It is unclear whether the effect is linear or not. For instance, every time a mandate is dropped, does the premium change by 0.4-0.9% or does the premium change non-linearly? Also, several papers have shown that the effect of individual mandates such as drug abuse and mental mandates is much stronger than even the total count of mandates. How would this affect the calculations?
- It would also be interesting to model something more dynamic, where in the long-run, competition among state legislatures could actually lead to fewer regulations

## Alternative Approach

- Analysis of Variance (ANOVA)
- Regression of Annual Premiums on state regulations, as well as state-level factors
- How much of the explained premium variation is due to state regulations?
- Sample Regression: CTS:1996-2003(individual or state-level)
  - About 12 percent of overall variation is due to regulations such as mandates (five costly), CR, GI.
  - Control for state health characteristics, per capita income, unemployment rate, small firm employment, medicare expenditures
- Limited variation in state regulations over time

## Conclusion

- Useful model and framework
  - A national market could indeed increase competition, lower prices and lead to more coverage
  
- Suggestions
  - Original empirical estimates
  - Adjust premium data to reflect policy and policyholder characteristics to some extent across states
  - Experiment with alternative methods: ANOVA